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Notices of Rulemaking and Proposed Rules

ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT
OIL CONSERVATION COMMISSION

NOTICE OF PUBLIC MEETING AND PUBLIC HEARING

The State of New Mexico through its Oil Conservation Commission (Commission) hereby gives notice of the following special meeting and public hearing to be held commencing at 9:00 a.m. on May 24**,** 2018, in Porter Hall, 1st floor, Wendell Chino Building, 1220 South St. Francis Drive, Santa Fe, New Mexico, before the Oil Conservation Commission. A preliminary agenda for the meeting will be available to the public no later than two weeks prior to the meeting. A final agenda will be available no later than 72 hours preceding the meeting. At the meeting, a public hearing will be held on the following case.

Case No. 16078: **IN THE MATTER OF PROPOSED AMENDMENTS TO THE COMMISSION'S RULES ON FINANCIAL ASSURANCE AND PLUGGING AND ABANDONMENT OF WELLS, 19.15.2, 19.15.8, AND 19.15.25 NMAC**

The New Mexico Oil Conservation Division (OCD) proposes to amend 19.15.2, 19.15.8, and 19.15.25 NMAC to make changes concerning financial assurance and plugging and abandonment of wells and related matters. The proposed rule changes include:

19.15.2.7 NMAC. OCD proposes to amend 19.15.2.7 NMAC to add definitions of terms used in financial assurance provisions.

19.15.8 NMAC. OCD proposes to amend 19.15.8.9 NMAC to provide for the increase in blanket bond amounts authorized by the Legislature and to change the amount of single well bonds to conform to statutory requirements.

19.15.25 NMAC. OCD proposes to amend 19.15.25 NMAC to coordinate approved temporary abandonment with financial assurance requirements and to limit the use of approved temporary abandonment.

Purpose of Proposed Rule. The proposed changes will further the goals of the Oil and Gas Act to require proper plugging inactive wells and to protect natural resources by providing for financial assurance that more accurately reflects the actual cost of well plugging, by implementing the changes promulgated by the 2018 Legislature, and by limiting the overuse of approved temporary abandonment.

Legal Authority. These amendments are authorized by the Oil and Gas Act, NMSA 1978, Sections 70-2-1 through 70-2-38, and specifically Section 70-2-11 (which authorizes the adoption of rules to carry out the purposes of the Act and to prevent waste), Section 70-2-12(B)(1) (which authorizes the adoption of rules on plugging and financial assurance), and Section 70-2-14 (which requires the agency to establish categories of financial assurance). The rulemaking proceeding will be governed by the Commission's rule on rulemaking, 19.15.3 NMAC.

The full text of the proposed rule amendments is available from Commission Clerk, Florene Davidson at (505) 476-3458 or can be viewed on the Rules page at the Oil Conservation Division's website at http://www.emnrd.state.nm.us/ocd, or at Oil Conservation Division offices in Santa Fe, Hobbs, Artesia, or Aztec.

Public Hearing and Comment. The Commission will hold a **public hearing** on the proposed rules at the Commission meeting which will commence at 9:00 A.M. on May 24, 2018, in Porter Hall, 1st Floor, Wendell Chino Building, 1220 South St. Francis Drive, Santa Fe, New Mexico. The hearing may be continued to following days if not completed.

Written or electronic comments on the proposed rule may be hand delivered or mailed to the Commission Clerk, Florene Davidson, 3d floor, 1220 South St. Francis Drive, Santa Fe, NM 87505, or e-mailed to florene.davidson@state.nm.us. All written or electronic comments must be received by the Commission Clerk no later than 9:00 A.M. on May 24, 2018, unless the Commission or the Commission Chair extends this deadline.

Persons intending to submit proposed modifications to the proposed rule amendments, to present technical testimony at the hearing, or to cross-examine witnesses must file six copies of a Pre-hearing Statement conforming to the requirements of Subsection B of 19.15.3.11 NMAC, no later than 5:00 P.M. on May 10, 2018. Pre-hearing Statements must be hand-delivered, mailed, or e-mailed to the Commission Clerk at the above address.

Any person who has not submitted a pre-hearing statement may present non-technical testimony or make an unsworn statement at the hearing. A person may also offer exhibits with the testimony so long as the exhibits are relevant to the proposed rule changes and do not unduly repeat the testimony. Any person who wishes to present non-technical testimony should indicate his or her intent on a sign-in sheet at the hearing. A person who testifies at the hearing is subject to cross-examination by the commissioners, commission counsel, or a party on the subject matter of the person's direct testimony.

If you are an individual with a disability who needs 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 Ms. Davidson at (505) 476-3458 or through the New

Mexico Relay Network at 1-800-659-1779 by May 10, 2018. Public documents can be provided in various accessible forms. Please contact Ms. Davidson if a summary or other type of accessible form is needed. A party who plans to use projection equipment at a hearing must contact Ms. Davidson seven business days prior to the hearing requesting the use of the projection equipment. Wireless internet is available; however, the person requesting to use the wireless connection must provide a laptop computer.

Technical Information that served as a basis for the proposed rule includes: OCD Well Plugging Costs FY2014-FY2018 (spreadsheet)

These materials can be viewed on the Rules page at the Oil Conservation Division's website at http://www.emnrd.state.nm.us/ocd.

ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT
OIL CONSERVATION COMMISSION

NOTICE OF PROPOSED RULEMAKING

The New Mexico Oil Conservation Commission (Commission) hereby gives notice of the following proposed rulemaking (Case No. 15959).

The Commission proposes to repeal and replace its rule, 19.15.29 NMAC, for releases of oil, gases, produced water, condensate, or other oil field waste. The proposed rule amends the definition of major release, adds a definition for "responsible party", amends the current requirements for release notification, and adds the following new sections:

19.15.29.9 NMAC – Release Notification and Reporting Requirements

19.15.29.10 NMAC – Initial Response

19.15.29.11 NMAC – Site Assessment/Characterization

19.15.29.12 NMAC – Remediation and Closure

19.15.29.13 NMAC – Restoration, Reclamation, and Re-Vegetation

19.15.29.14 NMAC – Variances

19.15.29.15 NMAC – Enforcement

19.15.29.16 NMAC – Transitional Provisions

Purpose of Proposed Rule. The proposed changes establish requirements and processes for initial response to releases, site assessment/characterization of releases, remediation and closure of sites where releases have occurred; restoration, reclamation, and re-vegetation of sites whether releases have been remediated; requesting variances, and enforcement.

Legal Authority. These amendments are authorized by the Oil and Gas Act, NMSA 1978, Sections 70-2-1 through 70-2-38, and specifically Section 70-2-11(A), (which authorizes the adoption of rules to carry out the purposes of the Act), Section 70-2-12(B)(21) (which authorizes the Commission to adopt rules to regulate the disposition of nondomestic wastes resulting from the exploration, development, production, or storage of crude oil or natural gas to protect public health and the environment), and Section 70-2-12(B)(22) (which authorizes the Commission to regulate the disposition of nondomestic wastes resulting from the oil field service industry, the transportation of crude oil or natural gas, the treatment of natural gas or the refinement of crude oil to protect public health and the environment). The rulemaking proceeding will be governed by the Commission's rule on rulemaking, 19.15.3 NMAC.

The full text of the proposed rule amendments is available from Commission Clerk, Florene Davidson at (505) 476-3458 or can be viewed on the Rules page at the Oil Conservation Division's website at http://www.emnrd.state.nm.us/ocd, or at Oil Conservation Division offices in Santa Fe, Hobbs, Artesia, or Aztec.

Public Hearing and Comment. The Commission will hold a **public hearing** on the proposed rules at the Commission meeting which will commence at 9:00 A.M. on June 5, 2018, in Porter Hall, 1st Floor, Wendell Chino Building, 1220 South St. Francis Drive, Santa Fe, New Mexico.

Written or electronic comments on the proposed rule may be hand delivered or mailed to the Commission Clerk, Florene Davidson, 3rd floor, 1220 South St. Francis Drive, Santa Fe, NM 87505, or e-mailed to florene.davidson@state.nm.us. All written or electronic comment must be received by the Commission Clerk no later than 9:00 A.M. on June 5, 2018 (the date of the scheduled hearing), unless the Commission or the Commission Chair extends this deadline.

Persons intending to submit proposed modifications to the proposed rule amendments, to present technical testimony at the hearing, or to cross-examine witnesses must file six copies of a Pre-hearing Statement conforming to the requirements of Subsection B of 19.15.3.11 NMAC, no later than 5:00 P.M. on May 22, 2018 (10 business days prior to the scheduled date of the hearing). Pre-hearing Statements must be hand-delivered, mailed, or e-mailed to the Commission Clerk at the above address.

Any person who has not submitted a pre-hearing statement may present non-technical testimony or make an unsworn statement at the hearing. A person may also offer exhibits with the testimony so long as the exhibits are relevant to the proposed rule changes and do not unduly repeat the testimony. Any person who wishes to present non-technical testimony should indicate his or her intent on a sign-in sheet at the hearing. A person who testifies at the hearing is subject to cross-examination by the

commissioners, commission counsel or a party on the subject matter of the person's direct testimony.

If you are an individual with a disability who needs 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 Ms. Davidson at (505) 476-3458 or through the New Mexico Relay Network at 1-800-659-1779 by May 29, 2018. Public documents can be provided in various accessible forms. Please contact Ms. Davidson if a summary or other type of accessible form is needed. A party who plans to use projection equipment at a hearing must contact Ms. Davidson seven business days prior to the hearing requesting the use of the projection equipment. Wireless internet is available; however, the person requesting to use the wireless connection must provide a laptop computer.

Technical information that served as a basis for the proposed rule includes NRCS Field Guide, EPA SW-846, ASTM Method 4547, and EPA 600.

These materials except for ASTM Method 4547 can be viewed on the Rules page at the Oil Conservation Division's website at http://www.emnrd.state.nm.us/ocd. ASTM Method 4547 can be viewed at the OCD's Santa Fe Office at 1220 South St. Francis Dr., Santa Fe, NM 87505.

HEALTH, DEPARTMENT OF

NOTICE OF PUBLIC HEARING

The New Mexico Department of Health will hold a public hearing on the adoption of a new rule, 7.30.13 NMAC, "Crisis Triage Centers". The hearing will be held on May 30, 2018 at 9:00 a.m. in the auditorium of the Harold Runnels Building, located at 1190 St. Francis Drive in Santa Fe, New Mexico.

A Crisis Triage Center (CTC) provides stabilization of behavioral health crises and may include outpatient stabilization and short-term residential stabilization in a residential rather than institutional setting. The CTC provides emergency behavioral health triage, evaluation, and admission 24 hours a day, 7 days a week on a voluntary basis. The CTC may serve individuals 14 years of age or older who meet admission criteria. The CTC offers services to manage individuals at high risk of suicide or intentional self-harm and may offer drug and alcohol detox services**.**

The legal authority authorizing the proposed rule and the adoption of the rule by the Department is at Subsection E of Section 9-7-6, Subsections B and D of Section 24-1-2, Subsection J of Section 24-1-3 and Section 24-1-5 NMSA 1978.

A free copy of the full text of the proposed rule can be obtained from the Department's website at https://nmhealth.org/publication/regulation/

This hearing will be conducted to receive public comment regarding the proposed adoption of a new rule 7.30.13 NMAC. Any interested member of the public may attend the hearing offer public comment on the proposed new rule during the hearing. Written public comments may be submitted prior to the date of the hearing. Please submit any written comments regarding the proposed rule to the attention of:

Christopher Burmeister
District Manager, Division of Health Improvement
New Mexico Department of Health
2040 S. Pacheco,
Santa Fe, NM 87505
Christopher.Burmeis@state.nm.us

All written comments must be received by 5pm on May 24, 2018.

If you are an individual with a disability who is in need of special assistance or accommodations to attend or participate in the hearing, please contact Samantha Baca by telephone at (505) 827-2997. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

NOTICE OF RULEMAKING

The Human Services Department (the Department), through the Medical Assistance Division (MAD), is proposing to amend the New Mexico Administrative Code (NMAC) rule *8.200.410-General Recipient Requirements*. The Department is re-promulgating this section of the rule in full within six months of issuance of the emergency rule (Volume 40 Register 27) in accordance with the New Mexico State Rules Act.

Section 9-8-6 NMSA 1978, authorizes the Department Secretary to promulgate rules and regulations that may be necessary to carry out the duties of the Department and its divisions.

Notice Date: April 24, 2018
Hearing Date: May 24, 2018
Adoption Date: Proposed as July 1, 2018
Technical Citations: 42 CFR 435.4, 435.406, 435.956, 8 USC Section 1641

SUMMARY OF REVISIONS:

Paragraph (4) of Subsection A of 8.200.410.11 NMAC

The Department is deleting language that covers non-citizens permanently residing in the United States under color of law (PRUCOL) because the Department is aligning its rules for Medicaid eligibility to mirror the federal structure for eligibility. For individuals who entered the United States prior to August 22, 1996, it is unnecessary to look at whether their immigration standard met PRUCOL.

PRUCOL immigration standards were no longer in effect under federal law, after the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) was enacted on August 22, 1996.

Subparagraph (l) of Paragraph (1) of Subsection B of 8.200.410.11 NMAC

Language was added to state that the Department covers battered non-citizens under state general funds until the five year bar is met.

Subparagraph (h) of Paragraph (3) of Subsection B of 8.200.410.11 NMAC

Language was deleted to exclude non-citizens who are lawfully present in the Commonwealth of the Northern Mariana Islands. Federal rulemaking removes the language related to individuals who are lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. 1806(e) from the definition of lawfully present at 42 CFR 435.4. Most of these individuals will continue to be covered under the definition of lawfully present in other categories.

This proposed rule will be contained in 8.200.410 NMAC. This register and the proposed rule are available on the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/registers.aspx and http://www.hsd.state.nm.us/public-notices-proposed-rule-and-waiver-changes-and-opportunities-to-comment.aspx. If you do not have internet access, a copy of the proposed register and rule may be requested by contacting MAD at 505-827-6252.

The Department proposes to implement this rule effective July 1, 2018. A public hearing to receive testimony on this proposed rule will be held in Hearing Room 1, Toney Anaya Building, Santa Fe, New Mexico on Thursday, May 24, 2018 from 9:30 a.m. to 10:30 a.m., Mountain Daylight Time (MDT).

Interested parties may submit written comments directly to: Human Services Department, Office of the Secretary, ATT: Medical Assistance Division Public Comments, P.O. Box 2348, Santa Fe, New Mexico 87504-2348.

Recorded comments may be left by calling (505) 827-1337. Electronic comments may be submitted to madrules@state.nm.us. Written, electronic and recorded comments will be given the same consideration as oral testimony made at the public hearing. All comments must be received no later than 5:00 p.m. MDT, May 24, 2018.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact MAD in Santa Fe at 505-827-6252. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the MAD upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

REGULATION AND LICENSING DEPARTMENT
ANIMAL SHELTERING BOARD

PUBLIC RULE HEARING AND REGULAR BOARD MEETING

The New Mexico Animal Sheltering Board will hold a rule hearing on Thursday, May 24, 2018 at 9:00 a.m., and following the rule hearing will convene a board meeting to adopt rules and take care of regular business. The rule hearing and board meeting will be held at the New Mexico Regulation and Licensing Department, 2550 Cerrillos Road, Santa Fe, New Mexico, in Hearing Room 2.

House Bill 219, passed by the New Mexico State Legislature in 2017, assimilated the Animal Sheltering Board into the New Mexico Board of Veterinary Medicine, effective July 1, 2018.

Pursuant to its authority in Section 77-1B-1 NMSA 1978, the Animal Sheltering Board is proposing to repeal the Animal Sheltering rules listed below.

16.24.1 NMAC – General Provisions;
16.24.2 NMAC – Licensure and Certification;
16.24.3 NMAC – Duties of Licensees and Certificate Holders;
16.24.4 NMAC – Complaints, Enforcement and Disciplinary Action;
16.24.5 NMAC – Fees and
16.24.6 NMAC – Formulary for Euthanasia Technicians.

To obtain and review copies of the current rules you may go to the Animal Sheltering Board's website: http://www.rld.state.nm.us/boards/Animal-Sheltering_Services.aspx or contact Martha Gallegos with the Boards and Commissions Division at 505-476-4622. To obtain and review copies of the proposed rule changes you may go to the New Mexico Board of Veterinary Medicine's website: www.nmbvm.org.

The Board is currently accepting public comments on the proposed amendments. Please submit written comments on the proposed changes to Martha Gallegos, via electronic mail at animal.sheltering@state.nm.us or by regular mail to P.O. Box 25101, Santa Fe, NM 87504. Persons wishing to present their written comments at the rule hearing will need to provide 6 copies for distribution to the Board members and staff.

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 Martha Gallegos at 505-476-4622.

End of Notices of Rulemaking and Proposed Rules

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Adopted Rules

Effective Date and Validity of Rule Filings

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

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

The Human Services Department reviewed at its 11/20/2017 hearing, to repeal its rule 8.302.3 NMAC, Medicaid General Provider Policies, Third Party Liability Provider Responsibilities (filed 4/16/2004) and replace it with 8.302.3 NMAC, Medicaid General Provider Policies, Third Party Liability Provider Responsibilities, adopted 04/06/2018 and effective 05/01/2018.

The Human Services Department reviewed at its 11/20/2017 hearing, to repeal its rule 8.308.2 NMAC, Managed Care Program, Provider Network (filed 12/17/2013) and replace it with 8.308.2 NMAC, Managed Care Program, Provider Network, adopted 04/11/2018 and effective 05/01/2018.

The Human Services Department reviewed at its 11/20/2017 hearing, to repeal its rule 8.308.6 NMAC, Managed Care Program, Eligibility (filed 12/17/2013) and replace it with 8.308.6 NMAC, Managed Care Program, Eligibility, adopted 04/11/2018 and effective 05/01/2018.

The Human Services Department reviewed at its 11/20/2017 hearing, to repeal its rule 8.308.7 NMAC, Managed Care Program, Enrollment and Disenrollment (filed 12/17/2013) and replace it with 8.308.7 NMAC, Managed Care Program, Enrollment and Disenrollment, adopted 04/11/2018 and effective 05/01/2018.

The Human Services Department reviewed at its 11/20/2017 hearing, to repeal its rule 8.308.8 NMAC, Managed Care Program, Member Education (filed 1/01/2014) and replace it with 8.308.8 NMAC, Managed Care Program, Member Rights, Responsibilities and Education, adopted 04/11/2018 and effective 05/01/2018.

The Human Services Department reviewed at its 11/20/2017 hearing, to repeal its rule 8.308.9 NMAC, Managed Care Program, Benefit Package (filed 12/13/2017) and replace it with 8.308.9 NMAC, Managed Care Program, Benefit Package, adopted 04/11/2018 and effective 05/01/2018.

The Human Services Department reviewed at its 11/20/2017 hearing, to repeal its rule 8.308.10 NMAC, Managed Care Program, Care Coordination (filed 12/17/2013) and replace it with 8.308.10 NMAC, Managed Care Program, Care Coordination, adopted 04/11/2018 and effective 05/01/2018.

The Human Services Department reviewed at its 11/20/2017 hearing, to repeal its rule 8.308.11 NMAC, Managed Care Program, Transition of Care (filed 12/17/2013) and replace it with 8.308.11 NMAC, Managed Care Program, Transition of Care, adopted 04/11/2018 and effective 05/01/2018.

The Human Services Department reviewed at its 11/20/2017 hearing, to repeal its rule 8.308.15 NMAC, Managed Care Program, Grievances and Appeals (filed 5/27/2014) and replace it with 8.308.15 NMAC, Managed Care Program, Grievances and Appeals, adopted 04/11/2018 and effective 05/01/2018.

The Human Services Department reviewed at its 11/20/2017 hearing, to repeal its rule 8.308.21 NMAC, Managed Care Program, Quality Management (filed 12/17/2013) and replace it with 8.308.21 NMAC, Managed Care Program, Quality Management, adopted 04/11/2018 and effective 05/01/2018.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 3 THIRD PARTY LIABILITY PROVIDER RESPONSIBILITIES

8.302.3.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.302.3.1 NMAC - Rp, 8.302.3.1 NMAC, 5/1/2018]

8.302.3.2 SCOPE: The rule applies to the general public.
[8.302.3.2 NMAC - Rp, 8.302.3.2 NMAC, 5/1/2018]

8.302.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by state statute. See Section 27-2-12 et seq., NMSA 1978.
[8.302.3.3 NMAC - Rp, 8.302.3.3 NMAC, 5/1/2018]

8.302.3.4 DURATION: Permanent.
[8.302.3.4 NMAC - Rp, 8.302.3.4 NMAC, 5/1/2018]

8.302.3.5 EFFECTIVE DATE: May 1, 2018 unless a later date is cited at the end of a section.
[8.302.3.5 NMAC - Rp, 8.302.3.5 NMAC, 5/1/2018]

8.302.3.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medicaid programs.
[8.302.3.6 NMAC - Rp, 8.302.3.6 NMAC, 5/1/2018]

8.302.3.7 DEFINITIONS: [**RESERVED**]

8.302.3.8 [RESERVED]
[8.302.3.8 NMAC - Rp, 8.302.3.8 NMAC, 5/1/2018]

8.302.3.9 THIRD PARTY LIABILITY PROVIDER RESPONSIBILITIES: The New Mexico medical assistance program (medicaid) is the payer of last resort. When resources are available from third parties, HSD administers a specific program to ensure that these resources are used to pay for the medical services furnished to eligible recipients. See 42 CFR Section 433 Subpart D - Third Party Liability and Subsection A of Section 27-2-23 NMSA 1978. This part provides an overview of this program, the collection process, and the responsibilities of providers, insurers, and the department. These provisions apply to the medical assistance program payments and to payments made on behalf of members by HSD contracted medicaid managed care organizations (MCOs).
[8.302.3.9 NMAC - Rp, 8.302.3.9 NMAC, 5/1/2018]

8.302.3.10 PAYMENT PROVISIONS: For claims for recipients with medical coverage furnished by a third party, such as an insurer or other third party who may be liable for the medical bill, medicaid limits payment for the claim to the medicaid allowed amount less the third party payment amount, not to exceed the co-payment, co-insurance, deductible or other patient responsibility amount calculated by the third party when the reimbursement methodology is similar to the methodology used to calculate a medicaid payment, as determined by medical assistance division (MAD). If the third party payment amount exceeds the medicaid allowed amount, the medicaid program makes no further payment. The claim is considered paid in full. The provider may not collect any remaining portion of the unpaid co-payment, co-insurance, or deductible from the client. If a hospital is reimbursed under the diagnostic related group (DRG) reimbursement methodology and receives payments from third party insurers, medicaid pays the hospital the difference between the amount received from the third party and the lower of the hospital billed amount or the medicaid allowed DRG amount.

A. Payment acceptance: When providers furnish medical services to eligible recipients who have health coverage or coverage from liable third parties, providers must not seek payment from the recipient.

B. Sanctions for seeking recipient payments: Sanctions are imposed if providers seek payment for services from recipients after receiving payments for these services from the eligible recipient's health insurance company or other third parties. An amount equal to three times the amount sought from eligible recipients is deducted from providers' next medicaid payment. See 42 CFR Section 447.21.

C. Refunds to MAD after receipt of payment: A provider must immediately refund the lower of the third party or medicaid payment, if he or she receives payment from insurance companies or health plans for services already paid for by medicaid.

D. Provider discounts: MAD does not pay the difference between the payment received from the third party, based on the discount agreement and the actual charges for services, when providers enter into agreements with third party payers to accept payment at less than actual charges.

(1) The provider acceptance of less than actual charges constitutes receipt of a full payment for services and neither medicaid nor eligible recipients have a further legal obligation for payment.

(2) Provider discount arrangements are often referred to as "preferred provider agreements" or "preferred patient care agreements".
[8.302.3.10 NMAC - Rp, 8.302.3.10 NMAC, 5/1/2018]

8.302.3.11 SUBROGATION RIGHTS: When MAD makes payments on behalf of eligible recipients, HSD is subrogated to the eligible recipient's right against a third party for recovery of medical expenses to the extent of the payment. See Subsection B of Section 27-2-23 NMSA 1978 (Repl. Pamp. 1991). If the eligible recipient is enrolled in the medicaid managed care program, the extent of the payment is the amount actually expended on the provision of care as documented by encounter data and not the capitation amount paid by MAD to the medicaid managed care contractor. All referrals indicating the existence of a third party medical resource are verified by MAD or its contractors. After verification, indicators are placed in the MAD claims processing contractor's eligibility file for use in claims processing.
[8.302.3.11 NMAC - Rp, 8.302.3.11 NMAC, 5/1/2018]

8.302.3.12 PROCESS USED IF THIRD PARTY LIABILITY IDENTIFIED:

A. Pay and chase process: When medicaid or a managed care organization (MCO) pays a claim before learning of the existence of health insurance coverage, or before liability has been established, MAD or its contractors seek reimbursement, up to the amount paid. See 42 CFR Section 433.139. This process is referred to as "pay and chase".

B. Prior to paying a

claim, the probable liability for the claim to be paid or partially paid by a third party must be determined by MAD for the medicaid fee-for-service program or MCOs for members enrolled in managed care. Probable liability includes determining if the eligible recipient or member has other primary insurance, the type of insurance, and if that insurance resource would likely include the coverage of the specific item or service being billed by a provider. It also includes the potential for coverage from casualty or tort case settlements.

C. If MAD, or the MCO following the instructions from MAD, has established the probable existence of third party liability at the time the claim is filed, and the probability that the claim services will be covered by the primary insurance, the claim must be cost avoided, which means the claim must be rejected or otherwise denied and the provider informed of the probable coverage of the claim by another insurance resource and the identity of that other insurance resource, subject to the following conditions.

(1) The claim may not be denied by MAD or a MCO due to probable third party liability from an insurance resource or a potential casualty or tort claim settlement when any of the following conditions apply. Rather, the claim must be paid by MAD, or the MCO if the eligible recipient is a member of a MCO, at the full amount allowed for the claim. MAD or the MCO must then seek reimbursement directly from the liable third party as "pay and chase" or as a party to the settlement of a casualty or tort claim.

(a) When the claim is for labor and delivery or postpartum care. However, the claims for the inpatient hospital stay for labor and delivery and postpartum care must be cost-avoided.

(b) When the third party liability is derived from an absent parent whose obligation to pay support is being enforced by the state title IV-D agency.

(c) When the claim is for prenatal care for pregnant women, or preventive services for children including early and periodic screening, diagnosis and treatment services.

(d) When the third party liability is in the form of a potential or determined tort or casualty recovery and the extent of any liability is undetermined and not likely to be determined within 120 calendar days of the date of service on the claim.

(e) When the probable liability cannot be established or information on the benefits likely to be available under the third party resource are not available at the time claim is filed; or if third party benefits information is not available to pay the eligible recipient or member's medical expenses at the time the claim is filed.

(2) The claim may not be denied by MAD or a MCO due to probable third party liability (including medicare coverage) when the item or service or services by the type of provider are generally not covered by the third party as determined by MAD.

D. The establishment of third party liability takes place when MAD or the MCO receives confirmation from the provider or a third party resource indicating the extent of the third party liability.

[8.302.3.12 NMAC - Rp, 8.302.3.12 NMAC, 5/1/2018]

8.302.3.13 INSURANCE COVERAGE AND HEALTH MAINTENANCE ORGANIZATIONS AND OTHER INSURANCE PLANS: Providers must not refuse to furnish services to eligible recipients solely because an insurance company or third party may be liable for payment. See 42 CFR Section 447.20(b). When providers are aware of the existence of health insurance or health plan coverage for eligible recipients, the providers must seek payment from the insurance carrier before seeking payment from medicaid. Providers who do not participate in a specific health maintenance organization (HMO) or managed care plan (plan) are not required to furnish services to an eligible recipient who has primary coverage with such HMO or plan. The provider should refer the eligible recipient to a provider who participates in the eligible recipient's HMO or plan.

A. Eligible recipients with insurance coverage through a HMO or other insurance plan: When a medicaid eligible recipient belongs to a HMO or other insurance plan, the medicaid program limits the medicaid allowed amount less the third party payment amount, not to exceed the co-payment, deductible, co-insurance, and other patient responsibility amounts calculated by the HMO or other insurance plan. If the third party payment amount exceeds the medicaid allowed amount, the medicaid program makes no further payment and the claim is considered paid in full. The provider may not collect any portion of the unpaid co-payment, co-insurance, or deductible, or other patient responsibility from the eligible recipient. All other HMO requirements, including servicing provider restrictions, apply to the provision of services.

B. Eligible recipients covered by a HMO or other insurance plan are responsible for payment for medical services obtained outside the other plan without complying with the rules or policies of the HMO or other insurance plan.

[8.302.3.13 NMAC - Rp, 8.302.3.13 NMAC, 5/1/2018]

8.302.3.14 PROVIDER LIENS ON PERSONAL INJURY AWARDS:

A. Hospital liens: Hospitals are prohibited from imposing liens on potential lawsuit recoveries for the difference between the MAD payment and hospital billed amounts. MAD payment amounts are payment in full.

(1) Hospitals furnishing services to eligible recipients who have been injured in

accidents may choose to file claims with MAD or forego medicaid reimbursement and file hospital liens against any potential lawsuit recoveries.

(2) If hospitals choose to bill medicaid, they must file claims within 120 calendar days of the date of discharge.

(3) If hospitals choose to impose a lien, they cannot bill eligible recipients or medicaid for any unpaid balance remaining after future settlement or lack of settlement.

(4) If hospitals file claims with MAD, the amounts received are payment in full.

B. Non-hospital providers: For non-hospital providers, medicaid payments are payment in full for medical services furnished to eligible recipients injured in accidents caused by other parties. Providers may not seek additional payment for these services from eligible recipients, even if eligible recipients later receive monetary awards or settlements from liable parties.

[8.302.3.14 NMAC - Rp, 8.302.3.14 NMAC, 5/1/2018]

8.302.3.15 NOTIFICATION REQUIREMENTS: Providers must notify MAD or its appropriate contractor any time they are contacted by an attorney or another interested party who requests information relating to services furnished to eligible recipients, including information on amounts billed or paid, procedures performed or medical records. If an inquiry is received, providers must report to MAD or its appropriate contractor the name and address of the party requesting the information; the name and identification number of the eligible recipient and dates on which services were furnished.

[8.302.3.15 NMAC - Rp, 8.302.3.15 NMAC, 5/1/2018]

8.302.3.16 CANCELLATION OF INSURANCE: Providers must not advise or recommend that eligible recipients cancel their health coverage. Failure to comply with this provision is grounds for termination of the provider agreement.

[8.302.3.16 NMAC - Rp, 8.302.3.16 NMAC, 5/1/2018]

8.302.3.17 MAD RESPONSIBILITIES:

A. MAD has the following responsibilities in administering the TPL program:

(1) determining the legal liability of third parties, including health insurers, in paying for the medical services furnished to eligible recipients 42 CFR 433.138(a);

(2) pursuing claims and recovery against third parties when the amount of the third party payment that HSD can reasonably expect to recover exceeds the cost of the recovery; and

(3) pays to the extent that the medicaid allowed amount exceeds the TPL amount after the amount of third party liability is established not to exceed any patient responsibility determined by another payer.

(4) The child support enforcement division (CSED) provides information to MAD or its contractors on cases identified by CSED as having health insurance. Unless the custodial parent and child have satisfactory insurance, absent parents can be ordered by the court to provide coverage for the child. See 45 CFR 303.31(b)(1). MAD transmits information on absent parents who are not providing health coverage, as required by court order, or who have health insurance available through an employer but have not obtained it for their dependents to CSED.

(5) The New Mexico IV-D agency establishes paternity and obtains support orders for medical payments. MAD notifies this agency of lapses and changes of coverage information when it is identified by MAD. See 45 CFR 303.31(b)(8). This notification takes place when MAD learns that claims for a dependent child are rejected by the health insurance companies of the absent parent because his or her policy have been canceled, revised or no longer cover the child receiving IV-D services.

B. Trauma diagnosis claims processing: To help identify liable third parties with respect to injuries received by eligible recipients, MAD or its contractors have implemented a process which recognizes all claims with a trauma diagnosis. See 42 CFR 433.138(4).

(1) Trauma inquiry letters are mailed to identified eligible recipients. The letters ask eligible recipients for information about possible accidents, causes of accidents and whether legal counsel has been obtained.

(2) Failure to respond to these inquiries is considered a failure to cooperate and results in termination of the eligible recipient's medicaid benefits.

[8.302.3.17 NMAC - Rp, 8.302.3.17 NMAC, 5/1/2018]

8.302.3.18 INSURER RESPONSIBILITIES: Individual, blanket, group accident or health policies or certificates of insurance, including employee retirement income security Act (ERISA) plans, delivered, issued or renewed in the state of New Mexico must not contain exclusions or clauses which deny or limit insurance benefits to eligible recipients because of their eligibility for medicaid benefits. See Subsection D of Section 59-18-31 NMSA 1978 (Repl. Pamp. 1992).

A. Direct payments to HSD: All individual, blanket, or group accident or health policies or certificate of insurance, including ERISA plans, delivered, issued or renewed in the state of New Mexico must require insurers to reimburse HSD for benefits paid on behalf of eligible recipients in the following situations:

(1) HSD has paid or is paying benefits;

(2) HSD pays medicaid providers for the services in question; and

(3) insurers are notified that insured individuals

receive medicaid benefits and that the benefits must be paid directly to HSD. HSD certifies to insurers at the time it files claims for reimbursement that these individuals are eligible for medicaid; and

(4) when the claim was paid by a MCO, payment may be made directly to the MCO. If the MCO fails to initiate recovery within 12 months following the original payment date, the payment must be made to HSD.

B. Direct provider payments: Medicaid providers may be paid directly by insurers for furnishing medical services to eligible recipients. Providers must inform insurers that the recipients are eligible for medicaid benefits by providing medicaid eligibility information on the recipient. See Subsection C of Section 59A-18-31 NMSA 1978 (Repl. Pamp. 1992).

C. Level of insurance required: The minimum standards of acceptable coverage, deductibles, coinsurance, lifetime benefits, out-of-pocket expenses, co-payments, and plan requirements are the minimum standards of health insurance policies and managed care plans established for small businesses in New Mexico. See the New Mexico Insurance Code.
[8.302.3.18 NMAC - Rp, 8.302.3.18 NMAC, 5/1/2018]

HISTORY OF 8.302.3 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 303.1000, Covered Services, filed 1/7/1980.
ISD 303.1000, Covered Services, filed 4/2/1982.
MAD Rule 303, Benefits, filed 11/8/1989.
MAD Rule 303, Benefits, filed 4/17/1992.
MAD Rule 303, Benefits, filed 3/10/1994.
SP-004.2200, Section 4, General Program Administration Third Party Liability, filed 3/5/1981.

History of Repealed Material:
MAD Rule 303, Benefits, filed 3/10/1994 - Repealed effective 2/1/1995.
8.302.3 NMAC - Medicaid General Provider Policies, Third Party Liability Provider Responsibilities, filed 4/16/2004 Repealed effective 5/1/2018.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 2 PROVIDER NETWORK

8.308.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.2.1 NMAC - Rp, 8.308.2.1 NMAC, 5/1/2018]

8.308.2.2 SCOPE: This rule applies to the general public.
[8.308.2.2 NMAC - Rp, 8.308.2.2 NMAC, 5/1/2018]

8.308.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.308.2.3 NMAC - Rp, 8.308.2.3 NMAC, 5/1/2018]

8.308.2.4 DURATION: Permanent.
[8.308.2.4 NMAC - Rp, 8.308.2.4 NMAC, 5/1/2018]

8.308.2.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.2.5 NMAC - Rp, 8.308.2.5 NMAC, 5/1/2018]

8.308.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.2.6 NMAC - Rp, 8.308.2.6 NMAC, 5/1/2018]

8.308.2.7 DEFINITIONS: [**RESERVED**]

8.308.2.8 [**RESERVED**]
[8.308.2.8 NMAC - Rp, 8.308.2.8 NMAC, 5/1/2018]

8.308.2.9 GENERAL REQUIREMENTS: The HSD managed care organization (MCO) shall establish and maintain a comprehensive network of providers and required specialists in sufficient numbers to make all services included in the benefit package available in accordance with access standards. The MCO shall require any contracted provider to be enrolled through a fully executed provider participation agreement (PPA) with HSD's medical assistance division (MAD). In completing the PPA, the provider may choose to participate only in managed care, only in fee-for-service, or both. Providers who have completed a PPA can choose to pursue contracting with one or more MCOs but do not have to contract with all MCOs. The MCO shall refer any provider who notifies the MCO of a change in his or her location, licensure, certification, or status to the MAD provider web portal to update his or her provider information. In addition, the MCO shall provide an e-mail notification to MAD regarding changes in provider servicing location; change in licensure or certification; and the date on which the provider is no longer participating with the MCO, including the reason.

A. Required MCO policies and procedures:

(1) Pursuant to section 1932(b)(7) of the Social Security Act, and consistent with 42 CFR 438.12, the MCO shall not discriminate against a provider that serves high-risk populations or specializes in conditions that require costly treatment.

(2) The MCO shall not discriminate with respect

to participation, reimbursement, or indemnification of any provider acting within the scope of his or her provider's license or certification under applicable state statute or rule solely on the basis of the provider's license or certification.

(3) The MCO shall upon declining to include an individual or a group of providers in its network, give the affected provider written notice of the reason for the MCO decision.

(4) The MCO shall conduct screenings of all subcontractors and contract providers in accordance with the Employee Abuse Registry Act, 27-7A-3 NMSA 1978, the New Mexico Caregivers Criminal History Screening Act, 2-17-2 et seq., NMSA 1978 and 7.1.9 NMAC, the New Mexico Children's and Juvenile Facility Criminal Records Screening Act, 32A-15-1 to 32A-15-4 NMSA 1978, Patient Protection and Affordable Care Act (PPACA), and ensure that all subcontracted and contracted providers are screened against the federal "list of excluded individuals or entities" (LEIE) and the federal "excluded parties list system" (EPLS) (now known as the system for award management (SAM)) and any other databases that may be required through federal or state regulation.

(5) The MCO shall require that any provider, including a provider making a referral or ordering a covered service, have a national provider identifier (NPI) unless the provider is an atypical provider as defined by the centers for medicare and medicaid services (CMS).

(6) The MCO shall require that each provider billing for or rendering services to a MCO member has a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act.

(7) The MCO shall consider in establishing and maintaining the network of appropriate providers its:

(a) anticipated enrollment;

(b) numbers of contracted providers who are not accepting new patients; and

(c) geographic locations of contracted providers and members, considering distance, travel time, the means of transportation ordinarily used by members; and whether the location provides physical access for members with disabilities.

(8) The MCO shall ensure that a contracted provider offers hours of operation that are no less than the hours of operation offered to its commercial enrollees.

(9) The MCO shall establish mechanisms such as notices or training materials to ensure that a contracted provider comply with the timely access requirements, monitor such compliance regularly, and take corrective action if there is a failure to comply.

(10) The MCO shall provide to its members and contracted providers clear instructions on how to access covered services, including those that require prior approval and referral.

(11) The MCO shall ensure that all contracted providers meet all availability; time and distance standards set by HSD, and have a system to track and report this data.

(12) The MCO shall provide access to a non-contracted provider if the MCO is unable to provide covered benefits covered under its agreement with HSD in an adequate and timely manner to a member and continue to authorize the use of a non-contracted provider for as long as the MCO is unable to provide these services through its contracted providers. The MCO must ensure that the cost to its members utilizing a non-contracted provider is not greater than it would be if the service was provided within the MCO's network.

B. Health services contracting: Contracts with an individual and an institutional provider shall mandate compliance with the MCOs quality management (QM) and quality improvement (QI) programs.

C. Provider qualifications and credentialing: The MCO shall verify that each contracted or subcontracted provider (practitioner or facility) participating in, or employed by, the MCO meets applicable federal and state requirements for licensing, certification, accreditation and re-credentialing for the type of care or services within the scope of practice as defined by federal and state statutes, regulations, and rules.

D. 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 its network. All services must be rendered within the boundaries of the United States. No payment is allowed to any financial institution or entity located outside of the United States.

E. Provider lock-in: HSD shall allow 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 the member's behavior is detrimental or indicates a need to provide case continuity. Prior to placing a member on a provider lock-in, the MCO shall inform the member of its 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 and provider lock-in removals at the time they occur as well as receiving existing lock-in information on a quarterly basis.

F. Pharmacy lock-in: HSD shall allow the MCO to require that its member see a certain pharmacy provider when the member's compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the MCO shall inform the member of the intent to lock-in. The MCO's grievance procedure shall be made available to a member being designated for pharmacy lock-in. The member shall be removed from pharmacy lock-in when the MCO has determined that the compliance or drug seeking behavior has been resolved and the recurrence of the problem is judged to be improbable. HSD shall be notified of all provider lock-ins and provider lock-in removals at the time they occur as well as receiving existing lock-in information on a quarterly basis. [8.308.2.9 NMAC - Rp, 8.308.2.9 NMAC, 5/1/2018]

8.308.2.10 PRIMARY CARE PROVIDER (PCP): The MCO shall ensure that each member is assigned a primary care provider (PCP), except a member that is dually eligible for medicare and medicaid (dual eligible). The PCP shall be a provider identified in Subsection A below, participating in the MCO's network who will assume the responsibility for supervising, coordinating, and providing primary health care to its member, initiating referrals for specialist care, and maintaining the continuity of the member's care. For a dual-eligible member, the MCO will be responsible for coordinating the primary, acute, behavioral health and long-term care services with the member's medicare PCP.

A. Types of PCPs: The MCO shall designate the following types of providers as a PCP as appropriate:

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

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

(3) specialists, on an individual basis, for members whose care is more appropriately managed by a specialist, such as members with infectious diseases, chronic illness, complex behavioral health conditions, or disabilities;

(4) a primary care team consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that include 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 team to ensure continuity of care to the member 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 may not serve as "lead physicians";

(5) federally qualified health centers (FQHC), rural health clinics (RHC), or Indian health service (IHS), tribal health providers, and urban Indian providers (I/T/U); or

(6) other providers that meet the credentialing requirements for PCPs.

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

(1) Initial enrollment: At the time of enrollment, the MCO shall ensure that each member has the freedom to choose a PCP within a reasonable distance from his or her place of residence.

(2) Subsequent change in PCP initiated by a member: the MCO shall allow its member to change his or her PCP at any time for any reason. The request can be made in writing or verbally via telephone:

(a) if a request is made on or before the 20th calendar day of the month, the change shall be effective as the first of the following month;

(b) if a request is made after the 20th calendar day of the month, the change shall be effective the first calendar day of the second month following the request.

(3) A subsequent change in PCP initiated by the MCO: The MCO may initiate a PCP change for its member under the following circumstances:

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

(b) a member's PCP ceases to be a contracted provider;

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

(d) a member has initiated legal actions against the PCP; or

(e) the PCP is suspended for any reason.

(4) The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from or was seen on a regular basis by the terminated provider. In such instances, the MCO shall allow affected members to select a PCP or the MCO shall make an assignment within 15 calendar days of the termination effective date. [8.308.2.10 NMAC - Rp, 8.308.2.10 NMAC, 5/1/2018]

8.308.2.11 STANDARDS FOR ACCESS: The MCO shall establish and follow protocols to ensure the accessibility, availability and referral to health care providers for each medically necessary service to its members. The MCO shall provide access to the full array of covered services within the benefit package. If a service is unavailable based on the access guidelines, a

service equal to or higher than that service shall be offered.

A. Access to urgent and emergency services: Services for emergency conditions provided by physical and behavioral 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). 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 child and adolescent members 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 treatment, could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the overall health of the member or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy. 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 shall ensure that there is no clinically significant delay caused by the MCO's utilization control measures. Prior authorization is not required for emergency services in or out of the MCO's network, and all emergency services shall be reimbursed at the HSD approved rate. The MCO 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 layperson standard, turned out to be non-emergent in nature.

(2) The MCO 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.

(3) The MCO shall ensure that the member has access to the nearest appropriately designated trauma center according to established emergency medical standards (EMS) triage and transportation protocols.

B. PCP availability: The MCO shall follow a process that ensures a sufficient number of PCPs are available to allow members a reasonable choice among providers.

(1) The MCO shall have at least one PCP available per 2,000 members and not more than 2,000 members are assigned to a single provider unless approved by HSD.

(2) The MCO must ensure that members have adequate access to specialty providers.

(3) The minimum number of PCPs from which to choose and the distances to those providers shall vary by county based on whether the county is urban, rural or frontier. Urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana. Frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola. Rural counties are those that are not urban or frontier. The standards are as follows:

(a) ninety percent of urban member residents shall travel no farther than 30 miles;

(b) ninety percent of rural member residents shall travel no farther than 45 miles; and

(c) ninety percent of frontier member residents shall travel no farther than 60 miles.

C. Pharmacy provider availability: The MCO shall ensure that a sufficient number of pharmacy providers are available to its members. The MCO shall ensure that pharmacy services meet geographic access standards based on its member's county of residence. The access standards are as follows:

(1) ninety percent of urban residents shall travel no farther than 30 miles;

(2) ninety percent of rural residents shall travel no farther than 45 miles; and

(3) ninety percent of frontier residents shall travel no farther than 60 miles.

D. For all other provider types, including, but not limited to behavioral health providers, physical health providers, long term care providers, hospitals and transportation providers, as directed by MAD, the following standards shall apply:

(1) ninety percent of urban residents shall travel no farther than 30 miles;

(2) ninety percent of rural residents shall travel no farther than 60 miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted by MAD; and

(3) ninety percent of frontier residents shall travel no farther than 90 miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted by MAD.

E. The MCO must provide transportation as necessary to meet the standards of access.

[8.308.2.11 NMAC - Rp, 8.308.2.11 NMAC, 5/1/2018]

8.308.2.12 ACCESS TO HEALTH CARE SERVICES: The MCO shall ensure that there are a sufficient number of PCPs and dentists available to members to allow members a reasonable choice, and ensure that there are

a sufficient number of behavioral health providers, based on the least restrictive, medically necessary needs of its members, available statewide to members to allow members a reasonable choice.

A. The MCO shall report to HSD all provider groups, health centers and individual physician practices and sites in its network that are not accepting new MCO members.

B. For routine, asymptomatic, member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than 30 calendar days, unless the member requests a later time.

C. For routine asymptomatic member-initiated dental appointments the request-to-appointment time shall be no more than 60 calendar days unless the member requests a later date.

D. For routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical and dental care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time.

E. For non-urgent behavioral health care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time.

F. Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours.

G. For specialty outpatient referral and consultation appointments, excluding behavioral health, which is addressed in Subsection E of this Section, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 calendar days, unless the member requests a later time.

H. 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 calendar days, unless the member requests a later time.

I. 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.

J. 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.

K. The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.

L. 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.

M. The MCO's preferred drug list (PDL) shall follow HSD guidelines for services and items included in the managed care benefit package, pharmacy services.

N. Access to durable medical equipment: 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.

(1) 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 calendar days of the request date.

(2) All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

(3) All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

(4) All DME repairs or non-customized modifications shall be delivered within 60 calendar days of the request date.

(5) The MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.

(6) The MCO shall ensure that its member and his or her family or caretaker receive proper instruction on the use of DME provided by the MCO or its subcontractor.

O. Access to prescribed medical supplies: 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:

(1) a member can access prescribed medical supplies within 24 hours when needed on an urgent basis;

(2) a member can access routine medical supplies within a time frame consistent with the clinical need;

(3) subject to any requirements to procure a PCP order to provide supplies to its members, 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; and

(4) the MCO shall ensure that its member and his or her family receive proper instruction on the use of medical supplies provided by the MCO or its subcontractors.

P. Access to transportation services: The MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The MCO shall have sufficient transportation providers available to meet the needs of its members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependent 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) minor aged members are accompanied by a parent or legal guardian as indicated to provide safe transportation. See 8.301.6 NMAC for a detailed description of attendant coverage for a member 18 years of age and older.

Q. Use of technology: The MCO is encouraged to use technology, such as telemedicine, to ensure access and availability of services statewide.

R. For behavioral health crisis services, face-to-face appointments shall be available within two hours.

[8.308.2.12 NMAC - Rp, 8.308.2.12 NMAC, 5/1/2018]

8.308.2.13 SPECIALTY PROVIDERS: The MCO shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of the members are met within the MCO's provider network. The MCO shall also have a system to refer members to non-contracted providers if providers with the necessary qualifications or certifications do not participate in the network. Out-of-network providers must coordinate with the MCO with respect to payment. The MCO must ensure that cost to its member is no greater than it would be if the services were furnished within the network.

[8.308.2.13 NMAC - Rp, 8.308.2.13 NMAC, 5/1/2018]

8.308.2.14 FAMILY PLANNING PROVIDERS:

A. The MCO shall give each adolescent and adult member the opportunity to use his or her own PCP or to use any family planning provider for family planning services without requiring a referral. Each female member shall also have the right to self-refer to a contracted women's health specialist for covered services necessary to provide women's routine and preventive health services. This right to self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist. Family planning providers, including those funded by Title X of the public health service, shall be reimbursed by the MCO for all covered family planning services, regardless of whether they are contracted providers of the member's MCO. Unless otherwise negotiated, the MCO shall reimburse providers of family planning services pursuant to the medicaid fee schedule.

B. Pursuant to state statute and rule, a non-contracted provider is responsible for keeping family planning information confidential in favor of the individual member even if the member is a minor. The MCO is not responsible for the confidentiality of medical records maintained by a non-contracted provider, but shall notify the non-contracted provider of the confidentiality provisions contained herein.

[8.308.2.14 NMAC - Rp, 8.308.2.14 NMAC, 5/1/2018]

8.308.2.15 INDIAN HEALTH SERVICES, TRIBAL HEALTHCARE, AND URBAN INDIAN PROVIDERS (I/T/U):

A. The MCO shall make best efforts to contract with I/T/Us in the state, including, but not limited to, contracting for such services as transportation, care coordination and case management. The MCO is encouraged to use the sample I/T/U addendum as described in 42 CFR 438.14 to develop an addendum specific to New Mexico that can be used to establish network provider agreements with I/T/Us as such agreements include the federal protections for I/T/Us.

B. The MCO shall allow native American members to seek care from any I/T/U whether or not the I/T/U is a contract provider and shall reimburse I/T/Us as specified in 8.308.20 NMAC. The MCO shall permit non-contracted I/T/Us to refer native American members to a contracted provider.

C. The MCO shall not prevent members from seeking care from I/T/Us or from contract providers due to their status as native Americans.

[8.308.2.15 NMAC - N, 5/1/2018]

8.308.2.16 STANDARDS FOR CREDENTIALING AND RE-CREDENTIALING: The MCO shall verify that each contracted or subcontracted provider participating in, or employed by the MCO meets applicable federal and state requirements for licensing, certification, accreditation and re-credentialing for the type of care or services within the scope of practice as defined by federal medicaid statues and state law. The MCO shall verify that billing providers, rendering providers, ordering providers, attending providers, and prescribing providers are enrolled with MAD, unless the services or providers are otherwise exempted by MAD. The MCO shall document the mechanism for credentialing and re-credentialing of a provider with whom it contracts or employs to treat its members outside the inpatient setting and who fall under its scope of authority. The documentation shall include, but not be limited to, defining the provider's scope of practice, 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 re-credentialing arrangements. The credentialing process shall be completed within

45 calendar days from receipt of completed application with all required documentation unless there are extenuating circumstances. The MCO shall use the HSD approved primary source verification entity or one entity for the collection and storage of provider credentialing application information unless there are more cost effective alternatives approved by HSD. The MCO must load provider contracts and claims systems must be able to recognize the provider as a network provider no later than 45 calendar days after a provider is credentialed, when required.

A. Practitioner participation: The MCO shall have a process for receiving input from participating providers regarding credentialing and re-credentialing of its providers.

B. Primary source verification: The MCO shall verify the following information from primary sources during its credentialing process:

(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 practitioner 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 he or she is board certified in a specialty;

(6) current, adequate malpractice insurance, according to the MCOs 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 shall use the HSD approved credentialing form. The provider shall complete a credentialing application that includes a statement by him or her regarding:

(1) ability to perform the essential functions of the positions, with or without accommodation;

(2) lack of present illegal drug use;

(3) history of loss of license and felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity;

(5) sanctions, suspensions or terminations imposed by medicare or medicaid; and

(6) applicant attests to the correctness and completeness of the application.

D. External source verification: Before a practitioner is credentialed, the MCO 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) a health and human services (HHS) office of inspector general (OIG) exclusion from participation on medicare, medicaid, the children's health insurance plan (CHIP), and all federal health care programs (as defined in Section 1128B(f) of the Social Security Act), and sanctions by medicare, medicaid, CHIP or any federal health care program.

E. Evaluation of practitioner site and medical records: The MCO shall perform an initial visit to the offices of a potential PCP, obstetrician, and gynecologist, and shall perform an initial visit to the offices of a potential high volume behavioral health care practitioner prior to acceptance and inclusion as a contracted provider. The MCO shall determine its method for identifying high volume behavioral health practitioners.

(1) The MCO shall document a structured review to evaluate the site against the MCO's organizational standards and those specified by the HSD managed care contract.

(2) The MCO shall document an evaluation of the medical record keeping practices at each site for conformity with the MCO's organizational standards.

F. Re-credentialing: The MCO shall have formalized re-credentialing procedures.

(1) The MCO shall re-credential its providers at least every three years. The MCO shall verify the following information from primary sources during re-credentialing:

(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 re-credentialed;

(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 re-credentialing 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 provider types;

(i) other recognized monitoring organizations appropriate to the provider's discipline; and

(j) HHS/OIG exclusion from participation in medicare, medicaid, CHIP and all federal health care programs.

(3) The MCO shall incorporate data from the following sources in its re-credentialing decision making process for its providers:

(a) member grievances and appeals;

(b) information from quality management and improvement activities; and

(c) medical record reviews conducted under Subsection E this Section.

G. Imposition of remedies: The MCO shall have policies and procedures for altering the conditions of the provider's participation with the MCO based on issues of quality of care and service. These policies and procedures shall define the range of actions that the MCO may take to improve the provider's performance prior to termination:

(1) The MCO 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 shall have an appeal process by which the MCO may change the conditions of a practitioner's participation based on issues of quality of care and service. The MCO shall inform providers of the appeal process in writing.

H. Assessment of organizational providers: The MCO 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. At least every three years, the MCO shall:

(1) 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) the department of health (DOH) is the certification agency for organizational services and providers that require certification, except for child and adolescent behavioral health services; and

(b) the children, youth and families department (CYFD) is the certification agency for child and adolescent behavioral health organizational services and providers that require certification; and

(2) confirm that the provider has been accredited by the appropriate accrediting body or has a detailed written plan expected to lead to accreditation within a reasonable period of time; behavioral health organizational providers and services are accredited by the following:

(a) adult behavioral health organizational services or providers are accredited by the council on accreditation of rehabilitation facilities (CARF);

(b) child and adolescent accredited residential treatment centers are accredited by the joint commission (JC); 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.

[8.308.2.16 NMAC - Rp, 8.308.2.15 NMAC, 5/1/2018]

8.308.2.17 PROVIDER TRANSITION: The MCO shall notify HSD within five calendar days of unexpected changes to the composition of its provider network that would have an effect on member access to services or on the MCOs ability to deliver services included in the benefit package. Anticipated material changes in the MCO provider network shall be reported in writing to HSD within 30 calendar days prior to the change or as soon as the MCO

becomes aware of the anticipated change. For both expected and unexpected changes in the network, the MCO shall be required to assess the significance of the change or closure to the network and shall submit a notification narrative and specific transition plans, if applicable, as detailed in the MCO policy manual.
[8.308.2.17 NMAC - Rp, 8.308.2.16 NMAC, 5/1/2018]

8.308.2.18 DELEGATION: Delegation is a process whereby a MCO gives another entity the authority and responsibilities to perform certain functions on its behalf. The MCO is fully accountable for all pre-delegation and delegation activities and decisions made. The MCO shall document its oversight of the entity that performs the delegated activity. The MCO may assign, transfer, or delegate to a subcontractor key management functions with the explicit written approval of HSD.

A. Each contract or written agreement between the MCO and delegated entity shall describe:

(1) the responsibilities of the MCO and the entity to which the activity is delegated;

(2) the delegated activities or obligations;

(3) the reporting responsibilities to include the frequency and method of reporting to the MCO;

(4) the process by which the MCO evaluates the delegated entity's performance;

(5) the remedies up to, and including, revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations; and

(6) the requirements specified in 42 CFR § 438.214, if the delegated entity will be providing or securing covered services to members.

B. The MCO shall provide evidence to HSD that it:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) monitors the delegated entity's performance on an ongoing basis and identifies deficiencies or areas for improvement that require the delegated entity to take corrective action as necessary; and

(3) conducts an annual evaluation of its delegated entity in accordance with the MCO's expectations and HSD's standards.
[8.308.2.18 NMAC - Rp, 8.308.2.17 NMAC, 5/1/2018]

HISTORY OF 8.308.2 NMAC: [**RESERVED**]

History of Repealed Material: 8.308.2 NMAC - Managed Care Program, Provider Network, filed 12/17/2013 Repealed effective 5/1/2018.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 6 ELIGIBILITY

8.308.6.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.6.1 NMAC - Rp, 8.308.6.1 NMAC, 5/1/2018]

8.308.6.2 SCOPE: This rule applies to the general public.
[8.308.6.2 NMAC - Rp, 8.308.6.2 NMAC, 5/1/2018]

8.308.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.308.6.3 NMAC - Rp, 8.308.6.3 NMAC, 5/1/2018]

8.308.6.4 DURATION: Permanent.
[8.308.6.4 NMAC - Rp, 8.308.6.4 NMAC, 5/1/2018]

8.308.6.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.6.5 NMAC - Rp, 8.308.6.5 NMAC, 5/1/2018]

8.308.6.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.308.6.6 NMAC - Rp, 8.308.6.6 NMAC, 5/1/2018]

8.308.6.7 DEFINITIONS: [**RESERVED**]

8.308.6.8 [RESERVED]
[8.308.6.8 NMAC - Rp, 8.308.6.8 NMAC, 5/1/2018]

8.308.6.9 MANAGED CARE ELIGIBILITY:

A. General requirements: HSD determines eligibility for medicaid. An eligible recipient is required to participate in a HSD managed care program unless specifically excluded as listed below. Enrollment in a particular managed care organization (MCO) will be according to the eligible recipient's selection of a MCO at the time of application for eligibility, or during other permitted selection periods, or as assigned by HSD, if the eligible recipient makes no selection.

B. The following eligible recipients, as established by their eligibility category, are excluded from managed care enrollment:

(1) qualified medicare beneficiaries (QMB)-only recipients;

(2) specified low income medicare beneficiaries;

(3) qualified individuals;

(4) qualified disabled working individuals;

(5) refugees;

(6) participants in the program of all inclusive care for the elderly (PACE);

(7) children and adolescents in out-of-state foster care or adoption placements.; and

(8) family planning-only eligible recipients.

C. Native Americans may opt into managed care. If a native American is dually-eligible or in need of long-term care services, he or she is required to enroll in a MCO.

D. For those individuals who are not otherwise eligible for medicaid and who meet the financial and medical criteria established by HSD, HSD or its authorized agent may further determine eligibility for managed care enrollment through a waiver allocation process contingent upon available funding and enrollment capacity.

[8.308.6.9 NMAC - Rp, 8.308.6.9 NMAC, 5/1/2018]

8.308.6.10 SPECIAL SITUATIONS:

A. HSD has established newborn eligibility criteria.

(1) When a child is born to a member enrolled in a MCO, the hospital or other providers will complete a MAD Form 313 (*notification of birth*) or its successor, prior to or at the time of discharge. HSD shall ensure that upon receipt of the MAD Form 313 and upon completion of the eligibility process, the newborn is enrolled into his or her mother's MCO. The newborn is eligible for a period of 13 months, starting with the month of his or her birth.

(2) When the newborn's mother is covered by health insurance through the New Mexico health insurance exchange and the mother's qualified health plan is also a HSD-contracted MCO, HSD will enroll the newborn into the mother's MCO as of the month of his or her birth.

(3) When the newborn member's mother is covered by health insurance through New Mexico health insurance exchange and the mother's qualified health plan is not a HSD-contracted MCO, HSD shall auto-assign and enroll the newborn in a medicaid MCO as of the month of his or her birth. The newborn's parent or legal guardian will have one opportunity during the three month period from the effective date of enrollment to change the newborn's MCO assignment.

B. Community benefit eligibility:

(1) A member who meets a nursing facility (NF) level of care (LOC) and who does not reside in a NF will be eligible to receive home and community-based services and may choose to receive such services either through an agency-based or self-directed model according to the self-direction criteria as outlined in 8.308.12 NMAC.

(2) An individual who is not otherwise eligible for medicaid services but meets certain financial requirements and has a NF LOC determination may be eligible for enrollment through a waiver allocation process, contingent upon funding and enrollment capacity.

[8.308.6.10 NMAC - Rp, 8.308.6.10 NMAC, 5/1/2018]

HISTORY OF 8.308.6 NMAC: [**RESERVED**]

History of Repealed Material: 8.308.6 NMAC - Managed Care Program, Eligibility, filed 12/17/2013 Repealed effective 5/1/2018.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 7 ENROLLMENT AND DISENROLLMENT

8.308.7.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).

[8.308.7.1 NMAC - Rp, 8.308.7.1 NMAC, 5/1/2018]

8.308.7.2 SCOPE: This rule applies to the general public.

[8.308.7.1 NMAC - Rp, 8.308.7.2 NMAC, 5/1/2018]

8.308.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.

[8.308.7.3 NMAC - Rp, 8.308.7.3 NMAC, 5/1/2018]

8.308.7.4 DURATION: Permanent.

[8.308.7.4 NMAC - Rp, 8.308.7.4 NMAC, 5/1/2018]

8.308.7.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.

[8.308.7.5 NMAC - Rp, 8.308.7.5 NMAC, 5/1/2018]

8.308.7.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).

[8.308.7.6 NMAC - Rp, 8.308.7.6 NMAC, 5/1/2018]

8.308.7.7 DEFINITIONS: [**RESERVED**].

8.308.7.8 [RESERVED]

[8.308.7.8 NMAC - Rp, 8.308.7.8 NMAC, 5/1/2018]

8.308.7.9 MANAGED CARE ENROLLMENT

A. General: A medical assistance division (MAD) eligible recipient is required to enroll in a HSD managed care organization (MCO) unless he or she is:

(1) a native American and elects enrollment in MAD's fee-for-service (FFS); or

(2) is in an

excluded population. See 8.200.400 NMAC and 8.308.6 NMAC. Enrollment in a MCO may be the result of the eligible recipient's selection of a particular MCO or assignment by HSD. The MCO shall accept as a member an eligible recipient in accordance with 42 CFR. 434.25 and shall not discriminate against, or use any policy or practice that has the effect of discrimination against the potential or enrolled member on the basis of health status, the need for health care services, or race, color, national origin, ancestry, spousal affiliation, sexual orientation or gender identity. HSD reserves the right to limit enrollment in a specific MCO.

B. Newly eligible recipients: An individual who applies for a MAP category of eligibility and has an approved eligibility effective date of January 1, 2014, or later, and who is required to enroll in a MCO, must select a MCO at the time of his or her application for a MAP category of eligibility. An eligible recipient who fails to select a MCO at such time will be assigned to a MCO. See Subsection C of this Section. Members may choose a different MCO during the first three months of their enrollment.

C. Auto assignment:

(1) HSD will auto-assign an eligible recipient to a MCO in specific circumstances, including but not limited to:

(a) the eligible recipient is not exempt from managed care and does not select a MCO at the time of his or her application for MAD eligibility;

(b) the eligible recipient cannot be enrolled in the requested MCO pursuant to the terms of this rule (e.g., the MCO is subject to and has reached its enrollment limit). HSD may modify the auto-assignment algorithm, at its discretion, when it determines it is in the best interest of the program, including but not limited to, sanctions imposed on the MCO, consideration of quality measures, cost or utilization management performance criteria.

(2) The HSD auto-assignment process will consider the following:

(a) if the eligible recipient was previously enrolled with a MCO and lost his or her eligibility for a period of six months or less, he or she will be re-enrolled with that MCO;

(b) if the eligible recipient has a family member enrolled in a specific MCO, he or she will be enrolled with that MCO;

(c) if the eligible recipient is a newborn, he or she will be assigned to the mother's MCO; see Subsection A of 8.308.6.10 NMAC; or

(d) if none of the above applies, the eligible recipient will be assigned using the default logic that assigns an eligible recipient to a MCO.

D. Effective date for a newly eligible recipient's enrollment in managed care: In most instances, the effective date of enrollment with a MCO will be the same as the effective date of eligibility approval. In instances of an award of retroactive MAD eligibility, the effective date of managed care enrollment of the eligible recipient may not exceed a two year retroactive span.

E. Eligible recipient member lock-in: A member's enrollment with a MCO is for a 12-month lock-in period. During the first three months after his or her initial or annual MCO enrollment, either by the member's choice or by auto-assignment, he or she shall have one option to change MCOs for any reason, except as described below.

(1) If the member does not choose a different MCO during his or her first three months, the member will remain with this MCO for the full 12-month lock-in period before being able to switch MCOs.

(2) If during the member's first three months of enrollment in the initially or annually-selected or a HSD assigned MCO, and chooses a different MCO, he or she is subject to a new 12-month lock-in period and will remain with the newly selected MCO until the lock-in period ends. After that time, the member may switch to another MCO.

(3) At the conclusion of the 12-month lock-in period, the member shall have the option to select a new MCO, if desired. The member shall be notified of the option to switch MCOs 60 days prior to the expiration date of the member's lock-in period, the deadline by when to choose a new MCO.

(4) If a member loses his or her MAD eligibility for a period of six months or less, he or she will be automatically re-enrolled with the former MCO. If the member misses what would have been his or her annual switch MCO enrollment period, he or she may select another MCO within three months of reinstated MAD eligibility.

F. Open MCO enrollment period: Open enrollment periods are when a member can change his or her MCO without having to wait until the end of the 12 month lock-in period, and may be initiated at HSD's discretion in order to support program needs.

G. Mass transfers from another MCO: A MCO shall accept any member transferring from another MCO as authorized by HSD. The transfer of membership may occur at any time during the year.

H. Change of enrollment initiated by a member:

(1) A member may select another MCO during his or her annual renewal of eligibility, or re-certification period.

(2) A member may request to be switched to another MCO for cause, even during a lock-in period. The member must submit a written request to HSD. Examples of "cause" include, but are not limited to:

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

(b) the member requires related services (for example a cesarean section and a tubal ligation) to be performed at

the same time, not all of the related services are available within the network, and his or her PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(c) poor quality of care, lack of access to covered benefits, or lack of access to providers experienced in dealing with the member's health care needs.

(3) No later than the first calendar day of the second month following the month in which the request is filed by the member, HSD must respond. If HSD does not respond, the request of the member is deemed approved. If the member is dissatisfied with HSD's determination, he or she may request a HSD administrative hearing; see 8.352.2 NMAC for detailed description.

[8.308.7.9 NMAC - Rp, 8.308.7.9 NMAC, 5/1/2018]

8.308.7.10 DISENROLLMENT

A. Member disenrollment initiated by a MCO: The MCO shall not, under any circumstances, disenroll a member. The MCO shall not request disenrollment because of a change in the member's health status, because of the his or her utilization of medical or behavioral health services, his or her diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

B. Other HSD member disenrollment: A member may be disenrolled from a MCO or may lose his or her MAD eligibility if:

(1) he or she moves out of the state of New Mexico;

(2) he or she no longer qualifies for a MAP category of eligibility;

(3) he or she requests disenrollment for cause, including but not limited to the unavailability of a specific care requirement that none of the contracted MCOs are able to deliver and disenrollment is approved by HSD;

(4) a member makes a request for disenrollment which is denied by HSD, but the denial is overturned in the member's HSD administrative hearing final decision; or

(5) HSD imposes a sanction on the MCO that warranted disenrollment.

C. Effective date of disenrollment: All HSD-approved disenrollment requests are effective on the first calendar day of the month following the month of the request for disenrollment, unless otherwise indicated by HSD. In all instances, the effective date shall be indicated on the termination record sent by HSD to the MCO.

[8.308.7.10 NMAC - Rp, 8.308.7.10 NMAC, 5/1/2018]

8.308.7.11 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD determines that the transfer of MCO members from one MCO to another is in the best interests of the program.

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

(1) a maintenance change, such as changes in the MCO identification number or the MCO changes its name or other changes that is not relevant to the member and services will continue with that MCO; and

(2) a significant change in a MCO's contracting status, including but not limited to, the loss of licensure, substandard care, fiscal insolvency or significant loss in network providers; in such instances, a notice is sent to the member informing him or her of the transfer and the opportunity to select a different MCO.

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

[8.308.7.11 NMAC - Rp, 8.308.7.11 NMAC, 5/1/2018]

8.308.7.12 MEMBER IDENTIFICATION CARD

A. Each member shall receive an identification card (ID) that provides his or her MCO membership information within 20 calendar days of notification of enrollment with the MCO.

B. The MCO shall re-issue a member ID card within 10 calendar days of notice if the member reports a lost card or if information on the card needs to be changed.

C. The MCO shall ensure a member understands that the ID card:

(1) is intended to be used only by the member;

(2) the sharing the member's ID card constitutes fraud; and

(3) the process of how to report sharing of a member's ID card.

[8.308.7.12 NMAC - Rp, 8.308.7.12 NMAC, 5/1/2018]

8.308.7.13 MEDICAID MARKETING GUIDELINES: HSD shall review and approve the content, comprehension level, and language(s) of all marketing materials directed at a member before use by a MCO. The MCO shall comply with all federal regulations regarding medicare-advantage and medicaid marketing. See 42 CFR. Parts 422, 438.

[8.308.7.13 NMAC - Rp, 8.308.7.13 NMAC, 5/1/2018]

HISTORY OF 8.308.7 NMAC: [**RESERVED**]

History of Repealed Material: 8.308.7 NMAC - Managed Care Program, Enrollment and Disenrollment, filed 12/17/2013 Repealed effective 5/1/2018.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 8 MEMBER RIGHTS, RESPONSIBILITIES AND EDUCATION

8.308.8.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.8.1 NMAC - Rp, 8.308.8.1 NMAC, 5/1/2018]

8.308.8.2 SCOPE: This rule applies to the general public.
[8.308.8.2 NMAC - Rp, 8.308.8.2 NMAC, 5/1/2018]

8.308.8.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.308.8.3 NMAC - Rp, 8.308.8.3 NMAC, 5/1/2018]

8.308.8.4 DURATION: Permanent.
[8.308.8.4 NMAC - Rp, 8.308.8.4 NMAC, 5/1/2018]

8.308.8.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.8.5 NMAC - Rp, 8.308.8.5 NMAC, 5/1/2018]

8.308.8.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.8.6 NMAC - Rp, 8.308.8.6 NMAC, 5/1/2018]

8.308.8.7 DEFINITIONS: [**RESERVED**]

8.308.8.8 [RESERVED]
[8.308.8.8 NMAC - Rp, 8.308.8.8 NMAC, 5/1/2018]

8.308.8.9 [RESERVED]
[8.308.8.9 NMAC - Rp, 8.308.8.9 NMAC, 5/1/2018]

8.308.8.10 WRITTEN MEMBER MATERIALS:

A. All written materials will be available in English and all languages spoken by approximately five percent or more of the MCO's membership, as determined by the HSD contracted managed care organization (MCO) or HSD. Upon consent from the appropriate native American tribal leadership, the MCO shall make every effort when a written form is not in the member's native language to translate the form in the member's native language.

B. The MCO is responsible for providing a member or potential member with its member handbook and provider directory, as requested by a member.

(1) The MCO shall send such information to the member within 30 calendar days of receipt of notification of enrollment in the MCO.

(2) Thereafter, upon the request from a member, the MCO shall send such information within 10 calendar days. The MCO shall provide the requestor the option to receive the material in a written or electronic form or by citation to be found on the member's MCO's website.

(3) On an annual basis, the MCO shall notify the member of the availability of updated materials and how to obtain such materials.

C. All written member materials must comply with provisions set forth in 42 CFR 438.10.
[8.308.8.10 NMAC - Rp, 8.308.8.10 NMAC, 5/1/2018]

8.308.8.11 MEMBER RIGHTS AND RESPONSIBILITIES: The MCO shall provide each member or the member's authorized representative with written information concerning his or her rights and responsibilities.

A. These include the right:

(1) to be treated with respect and with due consideration for his or her dignity and privacy;

(2) to receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand such information;

(3) to make and have honored his or her advance directive that is consistent with state and federal laws;

(4) to receive covered services in a nondiscriminatory manner;

(5) to participate in decisions regarding his or her health care, including the right to refuse treatment;

(6) to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;

(7) to request and receive a copy of his or her medical records and to request that they be amended or corrected as specified in 45 CFR 164.524 and 526;

(8) to choose an authorized representative to be involved, as appropriate, in making his or her health care decisions;

(9) to provide informed consent;

(10) to voice grievances concerning the care provided by the MCO;

(11) to appeal any action regarding medicaid services that the member or his or her authorized representative or authorized provider believes is erroneous;

(12) to protect the member, his or her authorized representative or authorized provider who uses the grievance, appeal, and HSD administrative hearing processes from fear of retaliation;

(13) to choose from among contracted providers in accordance with his or her MCO's prior authorization requirements;

(14) to receive information about covered services and how to access these covered services, and providers;

(15) to be free from harassment by the MCO or its contracted providers in regard to contractual disputes between the MCO and the provider;

(16) to participate in understanding physical and behavioral health problems and developing mutually agreed-upon treatment goals; and

(17) to be assured that the MCO complies with any other applicable federal and state laws including: Title VI of the Civil Rights Act of 1964 as implemented by regulations in 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

B. The MCO shall ensure that each member or the member's authorized representative or authorized provider is free to exercise his or her rights, and the exercise of those rights does not adversely affect the way that the MCO or provider treats the member or member's authorized representative or authorized provider.

C. The member or his or her authorized representative or authorized provider, to the extent possible, has a responsibility:

(1) to provide information that the MCO and providers need in order to care for the member, such information includes, but is not limited to the member's:

(a) most current mailing address;

(b) most current e-mail address, if one is available;

(c) most current phone number, including any land line and cell phone, if available; and

(d) most current emergency contact information;

(2) to follow the care plans and instructions from his or her provider that have been agreed upon;

(3) to keep a scheduled appointment; and

(4) to reschedule or cancel a scheduled appointment rather than simply fail to keep it.

[8.308.8.11 NMAC - Rp, 8.308.8.11 NMAC, 5/1/2018]

8.308.8.12 MEMBER HEALTH RECORDS: The MCO shall provide a member with access to electronic or hard copy versions of his or her personal health records.

[8.308.8.12 NMAC - Rp, 8.308.8.12 NMAC, 5/1/2018]

8.308.8.13 MEMBER HEALTH EDUCATION: The MCO shall provide health education to its members. Health education is intended to advise or inform the MCO members about issues related to healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status or methods of medical treatment.

A. The MCO shall develop a member health education plan that uses classes, individual or group sessions, videotapes, written materials, media campaigns and modern technologies (e.g. mobile applications and tools).

(1) All educational materials shall be provided in a manner and format that is easily understood by a member.

(2) The MCO shall notify its members of the schedule of educational events and shall post such information on its website.

B. The MCO shall distribute a quarterly newsletter that is intended to educate members about the managed care system, the proper utilization of services, and to encourage utilization of preventative care services.

[8.308.8.13 NMAC - Rp, 8.308.8.13 NMAC, 5/1/2018]

8.308.8.14 MEMBER WEBSITE: The MCO shall have a member portal on its website that is available to all members and potential members, and contains accurate, up-to-date information about the MCO to include, services provided, the preferred drug list, the provider directory, member handbook, frequently asked questions (FAQs), contact phone numbers and e-mail addresses as set forth in 42 CFR 438.10. A member or potential member shall have access to the member handbook and provider directory via the website without having to log-in.

[8.308.8.14 NMAC - Rp, 8.308.8.14 NMAC, 5/1/2018]

8.308.8.15 MEMBER TOLL-FREE LINE: The MCO shall operate a call center with a toll-free phone line to respond to member questions, concerns, inquiries and complaints from a member and his or her provider. The line shall be equipped to handle calls from an individual with limited English proficiency, as well as calls from a member who is hearing impaired. It should be staffed 24 hours a day, seven days a week, with qualified nurses to triage urgent care and emergency calls from a member, and when necessary, to facilitate the transfer of such calls to a care coordinator.

[8.308.8.15 NMAC - Rp, 8.308.8.15 NMAC, 5/1/2018]

8.308.8.16 MEMBER ADVISORY BOARD: The MCO shall convene advisory boards that meet quarterly and are representative of its membership. The advisory board shall advise the MCO on issues concerning service delivery, quality of its covered services, and other member issues as needed or as directed by HSD.

[8.308.8.16 NMAC - Rp, 8.308.8.16

NMAC, 5/1/2018]

HISTORY OF 8.308.8 NMAC: [**RESERVED**]

History of Repealed Material: 8.308.8 NMAC - Managed Care Program, Member Education, filed 12/17/2013 Repealed effective 5/1/2018.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 9 BENEFIT PACKAGE

8.308.9.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.9.1 NMAC - Rp, 8.308.9.1 NMAC, 5/1/2018]

8.308.9.2 SCOPE: This rule applies to the general public.
[8.308.9.2 NMAC - Rp, 8.308.9.2 NMAC, 5/1/2018]

8.308.9.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.308.9.3 NMAC - Rp, 8.308.9.3 NMAC, 5/1/2018]

8.308.9.4 DURATION: Permanent.
[8.308.9.4 NMAC - Rp, 8.308.9.4 NMAC, 5/1/2018]

8.308.9.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.9.5 NMAC - Rp, 8.308.9.5 NMAC, 5/1/2018]

8.308.9.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.9.6 NMAC - Rp, 8.308.9.6 NMAC, 5/1/2018]

8.308.9.7 DEFINITIONS:

A. Alternative benefits plan services with limitations (ABP): The medical assistance division (MAD) category of eligibility "other adults" has an alternative benefit plan (ABP). The HSD contracted managed care organization (MCO) covers ABP specific services for an ABP member. Services are made available through MAD under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP member has limitations on specific benefits; and does not have all MCO medicaid benefits available. All early and periodic screening, diagnosis and treatment (EPSDT) program services are available to an ABP member under 21 years. ABP services for an ABP member under the age of 21 years are not subject to the duration, frequency, and annual or lifetime benefit limitations that are applied to an ABP eligible recipient 21 years of age and older. A MCO ABP contracted provider and an ABP member have rights and responsibilities as described in Title 8 Chapter 308 NMAC, Social Services.

B. Alternative benefits plan general benefits for ABP exempt member (ABP exempt): An ABP member who self-declares he or she has a qualifying condition is evaluated by the MCO's utilization management for determination if he or she meets the qualifying condition. An ABP exempt member utilizes his or her benefits described in 8.308.9 NMAC and in 8.308.12 NMAC.
[8.308.9.7 NMAC - Rp, 8.308.9.7 NMAC, 5/1/2018]

8.308.9.8 [**RESERVED**]
[8.308.9.8 NMAC - Rp, 8.308.9.8 NMAC, 5/1/2018]

8.308.9.9 BENEFIT PACKAGE: This part defines the benefit package for which a MCO shall be paid a fixed per-member-per-month capitated payment rate. The MCO shall cover the services specified in 8.308.9 NMAC. The MCO shall not delete a benefit from the MCO benefit package. A MCO is encouraged to offer value added services that are not medicaid covered benefits or in lieu of services or settings. The MCO may utilize providers licensed in accordance with state and federal requirements to deliver services. The MCO shall provide and coordinate comprehensive and integrated health care benefits to each member enrolled in managed care and shall cover the physical health, behavioral health and long-term care services per this section, its contract, and as directed by HSD. If the MCO is unable to provide covered services to a particular member using one of its contracted providers, the MCO shall adequately and timely cover these services for that member using a non-contract provider for as long as the member's MCO provider network is unable to provide the service. At such time that the required services become available within the MCO's network and the member can be safely transferred, the MCO may transfer the member to an appropriate contract provider according to a transition of care plan developed specifically for the member; see 8.308.11 NMAC.
[8.308.9.9 NMAC - Rp, 8.308.9.9 NMAC, 5/1/2018]

8.308.9.10 MEDICAL ASSISTANCE DIVISION PROGRAM RULES: New Mexico administrative code (NMAC) rules and related documents contain a detailed description of the services covered by MAD, the limitations and exclusions to covered services, and non-covered services. The NMAC rules are the official source of information on covered and non-covered services. Unless otherwise directed, the MCO shall determine

its own utilization management (UM) protocols and shall comply with state and federal requirements for UM including, but not limited to 42 CFR Part 456, which is based on reasonable medical evidence. The MCO shall comply with the most rigorous standards or applicable provisions of either NCQA, HSD regulation, the Balanced Budget Act of 1997, or 42 CFR Part 438 related to timeliness of decisions. The MCO shall ensure that medicaid covered benefits are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries pursuant to 42 CFR 440.230. MAD may review and approve the MCO's UM protocols. Unless otherwise directed by MAD, a HSD contracted MCO is not required to follow MAD's reimbursement methodologies or MAD's fee schedules unless otherwise required in a NMAC rule. The MCO shall comply with 42 CFR Parts 438, 440, and 456.

[8.308.9.10 NMAC - Rp, 8.308.9.10 NMAC, 5/1/2018]

8.308.9.11 GENERAL PROGRAM DESCRIPTION:

A. The MCO shall provide medically necessary services consistent with the following:

(1) a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit; benefits are to be determined by HSD;

(2) in making the determination of medical necessity of a covered service the MCO shall do so by:

(a) evaluating the member's physical and behavioral health information provided by a qualified professional who has personally evaluated the member within his or her scope of practice; who has taken into consideration the member's clinical history, including the impact of previous treatment and service interventions and who has consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(b) considering the views and choices of the member or his or her authorized representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(c) considering the services being provided concurrently by other service delivery systems;

(3) not denying physical, behavioral health and long-term care services solely because the member has a poor prognosis; medically necessary services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible member solely because of his or her diagnosis, type of illness or condition;

(4) governing decisions regarding benefit coverage for a member under 21 years of age by the EPSDT program coverage rule to the extent they are applicable; and

(5) making services available 24 hours, seven days a week, when medically necessary and are a covered benefit.

B. The MCO shall meet all HSD requirements related to the anti-gag requirement. The MCO shall meet all HSD requirements related to advance directives. This includes but is not limited to:

(1) providing a member or his or her authorized representative with written information on advance directives that include a description of applicable state and federal law and regulation, the MCO's policy respecting the implementation of the right to have an advance directive, and that complaints concerning noncompliance with advance directive requirements may be filed with HSD; the information must reflect changes in federal and state statute, regulation or rule as soon as possible, but no later than 90 calendar days after the effective date of such a change;

(2) honoring advance directives within its UM protocols; and

(3) ensuring that a member is offered the opportunity to prepare an advance directive and that, upon request, the MCO provides assistance in the process.

C. The MCO shall allow second opinions: A member or his or her authorized representative shall have the right to seek a second opinion from a qualified health care professional within his or her MCO's network, or the MCO shall arrange for the member to obtain a second opinion outside the network, at no cost to the member. A second opinion may be requested when the member or his or her authorized representative needs additional information regarding recommended treatment or believes the provider is not authorizing requested care.

D. The MCO shall meet all care coordination requirement set forth in 8.308.10 NMAC, Care Coordination.

E. The MCO shall meet all behavioral health parity requirements as set forth in CFR 42, Chapter IV, subchapter C, 438.905 - Parity requirements.

[8.308.9.11 NMAC - Rp, 8.308.9.11 NMAC, 5/1/2018]

8.308.9.12 GENERAL COVERED SERVICES:

A. Ambulatory surgical services: The benefit package includes surgical services rendered in an ambulatory surgical center setting as detailed in 8.324.10 NMAC.

B. Anesthesia services: The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures as detailed 8.310.2 NMAC.

C. Audiology services: The benefit package includes audiology services as detailed in 8.310.2 and 8.324.5 NMAC with some limitations. For a ABP member 21 years and older, audiology services are limited to hearing testing or screening when part of a routine health exam and are

not covered as a separate service. Audiologist services, hearing aids and other aids are not covered.

D. Client transportation: The benefit package covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health examination and treatment for a MCO member in or out of his or her home community as detailed in 8.301.6, 8.324.7 and 8.310.2 NMAC.

E. Community intervener: The benefit package includes community intervener services. The community intervener works one-on-one with a deaf-blind member who is five-years of age or older to provide critical connections to other people and his or her environment. The community intervener opens channels of communication between the member and others, provides access to information, and facilitates the development and maintenance of self-directed independent living.

(1) Member eligibility: To be eligible for community intervener services, a member must be five-years of age or older and meet the clinical definition of deaf-blindness, defined as:

(a) the member has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both these conditions;

(b) the member has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification or the progressive hearing loss having a prognosis leading to this condition; and

(c) the member for whom the combination of impairments described above cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

(2) Provider qualifications: The minimum provider qualifications for a community intervener are as follows:

(a) is at least 18 years of age;

(b) is not the spouse of the member to whom the intervener is assigned;

(c) holds a high school diploma or a high school equivalency certificate;

(d) has a minimum of two years of experience working with individuals with developmental disabilities;

(e) has the ability to proficiently communicate in the functional language of the deaf-blind member to whom the intervener is assigned; and

(f) completes an orientation or training course by any person or agency who provides direct care services to deaf-blind individuals.

F. Dental services: The benefit package includes dental services as detailed in 8.310.2 NMAC.

G. Diagnostic imaging and therapeutic radiology services: The benefit package includes medically necessary diagnostic imaging and radiology services as detailed in 8.310.2 NMAC.

H. Dialysis services: The benefit package includes medically necessary dialysis services as detailed in 8.310.2 NMAC. Dialysis benefits are limited to the first three months of dialysis pending the establishment of medicare eligibility unless the member does not qualify for medicare benefits as determined by the social security administration. A dialysis provider shall assist a member in applying for and pursuing final medicare eligibility determination. If the member does not qualify for medicare benefits, the MCO is responsible for covering dialysis services.

I. Durable medical equipment and medical supplies: The benefit package includes covered vision appliances, hearing aids and related services and durable medical equipment and medical supplies and oxygen as detailed in 8.324.5 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

J. Emergency and non-emergency transportation services:

(1) The benefit package includes transportation service such as ground ambulance and air ambulance in an emergency and when medically necessary, and 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. MAD covers the most appropriate and least costly transportation alternatives only when a member does not have a source of transportation available and the member does not have access to alternative free sources. The MCO shall coordinate efforts when providing transportation services for a member requiring physical or behavioral health services.

(2) The benefit package also includes non-medical transportation as detailed in 8.314.5 NMAC.

K. Experimental or investigational services: The benefit package includes medically necessary services which are not considered unproven, investigational or experimental for the condition for which they are intended or used as determined by MAD as detailed in 8.310.2 NMAC.

L. Health home services: The benefit package includes CareLink NM (or its successor) health home services as detailed in 8.310.10 NMAC for qualified beneficiaries in areas these services are available through by MAD-approved providers.

M. Home health agency services and other nursing care: The benefit package includes home health agency services as detailed in 8.325.9 and 8.320.2 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4

NMAC for service limitations.

(1) A MCO may also cover private duty nursing services and in home rehabilitation services as needed to provide medically necessary services to members even though those services are not rendered through a home health agency.

(2) In addition to home health agency services, a MCO is also required to provide in home services under the EPSDT program through private duty nursing and EPSDT personal care (which is not to be confused with the personal care option services covered as a community benefit). See 8.308.9.15 NMAC regarding EPSDT services.

(3) Services in the home are also a benefit under community based services. See 8.308.12. NMAC Community Benefit.

(4) For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

N. Hospice services: The benefit package includes hospice services as detailed in 8.325.4 NMAC.

O. Hospital outpatient service: 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.

P. Inpatient hospital services: The benefit package includes hospital inpatient acute care, procedures and services for the member as detailed in 8.311.2 NMAC. The MCO shall comply with the maternity length of stay in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Coverage for a hospital stay following a normal, vaginal delivery may not be limited to less than 48 hours for both the member and her newborn child. Health coverage for a hospital stay in connection with childbirth following a caesarean section may not be limited to less than 96 hours for the member and her newborn child.

Q. Laboratory services: The benefit package includes laboratory services provided according to the applicable provisions of Clinical Laboratory Improvement Act (CLIA) as detailed in 8.310.2 NMAC.

R. Nursing facility services: The benefit package includes nursing facility services as detailed in 8.312.2 NMAC. Nursing facility services are not a benefit for an ABP eligible recipient except as a short term "step-down" hospital discharge prior to going home.

S. Nutrition services: The benefit package includes nutritional services based on scientifically validated nutritional principles and interventions which are generally accepted by the medical community and consistent with the physical and medical condition of the member as detailed in 8.310.2 NMAC.

T. Physical health services:

(1) Primary care and specialty care services are found in the following 8.310.2, 8.310.3, 8.320.2, and 8.320.6 NMAC. The services are rendered in a hospital, clinic, center, office, school-based setting, and when facilities and settings are parent approved, including the home.

(2) The benefits specifically include:

(a) labor and delivery in a hospital;

(b) labor and delivery in an eligible recipient's home;

(c) labor and delivery in a midwife's unlicensed birth center;

(d) labor and delivery in a department of health licensed birth center; and

(e) other related birthing services performed by a certified nurse midwife or a direct-entry midwife licensed by the state of New Mexico, who is either validly contracted with and fully credentialed by the MCO or validly contracted with HSD and participates in MAD birthing options program as detailed in 8.310.2 NMAC.

(f) 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.

(g) The MCO shall participate in MAD's birthing options program.

U. Podiatry: The benefit package includes podiatric services furnished by a provider, as required by the condition of the member as detailed in 8.310.2 NMAC.

V. Prosthetics and orthotics: The benefit package includes prosthetic and orthotic services as detailed in 8.324.5 NMAC.

W. Rehabilitation services: The benefit package includes inpatient and outpatient hospital, and outpatient physical, occupational and speech therapy services as detailed in 8.323.5 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations

X. Private duty nursing: The benefit package includes private duty nursing services for a member under 21 years of age. See Subsection M of 8.308.9.12 NMAC.

Y. Swing bed hospital services: This benefit package includes services provided in hospital swing beds to a member expected to reside in such a facility on a long-term or permanent basis as defined in 8.311.5 NMAC. Swing bed hospital services are not a benefit for an ABP eligible recipient except as a short term "step-down" hospital discharge prior to going home.

Z. Tobacco cessation services: The benefit package includes cessation services as described in 8.310.2 NMAC and education.

AA. Transplant services: The following transplants are covered in the benefit package as long as the procedures 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 8.310.2 NMAC. See 8.325.6 NMAC for guidance whether MAD has determined if a transplant is experimental or investigational.

BB. Vision and eye care services: The benefit package includes specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for a member as detailed in 8.310.2 NMAC. All services must be furnished within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and rules. For an ABP eligible recipient 21 years and older, the service limitations are listed below:

(1) Routine vision care is not covered.

(2) MAD does not cover refraction or eyeglasses other than for aphakia following removal of the lens.

CC. Other services: When an additional benefit service is approved by MAD, the MCO shall cover that service as well**.**

[8.308.9.12 NMAC - Rp, 8.308.9.12 NMAC, 5/1/2018]

8.308.9.13 SPECIFIC CASE MANAGEMENT PROGRAMS: The benefit package includes case management services necessary to meet an identified service need of a member. The following are specific case management programs available when a member meets the requirements of a specific service.

A. Case management services for adults with developmental disabilities: Case management services are provided to a member 21 years of age and older who is developmentally disabled as detailed in 8.326.2 NMAC.

B. Case management services for pregnant women and their infants: Case management services are provided to a member who is pregnant up to 60 calendar days following the end of the month of the delivery as detailed in 8.326.3 NMAC.

C. Case management services for traumatically brain injured adults: Case management services are provided to a member 21 years of age and older who is traumatically brain injured as detailed in 8.326.5 NMAC.

D. Case management services for children up to the age of three: Case management services for a member up to the age of three years who is medically at-risk due to family conditions and who does not have a developmental delay as detailed in 8.326.6 NMAC.

E. Case management services for the medically at risk (EPSDT): Case management services for a member under 21 years of age who is medically at-risk for a physical or behavioral health condition as detailed in 8.320.2 NMAC.

[8.308.9.13 NMAC - Rp, 8.308.9.13 NMAC, 5/1/2018]

8.308.9.14 PHARMACY SERVICES: The benefit package includes pharmacy and related services, as detailed in 8.324.4 NMAC.

A. The MCO may determine its formula for estimating acquisition cost and establishing pharmacy reimbursement.

B. The MCO shall include on the MCO's formulary or PDL all multi-source generic drug items with the exception of items used for cosmetic purposes, items consisting of more than one therapeutic ingredient, anti-obesity items, items that are not medically necessary and as otherwise approved by MAD. Cough, cold and allergy medications must be covered but all multi-source generic products do not need to be covered. This requirement does not preclude a MCO from requiring authorization prior to dispensing a multi-source generic item.

C. The MCO is not required to cover all multi-source generic over-the-counter items. Coverage of over-the-counter items may be restricted to instances for which a practitioner has written a prescription, and for which the item is an economical or preferred therapeutic alternative to the prescribed item.

D. The MCO shall cover brand name drugs and drug items not generally on the MCO formulary or PDL when determined to be medically necessary by the MCO or as determined by the MCO member appeal process or a HSD administrative hearing. See 8.308.15 NMAC.

E. Unless otherwise approved by MAD, the MCO shall have an open formulary for all psychotropic medications. Minor tranquilizers, sedatives, and hypnotics are not considered psychotropic medications for the purpose of this rule.

F. MCO shall ensure that a native American member accessing the pharmacy benefit at an Indian health service (IHS), tribal, and urban Indian (I/T/U) facility is exempt from the MCO's PDL when these pharmacies have their own PDL.

G. The MCO shall reimburse family planning clinics, school-based health centers (SBHCs) and the department of health (DOH) public health clinics for oral contraceptive agents and plan B when dispensed to a member and billed using healthcare common procedure coding (HCPC) codes and CMS 1500 forms.

H. The MCO shall meet all federal and state requirements related to pharmacy rebates and submit all necessary information as directed by HSD.

I. For a member 21 years of age and older not residing in an institution, the MCO must, at a minimum , cover the over-the-counter items which are insulin**,** diabetic test strips, prenatal vitamins, electrolyte replacement items, ophthalmic lubricants, pediculosides and scabicides, certain insect repellants, sodium chloride for inhalations, topical and vaginal antifungals and topical anti-inflammatories. Other

over-the-counter items may be designated as covered items after making a specific determination that it is overall more economical to cover an over-the-counter item as an alternative to prescription items or when an over-the-counter item is a preferred therapeutic alternative to prescription drug items. Such coverage is subject to the generic-first coverage provisions. Otherwise, the eligible recipient 21 years and older, or his or her authorized representative is responsible for purchasing or otherwise obtaining an over-the-counter item.

(1) The MCO may cover additional over-the counter items, with or without prior authorization, at its discretion or as medically necessary when a specific regimen of over-the-counter drugs is required to treat chronic disease conditions.

(2) For a member under 21 years of age, the MCO must cover over-the-counter drug items as medically necessary for the member, with or without prior authorization.

J. The MCO shall meet all federal and state requirements for identifying drug items purchased under the 340B drug purchasing provisions codified as Section 340B of the federal Public Health Service Act.

[8.308.9.14 NMAC - Rp, 8.308.9.14 NMAC, 5/1/2018]

8.308.9.15 EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) SERVICES: The benefit package includes the delivery of the federally mandated EPSDT services (42 CFR Part 441, Subpart B) provided by a primary care provider (PCP) as detailed in 8.320.2 NMAC. The MCO shall provide access to early intervention programs and services for a member identified in an EPSDT screen as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder. Unless otherwise specified in a service rule, EPSDT services are for a member under 21 years of age. For detailed description of each service, see 8.320.2 NMAC. EPSDT behavioral health services are included in 8.308.9.19 NMAC.

A. EPSDT nutritional counseling and services: The benefit package includes nutritional services furnished to a pregnant member and a member under 21 years of age as detailed in 8.310.2 NMAC.

B. EPSDT personal care: The benefit package includes personal care services for a member.

C. EPSDT private duty nursing: The benefit package includes private duty nursing for a member and the services shall be delivered in either his or her home or school setting.

D. EPSDT rehabilitation services: A member under 21 years of age who is eligible for home and community based waiver services receives medically necessary rehabilitation services through the EPSDT program; see 8.320.2 NMAC for a detailed description. The home and community-based waiver program provides rehabilitation services only for the purpose of community integration.

E. Services provided in schools: The benefit package includes services to a member provided in a school, excluding those specified in his or her individual education plan (IEP) or the individualized family service plan (IFSP); see 8.320.6 NMAC.

F. Tot-to-teen health checks:

(1) The MCO shall adhere to the MAD periodicity schedule and ensure that each eligible member receives age-appropriate EPSDT screens (tot-to-teen health checks), referrals, and appropriate services and follow-up care. See 8.320.2 NMAC for detailed description of the benefits. The services include, but are not limited to:

(a) education of and outreach to a member or the member's family regarding the importance of regular screens and health checks;

(b) development of a proactive approach to ensure that the member receives the services;

(c) facilitation of appropriate coordination with school-based providers;

(d) development of a systematic communication process with MCO network providers regarding screens and treatment coordination;

(e) processes to document, measure and assure compliance with MAD's periodicity schedule; and

(f) development of a proactive process to insure the appropriate follow-up evaluation, referral and treatment, including early intervention for developmental delay, vision and hearing screening, dental examinations and immunizations.

(2) The MCO will facilitate appropriate referral for possible or identified behavioral health conditions. See 8.321.2 NMAC for EPSDT behavioral health services descriptions.

[8.308.9.15 NMAC - Rp, 8.308.9.15 NMAC, 5/1/2018]

8.308.9.16 REPRODUCTIVE HEALTH SERVICES: The benefit package includes reproductive health services as detailed in 8.310.2 NMAC. The MCO shall implement written policies and procedures approved by HSD which define how a member is educated about his or her rights to family planning services, freedom of choice, to include access to non-contract providers, and methods for accessing family planning services.

A. The family planning policy shall ensure that a member of the appropriate age of both sexes who seeks family planning services shall be provided with counseling pertaining to the following:

(1) human immunodeficiency virus (HIV) and other sexually transmitted diseases and risk reduction practices; and

(2) birth control pills and devices including plan B and long acting reversible contraception.

B. The MCO shall provide a member with sufficient information to allow him or her to make informed choices including the following:

(1) types of family planning services available;

(2) the member's right to access these services in a timely and confidential manner;

(3) freedom to choose a qualified family planning provider who participates in the MCO network or from a provider who does not participate in the member's MCO network; and

(4) if a member chooses to receive family planning services from a non-contracted provider, the member shall be encouraged to exchange medical information between the PCP and the non-contracted provider for better coordination of care.

C. Pregnancy termination procedures: The benefit package includes services for the termination of a pregnancy as detailed in 8.310.2 NMAC. Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 441.202 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.310.2 NMAC. [8.308.9.16 NMAC - Rp, 8.308.9.16 NMAC, 5/1/2018]

8.308.9.17 PREVENTIVE PHYSICAL HEALTH SERVICES: The MCO shall follow current national standards for preventive health services, including behavioral health preventive services. 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 under these standards shall be adopted and reviewed at least every two years, updated when appropriate and disseminated to its practitioners and members. Unless a member refuses and the refusal is documented, the MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The MCO shall document medical reasons not to perform these services for an individual member. Member refusal is defined to include refusal to consent to and refusal to access care.

A. Initial assessment: The MCO shall conduct a health risk assessment (HRA), per HSD guidelines and processes, for the purpose of obtaining basic health and demographic information about the member, assisting the MCO in determining the need for a comprehensive needs assessment (CNA) for care coordination level assignment.

B. Family planning: The MCO must have a family planning policy. This policy must ensure that a member of the appropriate age of both sexes who seeks family planning services is 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.

C. Guidance: The MCO shall adopt policies that shall ensure that an applicable asymptomatic member is provided guidance on the following topics unless the member's refusal is documented:

(1) prevention of tobacco use;

(2) benefits of physical activity;

(3) benefits of a healthy diet;

(4) prevention of osteoporosis and heart disease in a menopausal member citing the advantages and disadvantages of calcium and hormonal supplementation;

(5) prevention of motor vehicle injuries;

(6) prevention of household and recreational injuries;

(7) prevention of dental and periodontal disease;

(8) prevention of HIV infection and other sexually transmitted diseases;

(9) prevention of an unintended pregnancy; and

(10) prevention or intervention for obesity or weight issues.

D. Immunizations: The MCO shall adopt policies that to the extent possible, ensure that within six months of enrollment, a member is immunized according to the type and schedule provided by current recommendations of the state department of health (DOH). The MCO shall encourage providers to verify and document all administered immunizations in the New Mexico statewide immunization information system (SIIS).

E. Nurse advice line: The MCO shall provide a toll-free clinical telephone nurse advice line function that includes at least the following services and features:

(1) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral; and

(2) pre-diagnostic and post-treatment health care decision assistance based on the member's symptoms.

F. 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 a member 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 a pregnant member to identify high-risk cases for special management;

(4) counseling which strongly advises voluntary testing for HIV;

(5) case management services to address the special needs of a member who has 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.

G. 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, each asymptomatic member receives at least the following preventive screening services listed below.

(1) *Screening for breast cancer*: A female member between the ages of 40-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Blood pressure measurement*: A member 18 years of age or older shall receive a blood pressure measurement at least every two years.

(3) *Screening for cervical cancer*: A female member with a cervix shall receive cytopathology testing starting at the onset of sexual activity, but at least by 21 years of age and every three years thereafter until reaching 65 years of age when 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.

(4) *Screening for chlamydia*: All sexually active female members 25 years of age and younger shall be screened for chlamydia. All female members over 25 years of age 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.

(5) *Screening for colorectal cancer*: A member 50 years of age and older, who is at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy or colonoscopy or double contrast barium at a periodicity determined by the MCO.

(6) *EPSDT screening for elevated blood lead levels*: A risk assessment for elevated blood lead levels shall be performed beginning at six months and repeated at nine months of age. A member shall receive a blood lead measurement at 12 months and 24 months of age. A member between the ages of three and six years, for whom no previous test exists, should also be tested, and screenings shall be done in accordance with the most current recommendations of the American academy of pediatrics.

(7) *EPSDT newborn screening*: A newborn member shall be screened for those disorders specified in the state of New Mexico metabolic screen and any screenings shall be done in accordance with the most current recommendations of the American academy of pediatrics.

(8) *Screening for obesity*: A member shall receive body weight, height and length measurements with each physical exam. A member under 21 years of age shall receive a BMI percentile designation.

(9) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, Rh (D) 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.

(10) *Screening for rubella*: All female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology.

(11) *Screening for tuberculosis*: Routine tuberculin skin testing shall not be required for all members. The following high-risk members shall be screened or previous screenings noted:

(a) a member who has immigrated from countries in Asia, Africa, Latin America or the middle east in the preceding five years;

(b) a member who has substantial contact with immigrants from those areas; a member who is a migrant farm worker;

(c) a member who is an alcoholic, homeless or is an injecting drug user. HIV-infected persons shall be screened annually; and

(d) a member whose screening tuberculin test is positive (>10 mm of induration) must be referred to the local DOH public health office in his or her community of residence for contact investigation.

(12) *Serum cholesterol measurement*: A male member 35 years and older and a female member 45 years and older who is at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. A member 20 years and older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements annually.

(13) *Tot-to-teen health checks*: The MCO shall operate the tot-to-teen mandated EPSDT program as outlined in 8.320.2 NMAC. Within three months of enrollment lock-in, the MCO shall ensure that the member is current

according to the screening schedule, unless more stringent requirements are specified in these standards. The MCO shall encourage its PCPs to assess and document for age, height, gender appropriate weight, and body mass index (BMI) percentage during EPSDT screens to detect and treat evidence of weight or obesity issues in members under 21 years of age.

(14) *Screening for type 2 diabetes*: A member with one or more of the following risk factors for diabetes shall be screened. Risk factors include:

(a) a family history of diabetes (parent or sibling with diabetes); obesity (>twenty percent over desired body weight or BMI >27kg/m2);

(b) race or ethnicity (e.g. hispanic, native American, African American, Asian-Pacific islander);

(c) 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); and

(d) a delivery of newborn over nine pounds.

(15) A member 21 years of age and older must be screened to detect high risk for behavioral health conditions at his or her first encounter with a PCP after enrollment.

(16) The MCO shall require its PCPs to refer a member, whenever clinically appropriate, to behavioral health provider, see 8.321.2 NMAC. The MCO shall assist the member with an appropriate behavioral health referral.

(17) Screens and preventative screens shall be updated as recommended by the United States preventative services task force.

[8.308.9.17 NMAC - Rp, 8.308.9.17 NMAC, 5/1/2018]

8.308.9.18 TELEMEDICINE SERVICES: The benefit package includes telemedicine services as detailed in 8.310.2 NMAC.

A. The MCO must:

(1) promote and employ broad-based utilization of statewide access to Health Insurance Portability and Accountability Act (HIPAA)-compliant telemedicine service systems including, but not limited to, access to text telephones or teletype (TTYs) and 711 telecommunication relay services;

(2) follow state guidelines for telemedicine equipment or connectivity;

(3) follow accepted HIPAA and 42 CFR part two regulations that affect telemedicine transmission, including but not limited to staff and contract provider training, room setup, security of transmission lines, etc; the MCO shall have and implement policies and procedures that follow all federal and state security and procedure guidelines;

(4) identify, develop, and implement training for accepted telemedicine practices;

(5) participate in the needs assessment of the organizational, developmental, and programmatic requirements of telemedicine programs;

(6) report to HSD on the telemedicine outcomes of telemedicine projects and submit the telemedicine report; and

(7) ensure that telemedicine services meet the following shared values, which are ensuring: competent care with regard to culture and language needs; work sites are distributed across the state, including native American sites for both clinical and educational purposes; and coordination of telemedicine and technical functions at either end of network connection.

B. The MCO shall participate in project extension for community healthcare outcomes (ECHO), in accordance with state prescribed requirements and standards, and shall:

(1) work collaboratively with HSD, the university of New Mexico, and providers on project ECHO;

(2) identify high needs, high cost members who may benefit from project ECHO participation;

(3) identify its PCPs who serve high needs, high cost members to participate in project ECHO;

(4) assist project ECHO with engaging its MCO PCPs in project ECHO's center for medicare and medicaid innovation (CMMI) grant project;

(5) reimburse primary care clinics for participating in the project ECHO model;

(6) reimburse "intensivist" teams;

(7) provide claims data to HSD to support the evaluation of project ECHO;

(8) appoint a centralized liaison to obtain prior authorization approvals related to project ECHO; and

(9) track quality of care and outcome measures related to project ECHO.

[8.308.9.18 NMAC - Rp, 8.308.9.18 NMAC, 5/1/2018]

8.308.9.19 BEHAVIORAL HEALTH SERVICES:

A. The MCO shall cover the following behavioral health services listed below. When an additional behavioral health service is approved by MAD, the MCO shall cover that service as well. See 8.321.2 NMAC for detailed descriptions of each service. MAD makes available on its website its behavioral health service definitions and crosswalk, along with other information.

(1) Applied behavior analysis: The benefit package includes applied behavior analysis (ABA) services for a member 12 months of age up to 21 years of age who has a well-documented medical diagnosis of autism spectrum disorder (ASD), and for a member 12 months to three years of age who has a well-documented risk for the development of ASD. The need for ABA services must be identified in

the member's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

(2) Assertive community treatment services (ACT): The benefit package includes assertive community treatment services for a member 18 years of age and older.

(3) Behavioral health respite: Behavioral health respite care is provided to a member under 21 years of age to support the member's family and strengthen their resiliency during the respite while the member is in a supportive environment. Respite care is provided to a member with a severe emotional disturbance who resides with his or her family and displays challenging behaviors that may periodically overwhelm the member's family's ability to provide ongoing supportive care. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines-respite services-for a detailed description. Behavioral health respite is not a benefit for ABP eligible recipients.

(4) Comprehensive community support services: The benefit package includes comprehensive community support services for a member.

(5) Crisis Services: The benefit package includes three types of crisis services:

(a) 24-hour crisis telephone support; and

(b) mobile crisis team; and

(c) crisis triage centers.

(6) Family support services: The benefit package includes family support services to a member whose focus is on the member and his or her family and the interactive effect through a variety of informational and supportive activities that assists the member and his or her family develop patterns of interaction that promote wellness and recovery over time. The positive interactive effect between the member and his or her family strengthens the effectiveness of other treatment and recovery initiatives. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines -family support services-for a detailed description. Family support services are not a benefit for ABP eligible recipients.

(7) Hospital outpatient services: The benefit package includes outpatient psychiatric and partial hospitalization services provided in PPS-exempt unit of a general hospital for a member.

(8) 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.

(9) Intensive outpatient (IOP) services: The benefit package includes intensive outpatient services for a member 13 years of age.

(10) Medication assisted treatment (MAT) and Opioid Treatment Programs: The benefit package includes opioid treatment services for opioid addiction to a member through an opioid treatment center as defined in 42 CFR Part 8, Certification of Opioid Treatment; and buprenorphine and related pharmaceuticals. Medication assisted treatments include use of buprenorphine and similarly acting products.

(11) Outpatient therapy services: The benefit package includes outpatient therapy services (individual, family, and group) for a member.

(12) Psychological rehabilitation services: The benefit package includes adult psychosocial rehabilitation services for a member 18 years and older.

(13) Recovery services: The MCO benefit package includes recovery services for a member. Recovery services are peer-to-peer support within a group setting to develop and enhance wellness and healthcare practices. The service enables a member to identify additional needs and goals and link him or herself to additional support as a result. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines -recovery services-for a detailed description. Recovery services are not a benefit for ABP eligible recipients.

B. Behavioral health EPSDT services: The benefit package includes the delivery of the federally mandated EPSDT services (42 CFR Section 441.57) provided by a behavioral health practitioner for a member under 21 years of age. See 8.321.2 NMAC for a detailed description of each service. The MCO shall provide access to EPSDT for a member identified in his or her EPSDT tot to teen health check screen or another diagnostic evaluation as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder.

(1) Accredited residential treatment center (ARTC): The benefit package includes services furnished in an ARTC furnished as part of the EPSDT program. ARTC services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The need for ARTC services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(2) Behavior management skills development services (BMS): The benefit package includes BMS services furnished as part of the EPSDT program. BMS services are provided to a member who has an identified need for such services and meets the required LOC. The need for BMS services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(3) Day

treatment services: The benefit package includes day treatment services furnished as part of the EPSDT program. Day treatment services are provided to a member who has an identified need for such services and meets the required LOC. The need for day treatment services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(4) Inpatient hospitalization services provided in freestanding psychiatric hospitals: The benefit package includes inpatient psychiatric care furnished in a freestanding psychiatric hospital furnished as part of the EPSDT program. Inpatient hospitalization services are provided in a freestanding psychiatric hospital are provided to a member who has an identified need for such services and meet the required LOC. The need for such services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(5) Multi-systemic therapy (MST): The benefit package includes MST services furnished as part of the EPSDT program. MST services are provided to a member who has an identified need for such services and meets the required LOC. The need for MST services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(6) Psychosocial rehabilitation services (PSR): The benefit package includes PSR services furnished as part of the EPSDT program. PSR is provided to a member who has an identified need for such services and meets the required LOC. The need for PSR services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(7) Treatment foster care I (TFC I): The benefit package includes TFC I furnished as part of the EPSDT program. TFC I services are provided to a member who has an identified need for such services and meets the required LOC. The need for TFC I services must be identified in the member's tot to teen health check or another diagnostic evaluation furnished through a health check referral.

(8) Treatment foster care II (TFC II): The benefit package includes TFC II services furnished as part of the EPSDT program. TFC II is provided to a member who has an identified need for such services and meets the required LOC. The need for TFC II services must be identified in the member's tot to teen health check or another diagnostic evaluation furnished through a health check referral.

(9) Residential non-accredited treatment center (RTC) and group home: The benefit package includes services furnished in a RTC center or group home as part of the EPSDT program. RTC or group home services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The need for RTC and group home services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

[8.308.9.19 NMAC - Rp, 8.308.9.19 NMAC, 5/1/2018]

8.308.9.20 COMMUNITY BENEFIT SERVICES: The MCO shall cover community benefit services for a member who meets the specific eligibility requirements for each MCO community benefit service as detailed in 8.308.12 NMAC. When an additional community benefit service is approved by MAD, the MCO shall cover that service as well.

[8.308.9.20 NMAC - Rp, 8.308.9.20 NMAC, 5/1/2018]

8.308.9.21 ALTERNATIVE BENEFITS PLAN (ABP) BENEFITS FOR ABP MCO MEMBERS: The MAD category of eligibility "other adults" has an alternative benefit plan (ABP). The MCO shall cover the ABP specific services for an ABP member. Services are made available through a MCO under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP member:

A. has limitations on specific benefits;

B. does not have all standard medicaid state plan benefits available; and

C. has some benefits, primarily preventive services that are available only to an ABP member. The ABP benefits and services are detailed in Sections 12 through 18 of 8.309.4 NMAC. All EPSDT services are available to an ABP member under 21 years. Services for an ABP member under the age of 21 years not subject to the duration, frequency, and annual or lifetime benefit limitations that are applied to an ABP eligible recipient 21 years of age and older. The MCO shall comply with all HSD contractual provisions and with all NMAC rules that pertain to the MCO's responsibilities to its members as listed below:

(1) provider networks found in 8.308.2 NMAC;

(2) managed care eligibility found in 8.308.6 NMAC;

(3) enrollment and disenrollment from managed care found in 8.308.7 NMAC;

(4) managed care member education - rights and responsibilities found in 8.308.8 NMAC;

(5) care coordination found in 8.308.10 NMAC;

(6) transition of care found in 8.308.11 NMAC;

(7) managed care cost sharing found in 8.308.14 NMAC;

(8) managed care grievance and appeals found in 8.308.15 NMAC;

(9) managed

care reimbursement found in 8.308.20 NMAC;

(10) quality management found in 8.308.21 NMAC; and

(11) managed care fraud, waste and abuse found in 8.308.22 NMAC.

[8.308.9.21 NMAC - Rp, 8.308.9.21 NMAC, 5/1/2018]

8.308.9.22 MAD ALTERNATIVE BENEFITS PLAN GENERAL BENEFITS FOR ABP EXEMPT MEMBERS (ABP exempt): An ABP member who self-declares he or she has a qualifying condition is evaluated by his or her MCO for determination if he or she meets an ABP qualifying condition. An ABP exempt member may select to no longer utilize his or her ABP benefits package. Instead, the ABP exempt member will utilize his or her MCO's medicaid benefits package. See 8.308.9.11-20 NMAC for detailed description of the MCO medicaid benefit services. All services, services limitations and co-payments that apply to full benefit medicaid recipients apply to APB-exempt recipients. An ABP-exempt recipient does not have access to the benefits that only apply to ABP recipients. The ABP co-payments do not apply to an ABP-exempt recipient. The limitations on services that apply only to ABP-recipients do not apply to ABP-exempt recipients. The MCO shall comply with all HSD contractual provisions and with all NMAC rules that pertain to the MCO's responsibilities to its members as listed below:

A. provider networks found in 8.308.2 NMAC;

B. managed care eligibility found in 8.308.6 NMAC;

C. enrollment and disenrollment from managed care found in 8.308.7 NMAC;

D. managed care member education - rights and responsibilities found in 8.308.8 NMAC;

E. care coordination found in 8.308.10 NMAC;

F. transition of care found in 8.308.11 NMAC;

G. community benefits found in 8.308.12 NMAC;

H. managed care member rewards found in 8.308.13 NMAC

I. managed care cost sharing found in 8.308.14 NMAC;

J. managed care grievance and appeals found in 8.308.15 NMAC;

K. managed care reimbursement found in 8.308.20 NMAC;

L. quality management found in 8.308.21 NMAC; and

M. managed care fraud, waste and abuse found in 8.308.22 NMAC.

[8.308.9.22 NMAC - Rp, 8.308.9.22 NMAC, 5/1/2018]

8.308.9.23 SERVICES EXCLUDED FROM THE MCO BENEFIT PACKAGE: MAD does not cover some services. For the following services that are covered in another MAP category of eligibility, reimbursement shall be made by MAD or its contractor. However, the MCO is expected to coordinate these services, when applicable, and ensure continuity of care by overseeing PCP consultations, medical record updates and general coordination.

A. Medicaid in the schools: Services are covered under 8.320.6 NMAC. Reimbursement for services is made by MAD or its contractor.

B. Special rehabilitation services-family infant toddler (FIT): Early intervention services provided for a member birth to three years of age who has or is at risk for a developmental delay. Reimbursement for services is made by MAD or its contractor.

[8.308.9.23 NMAC - Rp, 8.308.9.23 NMAC, 5/1/2018]

8.308.9.24 Emergency and post stabilization services.

A. In this section, emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:

(1) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

B. In this section, emergency services means covered inpatient and outpatient services as follows.

(1) Furnished by a provider that is qualified to furnish these services under the federal rules. See 42 CFR 438.114.

(2) Needed to evaluate or stabilize an emergency medical condition.

C. Post-stabilization care services means covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described 42 CFR 438.114 (e), to improve or resolve the member's condition.

D. The MCO is responsible for coverage and payment of emergency services and post-stabilization care services. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO. The MCO may not deny payment for treatment obtained under either of the following circumstances.

(1) A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition in Subsection A of 8.308.9.24 NMAC.

(2) A representative of the MCO instructs the member to seek emergency services.

E. The MCO may not:

(1) limit what constitutes an emergency medical condition with reference to Subsection A of 8.308.9.24 NMAC on the basis of lists of diagnoses or symptoms; or

(2) refuse to cover emergency services based on the emergency room provider or hospital not notifying the member's PCP or the MCO.

F. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

G. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO that is responsible for coverage and payment.

[8.308.9.24 NMAC - Rp, 8.308.9.24 NMAC, 5/1/2018]

8.308.9.25 Additional coverage requirements:

A. The MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

B. The services supporting members with ongoing or chronic conditions or who require long-term services and supports must be authorized in a manner that reflects the member's ongoing need for such services and supports.

C. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20, family planning services.

D. The MCO must specify what constitutes "medically necessary services" in a manner that:

(1) is no more restrictive than that used in the New Mexico administrative code (NMAC) MAD rules, including quantitative and non-quantitative treatment limits, as indicated in state statutes and rules. The state plan, and other state policy and procedures; and

(2) addresses the extent to which the MCO is responsible for covering services that address:

(a) the prevention, diagnosis, and treatment of a member's disease, condition, or disorder that results in health impairments or disability;

(b) the ability for a member to achieve age-appropriate growth and development;

(c) the ability for a member to attain, maintain, or regain functional capacity; and

(d) The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

E. Authorization of services: For the processing of requests for initial and continuing authorizations of services, the MCO must:

(1) have in place, and follow, written policies and procedures;

(2) have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

(3) consult with the requesting provider for medical services when appropriate;

(4) authorize long term services and supports (LTSS) based on an enrollee's current needs assessment and consistent with the person-centered service plan;

(5) assure 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 an individual who has appropriate expertise in addressing the member's medical, behavioral health, or LTSS needs;

(6) notify the requesting provider, and give the member written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested and the notice must meet the requirements of 42 CFR 438.404, timely and adequate notice of adverse benefit determination; and

(7) for drug items that require prior authorization and drug items that are not on the MCO preferred drug list:

(a) provide a response by telephone or other telecommunication device within 24 hours of a request for prior authorization;

(b) provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation;

(c) consider in the review process any medically accepted indications for the drug item consistent with the American hospital formulary service drug information; United States pharmacopeia-drug information (or its successor publications); the DRUGDEX information system; and peer-reviewed medical literature as described in section 1927(d)(5)(A) of the Social Security Act.

[8.308.9.25 NMAC - Rp, 8.308.9.25 NMAC, 5/1/2018]

HISTORY OF 8.308.9 NMAC:
[**RESERVED**]

History of Repealed Material:
8.308.9 NMAC - Managed Care Program, Benefit Package, filed 12/17/2013 Repealed effective 5/1/2018.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 10 CARE COORDINATION

8.308.10.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.10.1 NMAC - Rp, 8.308.10.1 NMAC, 5/1/2018]

8.308.10.2 SCOPE: This rule applies to the general public.
[8.308.10.2 NMAC - Rp, 8.308.10.2 NMAC, 5/1/2018]

8.308.10.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.308.10.3 NMAC - Rp, 8.308.10.3 NMAC, 5/1/2018]

8.308.10.4 DURATION: Permanent.
[8.308.10.4 NMAC - Rp, 8.308.10.4 NMAC, 5/1/2018]

8.308.10.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.10.5 NMAC - Rp, 8.308.10.5 NMAC, 5/1/2018]

8.308.10.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.10.6 NMAC - Rp, 8.308.10.6 NMAC, 5/1/2018]

8.308.10.7 DEFINITIONS: [**RESERVED**]

8.308.10.8 [**RESERVED**]
[8.308.10.8 NMAC - Rp, 8.308.10.8 NMAC, 5/1/2018]

8.308.10.9 CARE COORDINATION:

A. General requirements:

(1) Care coordination services are provided and coordinated with the eligible recipient member and his or her family, as appropriate. Care coordination involves, but is not limited to, the following: planning treatment strategies; developing treatment and service plans; monitoring outcomes and resource use; coordinating visits with primary care and specialists providers; organizing care to avoid duplication of services; sharing information among medical and behavioral care professionals and the member's family; facilitating access to services; and actively managing transitions of care, including participation in hospital discharge planning.

(2) Every member has the right to refuse to participate in care coordination. In the event the member refuses this service, the managed care organization (MCO) will document the refusal in the member's file and report to HSD. The member remains enrolled with the MCO with no reduction in the availability of services.

(3) If a native American member requests assignment to a native American care coordinator, the MCO must employ or contract with a native American care coordinator or contract with a community health representative (CHR) to serve as the care coordinator.

(4) Individuals with special health care needs (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 and who require health and related services of a type or amount beyond that required by other members. 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 members so that the MCO shall facilitate access to appropriate services through its care coordination process and comply with provisions of 42 CFR Section 438.208.

B. Health risk assessment (HRA): The MCO shall conduct a HSD approved health risk assessment (HRA) either by telephone, in person or as otherwise approved by HSD. The HRA is conducted for the purpose of:

(1) introducing the MCO to the member;

(2) obtaining basic health and demographic information about the member; and

(3) confirming the need for a comprehensive needs assessment (CNA); and

(4) determining the need for a nursing facility (NF) level of care (LOC) assessment, as applicable. Requirements for health risk assessments are defined in the HSD managed care policy manual (section 04 care coordination).

C. Assignment to care coordination levels two and three: The MCO shall conduct a HSD approved CNA to assess the member's medical, behavioral health, and long term care needs and determine the care coordination level. Requirements for care coordination level two and three determinations are defined in the HSD managed care policy manual (section 04 care coordination).

D. Increase in the level of care coordination services: The requirements establishing a need for a CNA for a higher level of care coordination determination are defined in the HSD managed care policy manual (section 04 care coordination).

E. Comprehensive care plan requirements: The MCO shall develop a comprehensive care

plan (CCP) for members in care coordination levels two and three. Requirements for CCP development are defined in the HSD managed care policy manual (section 04 care coordination).

F. On-going reporting: The MCO shall require that the following information about the member's care is shared amongst medical, behavioral health, and long-term care providers:

(1) drug therapy;

(2) laboratory and radiology results;

(3) sentinel events, such as hospitalization, emergencies, or incarceration;

(4) discharge from a psychiatric hospital, a residential treatment service, treatment foster care or from other behavioral health services; and

(5) all LOC transitions.

G. Electronic visit verification (EVV) system:

(1) The MCO, together with the other MCOs, shall contract with a vendor to implement an EVV system in accordance with the federal Twenty First Century Cures Act.

(2) The MCO shall maintain an EVV system capable of leveraging up to date technology as it emerges to improve functionality in all areas of the state, including rural areas.

[8.308.10.9 NMAC - Rp, 8.308.10.9 NMAC, 5/1/2018]

HISTORY OF 8.308.10 NMAC: [RESERVED]

History of Repealed Material: 8.308.10 NMAC - Managed Care Program, Care Coordination, filed 12/17/2013 Repealed effective 5/1/2018.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 11 TRANSITION OF CARE

8.308.11.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.11.1 NMAC - Rp, 8.308.11.1 NMAC, 5/1/2018]

8.308.11.2 SCOPE: This rule applies to the general public.
[8.308.11.2 NMAC - Rp, 8.308.11.2 NMAC, 5/1/2018]

8.308.11.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.308.11.3 NMAC - Rp, 8.308.11.3 NMAC, 5/1/2018]

8.308.11.4 DURATION: Permanent.
[8.308.11.4 NMAC - Rp, 8.308.11.4 NMAC, 5/1/2018]

8.308.11.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.11.5 NMAC - Rp, 8.308.11.5 NMAC, 5/1/2018]

8.308.11.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.11.6 NMAC - Rp, 8.308.11.6 NMAC, 5/1/2018]

8.308.11.7 DEFINITIONS: [**RESERVED**]

8.308.11.8 [**RESERVED**]
[8.308.11.8 NMAC - Rp, 8.308.11.8 NMAC, 5/1/2018]

8.308.11.9 TRANSITION OF CARE: Transition of care refers to movement of an eligible recipient or a manage care organization (MCO) member from one health care practitioner or setting to another as his or her condition and health care needs change. The MCO shall have the resources, the policies and the procedures in place to actively assist the member with his or her transition of care.

A. Care coordination will be offered to members who are:

(1) transitioning from a nursing facility or out-of-home placement to the community;

(2) moving from a higher level of care to a lower level of care (LOC);

(3) turning 21 years of age;

(4) changing MCOs while hospitalized;

(5) changing MCOs during major organ and tissue transplantation services; and

(6) changing MCOs while receiving outpatient treatments for significant medical conditions. A member shall continue to receive medically necessary services in an uninterrupted manner during transitions of care.

B. The following is a list of HSD's general MCO requirements for transition of care.

(1) The MCO shall establish policies and procedures to ensure that each member is contacted in a timely manner and is appropriately assessed by its MCO, using the HSD prescribed timeframes, processes and tools to identify his or her needs.

(2) The MCO shall have policies and procedures covering the transition of an eligible recipient into a MCO, which shall include:

(a) member and provider educational information about the MCO;

(b) self-care and the optimization of treatment; and

(c) the review and update of existing courses of the member's treatment.

(3) The MCO shall not transition a member to another provider for continuing services, unless the current provider is not a contracted provider.

(4) The MCO shall facilitate a seamless transition into a new service, a new provider, or both, in a care plan developed by the MCO without disruption in the member's services.

(5) When a member of a MCO is transitioning to another MCO, the receiving MCO shall immediately contact the member's relinquishing MCO and request the transfer of "transition of care data" as specified by HSD. If a MCO is contacted by another MCO requesting the transfer of "transition of care data" for a transitioning member, then upon verification of such a transition, the relinquishing MCO shall provide such data in the timeframe and format specified by HSD to the receiving MCO, and both MCOs shall facilitate a seamless transition for the member.

(6) The receiving MCO will ensure that its newly transitioning member is held harmless by his or her provider for the costs of medically necessary covered services, except for applicable cost sharing.

(7) For a medical assistance division (MAD) medically necessary covered service provided by a contracted provider, the MCO shall provide continuation of such services from that provider, but may require prior authorization for the continuation of such services from that provider beyond 30 calendar days. The receiving MCO may initiate a provider change only as specified in the MCO agreement with HSD.

(8) The receiving MCO shall continue providing services previously authorized by HSD, its contractor or designee, in the member's approved community benefit care plan, behavioral health treatment plan or service plan without regard to whether such a service is provided by contracted or non-contracted provider. The receiving MCO shall not reduce approved services until the member's care coordinator conducts a comprehensive needs assessment (CNA).

C. Transplant services, durable medical equipment and prescription drugs:

(1) If an eligible recipient has received HSD approval, either through fee-for-service (FFS) or any other HSD contractor, the receiving MCO shall reimburse the HSD approved providers if a donor organ becomes available during the first 30 calendar days of the member's MCO enrollment.

(2) If a member was approved by a MCO for transplant services, HSD shall reimburse the MCO approved providers if a donor organ becomes available during the first 30 calendar days of the eligible recipient's FFS enrollment. The MCO provider who delivers these services will be eligible for FFS enrollment if the provider is willing.

(3) If a member received approval from his or her MCO for durable medical equipment (DME) costing two thousand dollars ($2,000) or more, and prior to the delivery of the DME item, was disenrolled from the MCO, the relinquishing MCO shall pay for the item.

(4) If an eligible recipient received FFS approval for a DME costing two thousand dollars ($2,000) or more, and prior to the delivery of the DME item, he or she is enrolled in a MCO, HSD shall pay for the item. The DME provider will be eligible for FFS provider enrollment if the provider is willing.

(5) If a FFS eligible recipient enrolls in a MCO, the receiving MCO shall pay for prescribed drug refills for the first 30 calendar days or until the MCO makes other arrangements.

(6) If a MCO member is later determined to be exempt from MCO enrollment, HSD will pay for prescription drug refills for the first 30 calendar days of his or her FFS enrollment. The pharmacy provider will be eligible for FFS enrollment if the provider is willing;

(7) If a FFS eligible recipient is later enrolled in a MCO, the receiving MCO will honor all prior authorizations granted by HSD or its contractors for the first 30 calendar days or until it makes other arrangements for the transition of services. A provider who delivered services approved by HSD or through its contractors shall be reimbursed by the receiving MCO.

(8) If a MCO member is later determined to be exempt from MCO enrollment, HSD will honor the relinquishing MCO's prior authorizations for the first 30 calendar days or until other arrangements for the transition of services have been made. The provider will be eligible for FFS enrollment if the provider is willing.

D. Transition of care requirements for pregnant women:

(1) When a member is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to her enrollment in the MCO, the receiving MCO will be responsible for providing continued access to her prenatal care provider (whether a contracted or non-contracted provider) through the two month postpartum period without any form of prior approval.

(2) When a newly enrolled member is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to her enrollment, the receiving MCO shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care and delivery, without any form of prior approval from the receiving MCO and without

regard to whether such services are being provided by a contracted or non-contracted provider for up to 60 calendar days from her MCO enrollment or until she may be reasonably transferred to a MCO contracted provider without disruption in care, whichever is less.

(3) When a member is receiving services from a contracted provider, her MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the two month postpartum period.

(4) When a member is receiving services from a non-contracted provider, her MCO will be responsible for the costs of continuation of medically necessary covered prenatal services, delivery, through the two month postpartum period, without any form of prior approval, until such time when her MCO determines it can reasonably transfer her to a contracted provider without impeding service delivery that might be harmful to her health.

E. Transition from institutional facility to community:

(1) The MCO shall develop and implement methods for identifying members who may have the ability, the desire, or both, to transition from institutional care to his or her community, such methods include, at a minimum:

(a) the utilization of a CNA;

(b) the utilization of the preadmission screening and annual resident review (PASRR);

(c) minimum data set (MDS);

(d) a provider referral including hospitals, and residential treatment centers;

(e) an ombudsman referral;

(f) a family member referral;

(g) a change in medical status;

(h) the member's self-referral;

(i) community reintegration allocation received;

(j) state agency referral; and

(k) incarceration or detention facility referral.

(2) When a member's transition assessment indicates that he or she is a candidate for transition to the community, his or her MCO care coordinator shall facilitate the development and completion of a transition plan, which shall remain in place for a minimum of 60 calendar days from the decision to pursue transition or until the transition has occurred and a new care plan is in place. The transition plan shall address the member's transition needs including but not limited to:

(a) his or her physical and behavioral health needs;

(b) the selection of providers in his or her community;

(c) continuation of MAP eligibility;

(d) his or her housing needs;

(e) his or her financial needs;

(f) his or her interpersonal skills; and

(g) his or her safety.

(3) The MCO shall conduct an additional assessment within 75 calendar days of the member's transition to his or her community to determine if the transition was successful and identify any remaining needs of the member.

F. Transition from the New Mexico health insurance exchange:

(1) The receiving MCO must minimize the disruption of the newly enrolled member's care and ensure he or she has uninterrupted access to medically necessary services when transitioning between a MCO and his or her New Mexico health insurance exchange qualified health plan coverage.

(2) At a minimum, the receiving MCO shall establish transition guidelines for the following populations:

(a) pregnant members, including the two month postpartum period;

(b) members with complex medical conditions;

(c) members receiving ongoing services or who are hospitalized at the time of transition; and

(d) members who received prior authorization for services from their qualified health plan.

(3) The receiving MCO is expected to coordinate services and provide phase-in and phase-out time periods for each of these populations, and to maintain written policies and procedures to address these coverage transitions.

[8.308.11.9 NMAC - Rp, 8.308.11.9 NMAC, 5/1/2018]

HISTORY OF 8.308.11 NMAC:
[**RESERVED**]

History of Repealed Material:
8.308.11 NMAC - Managed Care Program, Transition of Care, filed 12/17/2013 Repealed effective 5/1/2018.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 15 GRIEVANCES AND APPEALS

8.308.15.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.15.1 NMAC - Rp, 8.308.15.1 NMAC, 5/1/2018]

8.308.15.2 SCOPE: This rule applies to the general public.

[8.308.15.2 NMAC - Rp, 8.308.15.2 NMAC, 5/1/2018]

8.308.15.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Sections 27-2-12 et seq., NMSA 1978.
[8.308.15.3 NMAC - Rp, 8.308.15.3 NMAC, 5/1/2018]

8.308.15.4 DURATION: Permanent.
[8.308.15.4 NMAC - Rp, 8.308.15.4 NMAC, 5/1/2018]

8.308.15.5 EFFECTIVE DATE: May 1, 2018 unless a later date is cited at the end of a section.
[8.308.15.5 NMAC - Rp, 8.308.15.5 NMAC, 5/1/2018]

8.308.15.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.15.6 NMAC - Rp, 8.308.15.6 NMAC, 5/1/2018]

8.308.15.7 DEFINITIONS:

A. "Administrative law judge (ALJ)" means the hearing officer appointed by the HSD fair hearings bureau (FHB) to oversee the claimant's administrative hearing process, to produce an evidentiary record and render a recommendation to the medical assistance division (MAD) director.

B. "Adverse action against a member" is when a HSD managed care organization (MCO) intends or has taken action against a member of his or her MCO as in one or more of the following situations.

(1) An adverse benefit determination is the denial, reduction, limited authorization, suspension, or termination of a newly requested benefit or benefit currently being provided to a member including determinations based on the type or level of service, medical necessity criteria or requirements, appropriateness of setting, or effectiveness of a service other than a value-added service. It includes the following:

(a) a change to a level of care (LOC) benefit currently being received through a MCO, including a reduction or other change in the member's LOC, and a transfer or discharge of a nursing facility (NF) resident;

(b) the retrospective denial, reduction, or limited authorization of a benefit rendered which was provided on a presumed emergency basis, whether in or out of network, or provided without having received any required authorization or LOC determination prior to the service being rendered, with the exception of a MCO value-added service;

(c) the denial in whole or in part of a member's provider claim by the MCO regardless of whether the member is being held responsible for payment;

(d) the failure of the MCO, or its designee:

(i) to make a benefit determination in a timely manner;

(ii) to provide a benefit in a timely matter;

(iii) to act within the timeframes regarding the MCO's established member appeal requirements;

(e) the belief of a member, his or her authorized representative or authorized provider that the MCO's admission determination, LOC determination, or preadmission screening and annual resident review (PASRR) requirements determination is not accurate or the belief that the frequency, intensity or duration of the benefit is insufficient to meet the medical needs of the member. When the issue stems from a PASRR determination, the member will request a HSD PASRR administrative hearing governed by 8.354.2 NMAC instead of a MCO member appeal or a HSD administrative hearing; and

(f) the denial of a request to dispute a financial liability, including co-payments, premiums or other member financial liabilities.

(2) Other actions include:

(a) a budget or allocation for which a member, his or her authorized representative, or authorized provider believes the member's home and community-based waiver benefit or the member's budget or allocations were erroneously determined or is insufficient to meet the member's needs; and

(b) a denial, limitation, or non-payment of emergency or non-emergency transportation, or meals and lodging.

C. "Adverse action against a provider" means when a MCO intends or has taken adverse action against a provider based on the MCO denial of the provider's payment, including a denial of a claim for lack of medical necessity or as not a covered benefit.

D. "Authorized provider" means the member's provider who has been authorized in writing by the member or his or her authorized representative to request a MCO expedited member appeal or a MCO standard member appeal on behalf of the member. An authorized provider does not have the full range of authority to make medical decisions on behalf of the member.

E. "Authorized representative" means the individual designated by the member or legal guardian to represent and act on the member's behalf.

(1) The member or authorized representative must provide documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time-frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or

individuals designated in writing by the member.

(2) If a member, due to his or her medical incapacity, is unable to appoint an authorized representative and the authorized representative is unable to be reached and immediate medical care is needed, the member's treating provider may act as the member's authorized representative until such time as the member's authorized representative is available or until such time as the member is able to appoint an authorized representative. In this case, the authorized provider is allowed to file a MCO expedited or standard member appeal. The member's medical record must demonstrate that the member was incapacitated and the member's medical condition required immediate action prior to the authorized representative being located.

F. "HSD expedited administrative hearing" means an expedited informal evidentiary hearing conducted by the HSD fair hearings bureau (FHB) in which evidence may be presented as it relates to an adverse action taken or intended to be taken, by the MCO. A member or his or her authorized representative may request a HSD expedited administrative hearing only after exhausting his or her MCO expedited or standard member appeal process and unless the request for a HSD expedited administrative hearing is because the MCO has denied the member's request for a member appeal to be expedited. See 8.352.2 NMAC for a detailed description of the HSD expedited administrative hearing process and Subsection B of 8.308.15.13 NMAC.

G. "HSD PASRR administrative hearing" means a HSD administrative hearing process which is an informal evidentiary hearing conducted by FHB in which evidence may be presented as it relates to an adverse action taken or intended to be taken by a MCO of a member's disputed PASRR determination, or a member's disputed transfer or discharge from a NF. See 8.354.2 NMAC for a detailed description of the HSD PASRR administrative hearing process.

H. "HSD standard administrative hearing" means an informal evidentiary hearing conducted by FHB in which evidence may be presented as it relates to an adverse action taken or intended to be taken, by the MCO. A member or his or her authorized representative may request a HSD standard administrative hearing only after exhausting his or her MCO expedited or standard member appeal process. See 8.352.2 NMAC for a detailed description of the HSD standard administrative hearing process.

I. "MAD" means the medical assistance division, which administers medicaid and other medical assistance programs under HSD.

J. "MAP" means the medical assistance programs administered under MAD.

K. "MCO" means the member's HSD contracted managed care organization.

L. "MCO expedited member appeal" means the process open to a member or his or her authorized representative or authorized provider when the member's MCO has taken or intends to take an adverse action against the member's benefit.

(1) A request for an expedited appeal is appropriate when the MCO, the member, his or her authorized representative, or the authorized provider believes that allowing the time for a standard member appeal resolution could seriously jeopardize the member's life, health, or his or her ability to attain, maintain, or regain maximum function.

(2) The process open to an authorized provider who has requested an authorization or other approval for the disputed benefit, including a LOC for a member which the MCO has denied in whole or in part or after the MCO has reconsidered any additional documentation or information from the authorized provider during the approval process.

M. "MCO standard member appeal" means:

(1) the process open to a member or his or her authorized representative when the member's MCO has taken or intends to take an adverse action against the member's benefit; or

(2) the process open to an authorized provider who has requested an authorization or other approval for the disputed benefit, including a LOC for a member which the MCO has denied in whole or in part or after the MCO has reconsidered any additional documentation or information from the authorized provider during the approval process.

(3) A MCO cannot change a member's, or his authorized representative's or authorized provider's request for a MCO expedited or standard member appeal to a MCO member grievance without the written consent of the appeal requestor.

N. "MCO member grievance" means an expression of dissatisfaction by a member or his or her authorized representative about any matter or aspect of the MCO or its operation that is not included in the definition of an adverse action. A MCO member grievance final decision does not provide a member the right to request a HSD expedited or standard administrative hearing, unless the reason for the request is based on the assertion by the member or his or her authorized representative that the MCO failed to act within the MCO member grievance time frames.

O. "MCO provider appeal" means the process open to a provider requesting a review by the MCO of his or her payment, including denial of a claim for lack of medical necessity or as not a covered benefit.

P. "MCO expedited or standard member appeal final decision" means the MCO's final decision regarding a member's or his or her authorized representative's or authorized provider's request for a MCO expedited or standard member appeal of the MCO's adverse action it intends to take or has taken against its

member.

Q. "MCO provider grievance" means an expression of dissatisfaction by a provider about any matter or aspect of the MCO or its operation that is not included in the definition of an adverse action. The MCO provider grievance final decision does not allow a provider to request a HSD provider administrative hearing.

R. "Member" means an eligible recipient enrolled in a MCO.

S. "Notice of action" means the notice of an adverse action intended or taken by the member's MCO.

T. "Provider" means a practitioner or entity which has delivered or intends to provide a service or item whether the provider is contracted or not contracted with the member's MCO at the time services or items are to be provided.

U. "Valued added services" means services offered by a MCO that are not part of the MCO's required benefit package. Disputes concerning value-added services are not eligible for a MCO appeal or a HSD administrative hearing.

[8.308.15.7 NMAC - Rp, 8.308.15.7 NMAC, 5/1/2018]

8.308.15.8 [**RESERVED**]

[8.308.15.8 NMAC - Rp, 8.308.15.8 NMAC, 5/1/2018]

8.308.15.9 MCO PROVIDER GRIEVANCE:

A. Upon a provider contracting with the MCO, the MCO shall provide at no cost a written description of its provider grievance policies and procedures to the provider. The MCO will notify each of its providers in writing of any changes to these policies and procedures. The description shall include:

(1) information on how the provider can file a MCO provider grievance and the MCO's resolution process;

(2) time frames for each step of the grievance process through its final resolution; and

(3) a description of how the provider's grievance is resolved.

B. A provider or its authorized representative shall have the right to file a grievance with its MCO to express dissatisfaction about any matter or aspect of the MCO's operation. The provider or representative may file the grievance either orally or in writing in accordance with its MCO's policies and procedures.

C. The MCO shall designate a specific employee as its provider grievance manager with the authority to:

(1) administer the policies, procedures and processes for resolution of a grievance; and

(2) review patterns and trends in grievances and initiate corrective action as necessary; and

(3) shall ensure that punitive or retaliatory action is not taken against any provider that files a grievance.

[8.308.15.9 NMAC - Rp, 8.308.15.9 NMAC, 5/1/2018]

8.308.15.10 MCO PROVIDER APPEALS:

A. Upon a provider contracting with the MCO, the MCO shall provide at no cost a written description of its provider appeal policies and procedures and instructions on how to act as a member's authorized provider to the provider. The MCO will update in writing each of its providers with any changes to these policies and procedures. The MCO will additionally provide to a non-contracted provider who is seeking to or has rendered services or items to the MCO's member, policies and procedures informing the provider of his or her rights and responsibilities to be designated by a member or the member's authorized representative to act as his or her authorized provider, and how to request a MCO expedited or standard member appeal as the authorized provider.

(1) The description shall include:

(a) information on how the provider can file a MCO provider appeal and the resolution process;

(b) time frames for each step of the MCO provider appeal process through its final resolution; and

(c) a description of how the provider's MCO appeal is resolved.

(2) The MCO shall designate a specific employee as its provider appeal manager with the authority to:

(a) administer the policies, procedures and processes for a resolution of an appeal;

(b) review patterns and trends in appeals and initiate corrective action; and

(c) ensure that punitive or retaliatory action is not taken against any provider that files a MCO provider appeal.

B. Standing to request a MCO provider appeal: A provider or its authorized representative may request a MCO provider appeal for an intended or taken adverse action against a provider based on the MCO denial of the provider's payment, including a denial of a claim for lack of medical necessity or as not a covered benefit.

C. Provider rights and limitations:

(1) A provider or representative may request a MCO provider appeal either orally or in writing in accordance with the MCO's policies and procedures.

(2) A provider or his or her authorized representative may have its legal counsel or a spokesperson be a party to the MCO provider appeal process.

(3) If the MCO upholds its adverse action in the MCO's provider appeal final decision, the appeal process will be considered exhausted. The provider is not eligible to request a HSD provider administrative hearing. The loss of the appeal does not make the member

liable for any payment to the provider. [8.308.15.10 NMAC - Rp, 8.308.15.10 NMAC, 5/1/2018]

8.308.15.11 GENERAL INFORMATION ON MCO MEMBER GRIEVANCES AND APPEALS PROCESSES:

A. Upon a member's enrollment:

(1) the MCO shall provide to the member and his or her authorized representative at no cost a written description of its member grievance and member expedited and standard appeal system and member expedited appeal system procedures and processes;

(2) the MCO will promptly provide in writing to each member, his or her authorized representative any changes to these procedures and processes. The description shall include:

(a) information on how the member or his or her authorized representative or authorized provider can request a MCO expedited or standard appeal, or how the member or his or her authorized representative can file a MCO member grievance; and the resolution processes for each;

(b) time frames for each step of the MCO member grievance and the MCO expedited and standard member appeal processes through to their final resolution;

(c) a description of how a MCO member's grievance or MCO expedited or standard member appeal is resolved;

(d) information that the MCO may have only one level of appeal for the member;

(e) in the case of a MCO that fails to adhere to the time frames for each step of its procedures and process, the member or his or her authorized representative is deemed to have exhausted the MCO's expedited or standard member appeal process and the member or his authorized representative may request a HSD expedited or standard administrative hearing.

(f) The MCO shall designate a specific employee as its member grievance and appeal manager with the authority to:

(i) administer the policies and procedures for resolution of a MCO member grievance and a MCO expedited or standard member appeal;

(ii) review patterns and trends in MCO member grievances, and MCO expedited or standard member appeals; and

(iii) ensure that punitive or retaliatory action is not taken against any member or his or her authorized representative that files a MCO member grievance or any member, his or her authorized representative or the authorized provider who requests a MCO expedited or standard member appeal.

(g) Prior to the MCO taking an adverse action, in order to avoid incomplete information during the MCO expedited or standard member appeal process or the HSD expedited or standard administrative hearing process, the MCO must contact the requesting provider for more information or justification regarding the request if lack of information or justification is likely to lead to the adverse action.

B. MCO member grievance and MCO expedited and standard member appeal rights and responsibilities:

(1) Standing to file a MCO member grievance:

(a) The member or his or her authorized representative may file a MCO member grievance concerning dissatisfaction with the MCO's operation.

(b) The member or his or her authorized representative may choose a relative, friend or other spokesperson to advocate or assist him or her through the MCO member grievance process; however, the spokesperson is limited to a supporting role and cannot act on behalf of the member or his or her authorized representative. The member or his or her authorized representative must provide the MCO a signed release-of-information in order for the designated spokesperson to have access to information to aid the spokesperson to assist or advocate for the member or his or her authorized representative during the MCO's member grievance process. A member or his or her authorized representative may elect not to sign such a release, but utilize the spokesperson during the MCO member grievance process.

(2) The member or his or her authorized representative may have legal counsel assist him or her during the MCO member grievance process.

(3) Grievance: A member or his or her authorized representative shall have the right to file a grievance with his or her MCO to express dissatisfaction about any matter or aspect of his or her MCO's operation other than an adverse benefit determination without time limitations. A MCO member grievance final decision cannot be appealed through the MCO member appeal process or the HSD administrative hearing process. If the member or his or her authorized representative or the authorized provider wishes to appeal an intended or taken adverse action against the member, the member, his or her authorized or the authorized provider must comply with all requirements to request a MCO expedited or standard member appeal including applicable time frames in which to request a MCO expedited or standard member appeal. A member may file both a MCO member grievance and a MCO expedited or standard member appeal, but the MCO appeal must meet all applicable filing time requirements which are not changed by the filing of a grievance.

(a) The member or his or her authorized representative may file a MCO member grievance either orally or in writing in accordance with the MCO's procedures and processes.

(b) The member or his or her authorized representative may file a MCO member grievance at any time when he or she wishes to register his or her dissatisfaction.

(c) The MCO will provide the member or his or her authorized representative with its resolution to the member's grievance within the time frame specified in the MCO's medicaid managed care services agreement.

(4) MCO expedited or standard member appeal: A member or his or her authorized representative or the authorized provider has the right to request a MCO standard member appeal orally and in writing in accordance with his or her MCO procedures within 60 calendar days of the date of notice of an intended or taken adverse action. If the request is orally, it must be followed up in writing within 13 calendar days of the oral request. A member, his or her authorized representative or authorized provider has the right to request a MCO expedited member appeal orally or in writing in accordance with the member's MCO procedures within 60 calendar days of the date of the notice of an intended or taken adverse action.

(a) The member or his or her authorized representative or the authorized provider may have legal counsel to assist him or her during the MCO expedited or standard member appeal process.

(b) Standing to request a MCO expedited or standard member appeal:

(i) The member or his or her authorized representative may request a MCO expedited or standard member appeal concerning his or her disputed benefit.

(ii) The member, his or her authorized representative or authorized provider may choose a relative, friend or other spokesperson to advocate or assist him or her through the MCO expedited or standard member appeal process; however, the spokesperson is limited to a supporting role and cannot act on behalf of the member or his or her authorized representative. The member or his or her authorized representative must provide the MCO a signed release-of-information in order for a designated spokesperson to have access to information to aid the spokesperson to assist and advocate for the member or his or her authorized representative during the MCO expedited or standard member appeal process.

(c) If a member or his or her authorized representative or authorized provider elects to request a continuation of the disputed current benefit, the member, his or her authorized representative or authorized provider must request a MCO expedited or standard member appeal and also request a continuation of the disputed benefit within 10 calendar days of the mailing of the MCO's notice of action or before the expected effective date of the MCO's proposed adverse action benefit determination, whichever is later. When the mailing date is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. The member or his or her authorized representative or authorized provider does not have the right to request a HSD expedited or standard administrative hearing related to a value-added services offered by the MCO. If the member or his or her authorized representative or authorized provider chooses to request a MCO expedited or standard member appeal, the following apply.

(i) The member, his or her authorized representative or authorized provider cannot request separate appeals. Only one appeal can be filed.

(ii) If the MCO upholds its adverse action, regardless of who requested the MCO expedited or standard member appeal, the MCO expedited or standard member appeal process is considered exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing concerning his or her disputed benefit. Once the member or his or her authorized representative requests a HSD expedited or standard administrative hearing, he or she is referred to as the claimant. The authorized provider is not eligible to request a HSD expedited or standard administrative hearing on the disputed benefit, unless the provider has been designated as the member's authorized representative. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes.

[8.308.15.11 NMAC - Rp, 8.308.15.11 NMAC, 5/1/2018]

8.308.15.12 MCO MEMBER GRIEVANCE PROCESS:

A. The MCO shall provide to its member or his or her authorized representative reasonable assistance in completing grievance forms and completing procedural steps, including but not limited to:

(1) providing interpreter services; and

(2) providing toll-free numbers that have adequate TTY/TTD and interpreter capability.

B. The MCO shall ensure that the individuals who make decisions related to grievances are not involved in any previous level of review or decision-making as to the matter that is grieved.

C. The MCO shall provide the member or his or her authorized representative with written notice:

(1) when a MCO member grievance request has been received;

(2) of the expected date of resolution which cannot be greater than 30 calendar days from the date of receipt of the grievance; and

(3) of the final resolution of the grievance.

D. The MCO shall ensure that punitive or retaliatory action is not taken against any member or authorized representative that files a grievance, or the member's provider that supports the member's

grievance.
[8.308.15.12 NMAC - Rp, 8.308.15.12 NMAC, 5/1/2018]

8.308.15.13 MCO EXPEDITED MEMBER APPEAL PROCESS: The MCO shall establish and maintain an expedited review process for a MCO expedited member appeal when the MCO, the member or his or her authorized representative or authorized provider believes that allowing the time for a standard member appeal resolution could seriously jeopardize the member's life, health, or his or her ability to attain, maintain, or regain maximum function. Once a member or his or her authorized representative or authorized provider requests a MCO expedited member appeal and the member or his or her authorized representative or authorized provider requests a continuation of the member's disputed current benefit, the MCO will grant a continuation of the disputed current benefit until the MCO expedited member appeal final decision is rendered by the MCO. However, if the date of the MCO expedited member appeal final decision letter is prior to the notice of action's adverse action effective date, the MCO must continue the disputed current benefit up to the adverse action's effective date. The MCO shall ensure that health care professionals with appropriate clinical expertise in addressing the physical health, behavioral health, or long-term services and supports needs of the member are utilized during the MCO expedited member appeal process when the MCO notice of action for the disputed benefit is based on a lack of medical necessity.

A. A member or his or her authorized representative or authorized provider in accordance with the member's MCO procedures has the right to request within 60 calendar days after the mailing of the MCO's notice of action a MCO expedited member appeal orally or in writing. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail.

(1) If a member, his or her authorized representative or authorized provider elects to request a continuation of the member's disputed current benefit, the member or his or her authorized representative or authorized provider must request a MCO expedited member appeal and request a continuation of the member's disputed current benefit within 10 calendar days of the mailing of the MCO's notice of action. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. The continuation of the disputed current benefits is not dependent on the approval to proceed to the MCO expedited appeal process. See 8.308.15.15 NMAC for a detailed description of the continuation of the disputed benefit process.

(2) If the member or authorized representative or authorized provider requests a MCO expedited member appeal, the following applies.

(a) If the member or his or her authorized representative designate in writing the member's provider to act as the member's authorized provider, the authorized provider may request a MCO expedited member appeal when the authorized provider believes that the MCO has made an incorrect decision concerning the member's disputed benefit.

(b) If the MCO upholds its adverse action, regardless of who requested the MCO expedited member appeal process, the MCO expedited member appeal process is considered exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing concerning the member's disputed benefit.

(c) Once the member or his or her authorized representative request a HSD expedited or standard administrative hearing, he or she is referred to as the claimant.

(4) The member or his or her authorized representative or the authorized provider may have legal counsel or a spokesperson assist him or her during the MCO expedited member appeal process.

(5) The member or his or her authorized representative or the authorized provider does not have the right to request a MCO expedited or standard member appeal or a HSD expedited or standard administrative hearing related to a value-added service offered by the MCO.

(6) The authorized provider is not eligible to request a HSD expedited or standard administrative hearing on the disputed benefit, unless the provider has been designated as the member's authorized representative. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes.

B. The request for a MCO expedited member appeal may be made orally or in writing to the member's MCO within the required time frame. The reasons why a MCO expedited member appeal is necessary must be detailed in the oral or written request. A member's provider (regardless if the provider is not the authorized provider) may assist the member or his or her authorized representative in stating the reasons and providing supporting documentation that a MCO expedited member appeal is medically necessary. There can only be one MCO member appeal request concerning the disputed benefit at one time. If the MCO denies the request for a MCO expedited member appeal, the member or his or her authorized representative may then request a HSD expedited or standard administrative hearing regarding the issue of the denial of a MCO expedited member appeal. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes.

C. The MCO shall

designate a specific employee as its MCO expedited member appeal manager with the authority to:

(1) administer the policies and procedures for resolution of a MCO expedited member appeal;

(2) review patterns and trends in member expedited appeals and initiate corrective action; and

(3) ensure there is no punitive or retaliatory action taken against any member, his or her authorized representative or authorized provider that files an expedited MCO member appeal, or a provider that supports the member's appeal.

D. The MCO shall provide reasonable assistance to the member or his or her authorized representative or the authorized provider requesting a MCO expedited member appeal in completing forms and completing procedural steps, including but not limited to:

(1) providing interpreter services;

(2) providing toll-free numbers that have adequate TTY/TTD and interpreter capability; and

(3) assisting the member, his or her authorized representative or the authorized provider in understanding the MCO rationale regarding the disputed benefit which was wholly denied, partially denied or that was limited in order to ensure that the issue under expedited appeal is sufficiently defined throughout the MCO expedited member appeal.

E. The MCO shall provide in writing to the member, his or her authorized representative, and the member's provider (regardless if the provider is not the authorized provider) with the following information once a request is made for a MCO expedited member appeal:

(1) the date the MCO expedited member appeal request was received by the MCO, and the MCO's understanding of what the member or his or her authorized representative or the authorized provider is appealing concerning the member's disputed benefit;

(2) the expected date of the MCO member appeal decision:

(a) that is not to exceed 72 hours from the date of the receipt of the request for a MCO expedited member appeal; and

(b) that alerts the member or his or her authorized representative or the authorized provider of the possibility of an appeal extension of up to an additional 14 calendar days when:

(i) the member or his or her authorized representative or authorized provider requests the extension; or

(ii) the MCO determines it requires additional information and provides a written justification to the member or his or her authorized representative or authorized provider, and also places in the member's MCO expedited member appeal file how the extension is in the best interest of the member.

F. Time frames:

(1) The MCO must act as expeditiously as the member's condition requires, but no later than 72 hours after receipt of a request for a MCO expedited member appeal, and provide the member and his or her authorized representative and the authorized provider its MCO expedited member appeal final decision. The MCO must also make reasonable efforts to provide oral notice of the decision.

(2) If the member or his or her authorized representative or the authorized provider requests an extension of the decision date, the MCO shall extend the 72-hour time period up to 14 calendar days to allow the member or his or her authorized representative or the authorized provider to submit additional documentation to the MCO supporting the need for the MCO expedited member appeal.

(3) The MCO may itself extend the 72-hour time period when it determines there is a need to collect and review additional information prior to rendering its MCO expedited member appeal final decision. The MCO must provide justification in writing to the member or his or her authorized representative or the authorized provider and also place in the member's expedited member appeal file how the extension of time is in the member's best interest.

(4) A member or his or her authorized representative may file a MCO member grievance against the MCO's decision to extend the 72-hour time frame and up to an additional 14 calendar days.

G. MCO-initiated expedited MCO member appeal: When the MCO determines that allowing the time for a standard MCO member appeal process could seriously jeopardize the member's life, health, or his or her ability to attain, maintain, or regain maximum function, the MCO shall:

(1) automatically file a MCO-initiated expedited member appeal on behalf of the member and continue the disputed current benefit without cost to the member if the MCO-initiated expedited member appeal final decision upholds the MCO adverse action;

(2) make reasonable efforts to provide the member, his or her authorized representative and the member's provider (regardless if the provider is not the authorized provider) prompt oral notice of the automatic appeal, following up as expeditious as possible, but within 72 hours of the MCO expedited member appeal final decision; and

(3) use its best effort to involve the member, his or her authorized representative and the member's provider (regardless if the provider is not the authorized provider) in the member's MCO-initiated expedited member appeal. The member's MCO expedited appeal record will contain the dates, times, and methods the MCO utilized to contact the member, his or her authorized representative or the authorized provider, or another provider of the member. If the MCO-

initiated member appeal final decision upholds the MCO's adverse action, the MCO member appeal process is exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing.
[8.308.15.13 NMAC - Rp, 8.308.15.13 NMAC, 5/1/2018]

8.308.15.14 MCO STANDARD MEMBER APPEAL PROCESS:

A. A member or his or her authorized representative or the authorized provider in accordance with the member's MCO procedures has the right to request within 60 calendar days after the mailing of the MCO's notice of action a MCO standard member appeal orally and in writing. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. If orally requested, the request must be followed up in writing within 13 calendar days of the oral request.

(1) If a member or his or her authorized representative or authorized provider elects to request a continuation of the member's disputed current benefit, the member or his or her authorized representative or the authorized provider must request a MCO standard member appeal and request a continuation of the member's disputed current benefit within 10 calendar days of the mailing of the MCO's notice of action. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. See 8.308.15.15 NMAC for a detailed description of the continuation of the disputed current benefit process.

(2) If the member or his or her authorized representative or the authorized provider requests a MCO standard member appeal, the following apply.

(a) If the member or his or her authorized representative designate in writing the member's provider to act as the member's authorized provider, the authorized provider may request a MCO standard member appeal when the authorized provider believes that the MCO has made an incorrect decision concerning the member's disputed benefit.

(b) If the MCO upholds its adverse action, regardless of who requested the MCO standard member appeal process, the MCO standard member appeal process is considered exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing concerning the member's disputed benefit.

(c) If a member or his or her authorized representative elects not to request a HSD expedited or standard administrative hearing, and if the date of the MCO standard member appeal final decision letter is prior to the notice of action's adverse action effective date, the MCO must continue the disputed current benefit up to the notice of action's adverse action effective date.

(d) Once the member or his or her authorized representative requests a HSD expedited or standard administrative hearing, he or she is referred to as the claimant.

(3) The member or his or her authorized representative or the authorized provider may have legal counsel or a spokesperson assist him or her during the MCO standard member appeal process.

(4) The member or his or her authorized representative or the authorized provider does not have the right to request a MCO expedited or standard member appeal or a HSD expedited or standard administrative hearing related to a value-added service offered by the MCO.

(5) The authorized provider is not eligible to request a HSD expedited or standard administrative hearing on the disputed benefit, unless the provider has been designated as the member's authorized representative. See 8.352.2 NMAC for a detailed description of the HSD expedited or standard administrative hearing processes.

B. The MCO shall designate a specific employee as its MCO standard member appeal manager with the authority to:

(1) administer the policies and procedures for resolution of a MCO standard member appeal;

(2) review patterns and trends in standard member appeals and initiate corrective action; and

(3) ensure there is no punitive or retaliatory action taken against any member or his or her authorized representative or authorized provider that files a MCO standard member appeal, or a provider that supports the member's appeal.

C. The MCO shall provide reasonable assistance to the member or his or her authorized representative or the authorized provider requesting a MCO standard member appeal in completing forms and completing procedural steps, including but not limited to:

(1) providing interpreter services;

(2) providing toll-free numbers that have adequate TTY/TTD and interpreter capability; and

(3) assisting the member or his or her authorized representative or the authorized provider in understanding the MCO rationale regarding the disputed benefit which was wholly denied, partially denied or that was limited in order that the issue under appeal is sufficiently defined throughout the MCO standard member appeal.

D. The MCO shall provide the member or his or her authorized representative, and the member's provider (regardless if the provider is not the authorized provider) with the following information once a request is made for a MCO standard member appeal.

(1) The date the MCO standard member appeal

request was received by the MCO, and the MCO's understanding of what the member or his or her authorized representative or the authorized provider is appealing concerning the member's disputed benefit;

(2) The expected date of the MCO standard member appeal decision:

(a) that is not to exceed 30 calendar days from the date of the receipt of the request for a MCO standard member appeal; and

(b) that alerts the member or his or her authorized representative or the authorized provider of the possibility of an appeal extension of up to an additional 14 calendar days when:

(i) the member or his or her authorized representative or authorized provider requests the extension; or

(ii) the MCO determines it requires additional information and provides to the member or his or her authorized representative or authorized provider, and also places in the member's MCO standard member appeal file how the extension is in the best interest of the member.

E. Time frames:

(1) The MCO must act as expeditiously as the member's condition requires, but no later than 30 calendar days after receipt of a request for a MCO standard member appeal, and provide the member or his or her authorized representative or the authorized provider its MCO standard member appeal final decision.

(2) If the member or his or her authorized representative or the authorized provider requests an extension of the decision date, the MCO shall extend the 30 calendar day time period up to an additional 14 calendar days to allow the member or his or her authorized representative or the authorized provider to submit additional documentation to the MCO supporting the medical necessity for the disputed benefit.

(3) The MCO may itself extend the final decision up to the additional 14 calendar day time period when it determines there is a need to collect and review additional information prior to rendering its MCO standard member appeal final decision. The MCO must provide justification in writing to the member or his or her authorized representative or the authorized provider and also place in the member's clinical file how the extension of time is in the member's best interest.

(4) A member or his or her authorized representative may file a MCO member appeal or grievance against the MCO's decision to extend the 30 calendar day time frame up to an additional 14 calendar days.

[8.308.15.14 NMAC - Rp, 8.308.15.14 NMAC, 5/1/2018]

8.308.15.15 CONTINUATION OF A DISPUTED CURRENT BENEFIT DURING THE MCO EXPEDITED AND STANDARD MEMBER APPEAL PROCESSES: A member or his or her authorized representative or authorized provider requesting a MCO expedited or standard member appeal of an adverse action may request that the disputed current benefit continue during the MCO expedited or standard member appeal process. However, if the date of the MCO expedited or standard member appeal final decision letter is prior to the effective date of the notice of action's adverse action effective date, the MCO must continue the disputed current benefit up to the notice of action's adverse action effective date.

A. A request for a continuation of the disputed current benefit shall be accorded to any member who or through the member's authorized representative or authorized provider requests the continuation of the disputed current benefit who also requests a MCO expedited or standard member appeal within 10 calendar days of the mailing of the notice of action or prior to the date the notice of action states the benefit will be terminated. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail.

B. The continuation of a disputed current benefit is only available to a member who is currently receiving the disputed benefit at the time of the MCO's notice of action.

(1) The continuation of the disputed current benefit is the same as the member's current benefit, which includes the member's current allocation, budget or LOC.

(2) The MCO must provide written information in its notice of action of the member's or his or her authorized representative's or authorized provider's rights and responsibilities to continue the disputed current benefit during the MCO expedited or standard member appeal process and of the possible responsibility of the member to repay the MCO for the disputed current benefit if the MCO expedited or standard member appeal final decision upholds the MCO's adverse action. If it was a MCO-initiated expedited member appeal, the MCO cannot recover the cost of the disputed current benefit if the MCO's adverse action is upheld.

C. A member or his or her authorized representative or authorized provider has the right to not request a continuation of the disputed current benefit during the MCO expedited or standard member appeal process.

[8.308.15.15 NMAC - Rp, 8.308.15.15 NMAC, 5/1/2018]

8.308.15.16 MCO EXPEDITED MEMBER APPEAL AND MCO STANDARD MEMBER APPEAL FINAL DECISION AND IMPLEMENTATION:

A. The MCO shall provide the member or his or her authorized representative and the provider (regardless if the provider was not the one requesting the MCO member appeal) with its MCO expedited or standard member appeal final decision within the required

time frames and provide supporting documentation substantiating the MCO's decision.

B. When the MCO expedited or standard member appeal final decision reverses the MCO's adverse action in total and the disputed benefit was not furnished during the member's expedited or standard member appeal process, the MCO shall authorize or provide the disputed benefit promptly and as expeditiously as the member's health condition requires.

C. When the MCO expedited or standard member appeal final decision reverses the MCO's adverse action in total and the member, his or her authorized representative or authorized provider had requested and the member had received a continuation of the disputed current benefit during the MCO expedited or standard member appeal process, the MCO may not recover from the member the cost of the continued disputed current benefit furnished during the MCO expedited or standard member appeal process.

D. When the MCO expedited or standard member appeal final decision upholds the MCO's adverse action and the member or his or her authorized representative or authorized provider had requested and the member had received a continuation of the disputed current benefit, the MCO may recover from the member the cost of the disputed current benefit furnished during the MCO expedited or standard member appeal process if:

(1) the member, his or her authorized representative or authorized provider was informed in writing by the MCO that the member could be responsible for the cost of the disputed current benefit if the MCO expedited or standard member appeal final decision upholds the MCO adverse action; and

(2) the member or his or her authorized representative elects not to request a HSD expedited or standard administrative hearing of the disputed current benefit.

(3) A MCO cannot recover the cost of the continued disputed benefit regardless if the final decision is upheld or reverses the MCO adverse action when the MCO initiated the MCO expedited member appeal process. See Subsection E of 8.308.15.13 NMAC for detailed description of a MCO-initiated expedited member appeal process.

E. A member or his or her authorized representative may request a HSD expedited or standard administrative hearing if the MCO expedited or standard member appeal decision does not reverse in total the MCO's adverse action as the member or his or her authorized representative has now exhausted the MCO expedited or standard member appeal process. The authorized provider cannot request a HSD expedited or standard administrative hearing on his or her own; this right is accorded only to the member or his or her authorized representative, unless the provider has been designated as the member's authorized representative.

F. A member or his or her authorized representative must request a HSD expedited administrative hearing within 30 calendar days of the date of the MCO member appeal final decision letter or request a HSD standard administrative hearing within 90 days of the date of the MCO member appeal final decision.

(1) A member or his or her authorized representative or authorized provider may request and the member receive a continuation of the disputed current benefit at any time prior to the MCO notice of action's intended date the disputed benefit will be terminated. The request may be made even after the MCO expedited or standard member appeal final decision letter is issued if issued before the date the disputed benefit will be terminated.

(2) If the member received a continuation of his or her disputed current benefit during the MCO member appeal process, the member or his or her authorized representative does not need to request another continuation of the disputed current benefit when requesting a HSD expedited or standard administrative hearing. It is automatically continued by the member's MCO.

(3) If the member or his or her authorized representative chooses to discontinue the disputed current benefit that is being provided during the MCO expedited or standard member appeal process or during the HSD expedited or standard administrative hearing process, the member or his or her authorized representative must notify the member's MCO in writing stating the date the disputed current benefit will end.

G. When the MCO expedited or standard member appeal final decision upholds the MCO's adverse action in total or in part and the member or his or her authorized representative or authorized provider had requested and the member had received the disputed current benefit during the MCO member appeal, and the member or his or her authorized representative elects to continue the member's disputed current benefit during the member's HSD expedited or standard administrative hearing process, the MCO must in writing inform the member or his or her authorized representative that if the HSD expedited or standard administrative hearing final decision upholds the MCO's adverse action, the member could be responsible for the cost of the disputed current benefit during MCO expedited or standard member appeal process and the HSD expedited or standard administrative hearing process.

H. If the member or his or her authorized representative requests a HSD expedited or standard administrative hearing and the member or his or her authorized representative or authorized provider requested and the member received the disputed current benefit during the MCO member appeal process, the MCO will not take action to recover the costs of the continued disputed current benefit until there is a HSD expedited or standard administrative hearing final decision upholding the

MCO adverse action.

I. If the member's MCO had automatically filed a MCO-initiated expedited member appeal on behalf of the member to continue the disputed current benefit during the MCO expedited member appeal process, the MCO cannot take action to recover the costs of the continued disputed current benefit if the MCO expedited member appeal final decision upholds the MCO's adverse action. However, if the member or his or her authorized representative wants to continue the disputed current benefit during the HSD expedited or standard administrative hearing, the member could be responsible for the cost of the continued disputed current benefit starting on the first calendar day the member or the authorized representative requested a HSD expedited or standard administrative hearing and requested the continuation of the disputed current benefit.

J. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes and for a detailed description of the MCO recovery process.

[8.308.15.16 NMAC Rp, 8.308.15.16 NMAC, 5/1/2018]

HISTORY OF 8.308.15 NMAC:

History of Repealed Material:
8.308.15 NMAC, Grievances and Appeals - Repealed 6/15/2014.
8.308.15 NMAC - Managed Care Program, Grievances and Appeals, filed 5/27/2014 Repealed effective 5/1/2018.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 21 QUALITY MANAGEMENT

8.308.21.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.21.1 NMAC - Rp, 8.308.21.1 NMAC, 5/1/2018]

8.308.21.2 SCOPE: This rule applies to the general public.
[8.308.21.2 NMAC - Rp, 8.308.21.2 NMAC, 5/1/2018]

8.308.21.3 STATUTORY AUTHORITY: The New Mexico Medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.308.21.3 NMAC - Rp, 8.308.21.3 NMAC, 5/1/2018]

8.308.21.4 DURATION: Permanent.
[8.308.21.4 NMAC - Rp, 8.308.21.4 NMAC, 5/1/2018]

8.308.21.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.21.5 NMAC - Rp, 8.308.21.5 NMAC, 5/1/2018]

8.308.21.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.21.6 NMAC - Rp, 8.308.21.6 NMAC, 5/1/2018]

8.308.21.7 DEFINITIONS: [**RESERVED**]

8.308.21.8 [**RESERVED**]
[8.308.21.8 NMAC - Rp, 8.308.21.8 NMAC, 5/1/2018]

8.308.21.9 QUALITY MANAGEMENT: A HSD managed care organization (MCO) quality management program includes a philosophy, a method of management, and a structured system designed to improve the quality of services; includes both quality assurance and quality improvement activities; and is incorporated into the health care delivery and administrative systems.

A. Quality management (QM) program structure: The MCO shall have QM structure and processes as detailed in the medicaid managed care services agreement or the medical assistance division (MAD) managed care policy manual.

B. QM program description: The MCO shall develop a written QM and a quality improvement (QI) program description that includes the requirements described in the medicaid managed care services agreement or the managed care policy manual.

C. QM and QI program principles: The MCO QM and QI programs are based on principles of continuous quality improvement (CQI) and total quality management (TQM). Such an approach will:

(1) recognize clinical and non-clinical opportunities are unlimited;

(2) be data driven;

(3) use real-time input from members and MCO contracted providers to develop CQI activities; and

(4) require on-going measurement of effectiveness and improvement.

D. QM program evaluation: The MCO will have a written QM and QI program evaluation as described in the medicaid managed care services agreement or the managed care policy manual.
[8.308.21.9 NMAC - Rp, 8.308.21.9 NMAC, 5/1/2018]

8.308.21.10 DISEASE MANAGEMENT: The MCO will have a disease management program as described in the medicaid managed care services agreement or the managed care policy manual.
[8.308.21.10 NMAC - Rp, 8.308.21.10 NMAC, 5/1/2018]

8.308.21.11 CLINICAL

PRACTICE GUIDELINES: As described in the medicaid managed care services agreement or the managed care policy manual, the MCO will have a process to adopt, review, update and disseminate evidence-based clinical practice guidelines, practice parameters, consensus statements, and specific criteria for the provision of acute and chronic physical and behavioral health care services.
[8.308.21.11 NMAC - Rp, 8.308.21.11 NMAC, 5/1/2018]

8.308.21.12 PERFORMANCE IMPROVEMENT: The MCO will implement performance assessment and improvement activities as described in the medicaid managed care services agreement or the managed care policy manual.
[8.308.21.12 NMAC - Rp, 8.308.21.12 NMAC, 5/1/2018]

8.308.21.13 INCIDENT MANAGEMENT: Critical incident reporting and management is considered part of ongoing quality management. Critical incident reporting and analysis of critical incident data helps to identify causes of adverse events in critical care and areas of focus for implementation of preventative strategies.

A. MCO incident management principles: The implementation of incident management practices and effective incident reporting processes as described in the medicaid managed care services agreement or the managed care policy manual are based on the following MAD MCO principles:

(1) a member is expected to receive home and community based services free of abuse, neglect, and exploitation;

(2) training addresses the response to and the report of to include the documentation of a critical incident;

(3) a member, his or her authorized representative will receive information on his or her MCO incident reporting process; and

(4) good faith incident reporting of or the allegation of abuse, neglect or exploitation is free from any form of retaliation.

B. Reportable incidents:

(1) The MCO shall ensure that any person having reasonable cause to believe an incapacitated adult member is being abused, neglected, or exploited must immediately report that information.

(2) The MCO shall develop and provide training covering the MCO's procedures for reporting a critical incident to all subcontracted individual providers, provider agencies, and its members who are receiving self-directed services, to include his or her employees.

(3) The MCO shall comply with all statewide reporting requirements for any incident involving a member receiving a MAD covered home and community based service.

(4) A community agency providing home and community based services is required to report critical incident involving a MCO member, including:

(a) the abuse of him or her;

(b) the neglect of him or her;

(c) the exploitation of him or her;

(d) any incident involving his or her utilization of emergency services;

(e) the hospitalization of him or her;

(f) his or her involvement with law enforcement;

(g) his or her exposure to or the potential of exposure to environmental hazards that compromise his or her health and safety; and

(h) the death of the member.

(5) The MCO shall provide, coordinate, or both, intervention and shall follow up upon the receipt of an incident report that demonstrates the health and safety of its member is in jeopardy.
[8.308.21.13 NMAC - Rp, 8.308.21.13 NMAC, 5/1/2018]

8.308.21.14 EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO): An EQRO will conduct independent reviews of the MCO's external quality review (EQR) activities as detailed in the medicaid managed care services agreement or the managed care policy manual.

A. The MCO shall fully cooperate with the following mandatory EQRO activities, such as:

(1) the validation of required performance improvement projects (PIP) as detailed in the medicaid managed care services agreement or the managed care policy manual;

(2) the validation of plan performance measures reported by the MCO as defined in the medicaid managed care services agreement or the managed care policy manual;

(3) a review to determine the MCOs' compliance with state standards for access to care, structure and operations, and QM and QI requirements; and

(4) the validation of network adequacy.

B. The MCO shall fully cooperate with the following EQRO optional activities:

(1) the validation of encounter data reported by the MCO;

(2) the administration or validation of member and provider surveys on the quality of care;

(3) the calculation of additional performance measures;

(4) conducting additional PIPs validations;

(5) conducting studies on quality focused on a particular aspect of clinical or nonclinical services at a specific point in time;

(6) assist with the quality rating of MCOs; and

(7) all other optional activities as deemed

appropriate.

C. The EQRO may, at the direction of MAD, provide technical guidance to the MCO to assist in conducting activities related to mandatory and optional EQR activities.

[8.308.21.14 NMAC - Rp, 8.308.21.14 NMAC, 5/1/2018]

8.308.21.15 QUALITY MANAGEMENT COMMITTEE: The MCO must have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of services provided to its members. A QM committee will provide oversight to quality monitoring and improvement activities, including safety review and the assignment of accountability.

A. Quality review:

(1) The MCO shall establish a review committee to act as the leadership body for QI activities. The review committee acts to identify and facilitate the accomplishment of a planned, systematic, valid, and valuable QM plan for members and its providers.

(2) The review committee will monitor key services delivered to members and associated supportive processes to include:

(a) the utilization of services;

(b) its member satisfaction;

(c) its clinical services, including disease management; and

(d) its administrative services.

(3) The review committee is authorized to take action upon issues related to member care and make recommendations related to contracts, compensation, and provider participation.

B. Critical incident review:

(1) The MCO shall establish a review committee to review events that result in a serious and undesired consequence; events that are not a result of an underlying health condition or from a risk inherent in providing health services, including:

(a) death;

(b) disability; and

(c) injury or harm to the member.

(2) The committee is authorized to make recommendations for the prevention from future harm of its members, as well as its system process improvement.

C. Oversight: The MCO will provide HSD with reports and records to ensure compliance with quality review and critical incident review requirements as detailed in the medicaid managed care services agreement or the managed care policy manual.

[8.308.21.15 NMAC - Rp, 8.308.21.15 NMAC, 5/1/2018]

8.308.21.16 MEDICAL RECORDS: The member's medical records, as described in the medicaid managed care services agreement or the managed care policy manual, shall be legible, timely, current, detailed and organized to permit effective and confidential patient care and quality reviews. The MCO shall:

A. have medical record confidentiality policies and procedures and medical record documentation standards for its providers and subcontractors;

B. have a process to review medical records to ensure compliance with MCO policy, procedures and standards;

C. cooperate with the EQRO in its review of medical records to ensure compliance with its medical record policy and standards;

D. provide HSD or its designee access to a member's medical and behavioral health records;

E. include provisions in contracts with providers for MCO and HSD or its designee, access to member medical records for the purposes of compliance or quality review;

F. ensure that the assigned primary care provider (PCP), the patient centered medical home or the patient centered health home maintain a primary medical and as appropriate, behavioral health record for each member; this record must contain sufficient information from each provider involved in the member's care to ensure continuity of care;

G. ensure all providers involved in the member's care have access to the primary medical record; and

H. have policies and processes that ensure the confidential transfer of medical and behavioral health information between its providers, its agencies or other health plans.

[8.308.21.16 NMAC - Rp, 8.308.21.16 NMAC, 5/1/2018]

8.308.21.17 UTILIZATION MANAGEMENT: A utilization management (UM) program is an organization-wide, interdisciplinary approach of evaluating the medical necessity, appropriateness, and efficiency of health care services. The MCO shall have an UM program as described in the medicaid managed care agreement services or the managed care policy manual.

[8.308.21.17 NMAC - Rp, 8.308.21.17 NMAC, 5/1/2018]

8.308.21.18 ADVISORY BOARDS: Advisory boards are federally mandated bodies that provide ongoing venues for discussions of policy, operations, service delivery and administrative issues for its members. The MCO will convene and facilitate an advisory board of its members and a native American advisory board in accordance with the requirements described in the medicaid managed care services agreement or the managed care policy manual.

[8.308.21.18 NMAC - Rp, 8.308.21.18 NMAC, 5/1/2018]

8.308.21.19 SATISFACTION SURVEYS: For the MCO to maintain a comprehensive system of health care that supports quality, as

well as cost-effectiveness depends largely on the satisfaction and cooperation of its members and its providers. The MCO will regularly survey these groups following the requirements described in the medicaid managed care services agreement or the managed care policy manual.
[8.308.21.19 NMAC - Rp, 8.308.21.19 NMAC, 5/1/2018]

HISTORY OF 8.308.21 NMAC:
[**RESERVED**]

History of Repealed Material:
8.308.21 NMAC - Managed Care Program, Quality Management, filed 12/17/2013 Repealed effective 5/1/2018.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.308.13 NMAC, Sections 8 and 9, effective 5/1/2018.

8.308.13.8 [~~MISSION STATEMENT:~~ ~~To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.~~]
[**RESERVED**]
[8.308.13.8 NMAC - N, 1/1/2014; Repealed, 5/1/2018]

8.308.13.9 ELIGIBLE MEMBERS: A member of a HSD contracted managed care organization (MCO) is eligible to participate in [~~his or her MCO's~~] the managed care member rewards program.

A. For a native American member who elects to opt out of receiving medical assistance division (MAD) services through a HSD contracted MCO, and retains [~~medical assistance programs~~] MAP category of eligibility, he or she no longer will earn reward credits as of the last day of enrollment in his or her MCO.

B. Upon losing eligibility for continued enrollment in a HSD contracted MCO, the individual no longer will earn member reward credits.
[8.308.13.9 NMAC - N, 1/1/2014; A, 5/1/2018]

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.310.10 NMAC, Section 8 through 12, 14 and 15, effective 5/1/2018.

8.310.10.8 [~~MISSION STATEMENT:~~ ~~To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.~~]
[**RESERVED**]
[8.310.10.8 NMAC - N, 4/1/2016; Repealed, 5/1/2018]

8.310.10.9 HEALTH HOMES: CareLink NM is a set of services authorized by Section 2703 of the Affordable Care Act (ACA). CareLink NM health home (CareLink NM) services are delivered through a designated provider agency. In addition to being enrolled as a provider, a provider agency must complete a CareLink NM application and successfully complete a readiness assessment by [~~the department~~] HSD prior to becoming a designated health home. CareLink NM services enhance the integration and the coordination of primary, acute, behavioral health, and long-term services and supports. The CareLink NM provider agency assists an eligible recipient by engaging him or her in a comprehensive needs assessment which is then utilized to develop his or her integrated service plan and individual treatment plan, increasing his or her access to health education and promotion activities, monitoring the eligible recipient's treatment outcomes and utilization of resources, coordinating appointments with the eligible recipient's primary care and specialty practitioners, sharing information among his or her physical and behavioral practitioners to reduce the duplication of services, actively managing the eligible recipient's transitions between services, and participating as appropriate in the development of the eligible recipient's hospital discharge.
[8.310.10.9 NMAC - N, 4/1/2016; A, 5/1/2018]

8.310.10.10 ELIGIBLE PROVIDERS AND PRACTITIONERS:

A. Health care to eligible recipients in a health home is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by medical assistance division (MAD). Upon approval of a New Mexico provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider agency must be enrolled before submitting a claim for payment to the MAD claims processing contractors or the HSD contracted managed care organizations (MCOs). MAD makes available on the HSD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by [~~HSD or its authorized agents,~~] MAD or its designees including program rules, billing instructions, utilization review (UR) instructions, supplements, policy, and other pertinent materials. When enrolled, a provider agency and a practitioner receive instruction on how to access these documents. It is the provider agency's and practitioner's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider agency must contact HSD or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider agency

and practitioner must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD, its selected claims processing contractor or the MCO, issues payments to a provider agency using electronic funds transfer (EFT) only. To be eligible to receive a CareLink NM health home designation, a provider agency must hold a comprehensive community support service (CCSS) certification [~~from the department of health (DOH) to service eligible recipients 21 years and older or the children, youth and families department (CYFD) to service eligible recipients under 21 years~~] or attest that the agency has received all required training.

B. A provider agency must follow CareLink NM staffing requirements found in this rule and further detailed in the CareLink NM policy manual. The provider agency must agree to fulfill other responsibilities as listed in Subsection B of [~~8.310.10 MAC~~] 8.310.10.10 NMAC. The following individuals and practitioners must be contracted or employed by the provider agency as part of its CareLink NM service delivery:

(1) A director specifically assigned to CareLink NM service oversight and administrative responsibilities.

(2) A health promotion coordinator with a bachelor's-level degree in a human or health services field and experience in developing curriculum and curriculum instruction. The health promotion coordinator manages health promotion services and resources appropriate for an eligible recipient such as interventions related to substance use prevention and cessation, nutritional counseling, or health weight management;

(3) A care coordinator who develops and oversees an eligible recipient's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. The number of care coordinators is based upon ratio in Paragraph (5) of Subsection D of 8.310.10.11 NMAC. The care coordinator:

(a) is a regulation and licensing department (RLD) licensed behavioral health practitioner; or

(b) holds a bachelor's or master's level degree and has [~~four~~] two years of relevant healthcare experience; or

(c) [~~holds a master's-level degree and has two years of relevant healthcare experience.~~] is registered nurse in the State of New Mexico; or

(d) is approved through the CLNM NM health home steering committee.

(4) A community liaison who speaks a language that is utilized by a majority of non-fluent English-speaking eligible recipients, and who is experienced with the resources in the eligible recipient's local community. The community liaison identifies, connects, and engages with community services, resources, and providers. The community liaison works with an eligible recipient's care coordinator in appropriately connecting and integrating the eligible recipient to needed community services, resources, and practitioners.

(5) [~~A supervisor of the care coordinator, community liaison, and the physical health and psychiatric consultants, who is an independently licensed behavioral health practitioner as described in 8.321.2 NMAC. The supervisor must have direct service experience in working with both adult and child populations.~~] A supervisor who is an independently licensed behavioral health practitioner as described in 8.321.2 NMAC who supervises the care coordinator, the community liaison, the health promotion coordinator, peer and family support workers, and other optional staff that is the part of the CareLink NM multidisciplinary team. The supervisor must have direct service experience in working with both adult and child populations. Physical health and psychiatric consultants must comply with their respective licensing boards' requirements for supervision.

(6) [~~A certified~~] Certified peer support [~~worker~~] worker(s) (CPSW) who [~~holds~~] hold a certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully [~~remediated~~] navigated his or her own behavioral health [~~disorder~~] experiences, and is willing to assist his or her peers in their recovery processes.

(7) Certified family support specialist(s) who hold a certification by the New Mexico credentialing board for behavioral health professionals as a certified family support worker.

[~~(7)~~] **(8)** A physical health consultant who is a physician licensed to practice medicine (MD) or osteopathy (DO), a licensed certified nurse practitioner (CNP), or a licensed certified nurse specialist (CNS) as described in 8.310.3 NMAC.

[~~(8)~~] **(9)** A psychiatric consultant who is a physician (MD or DO) licensed by the board of medical examiners or board of osteopathy and is board-eligible or board-certified in psychiatry as described in 8.321.2 NMAC.

[8.310.10.10 NMAC - N, 4/1/2016; A, 5/1/2018]

8.310.10.11 PROVIDER RESPONSIBILITIES:

A. A provider agency who furnishes MAD services to an eligible recipient must comply with all federal and state laws, rules, regulations, and executive orders relevant to the provision of services as specified in the MAD PPA. A provider agency also must comply with all appropriate New Mexico administrative code (NMAC) rules, billing instructions, supplements, and policy, as updated. A provider agency is also responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) national correct coding initiatives (NCCI), including not improperly unbundling or upcoding services.

B. A provider agency must verify that a recipient is eligible for a specific health care program administered by HSD and its authorized agents, and must verify the recipient's enrollment status at the time services are furnished. A provider agency must determine if an eligible recipient has other health insurance and notify [~~the department~~] HSD. A provider agency must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. When services are billed to and paid by a MAD fee-for-service (FFS) coordinated services contractor authorized by HSD, under an administrative services contract, the provider agency must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services; see 8.302.1 NMAC.

D. The provider agency must:

(1) demonstrate the ability to meet all data and quality reporting requirements as detailed in the CareLink NM policy manual;

(2) be approved through [~~an~~] a HSD application and readiness process as described in the CareLink NM policy manual;

(3) have the ability to provide primary care services for all ages of eligible recipients, or have a memorandum of agreement with at least one primary care practice in the area that serves eligible recipients under 21 years of age, and one that serves eligible recipients 21 years of age and older;

(4) have established eligible recipient referral protocols with the area hospitals and residential treatment facilities;

(5) maintain the following suggested range of care coordinator staff ratios for CareLink NM eligible recipients as described in the CareLink NM policy manual:

(a) [~~1:50 for care coordination level 3; and~~] 1:51-100 for care coordination level 6;

(b) [~~1:100 for care coordination level 2.~~] 1:30-50 for care coordination level 7;

(c) 1:50 for care coordination level 8; and

(d) 1:10 for care coordination level 9.

E. For the provider agency that renders physical health and behavioral health services, additional staff may be included; see CareLink NM policy manual for detailed descriptions.

[8.310.10.11 NMAC - N, 4/1/2016; A, 5/1/2018]

8.310.10.12 IDENTIFIED POPULATION: An eligible recipient:

A. [~~An eligible recipient:~~

~~**(1)** is 21 years of age and older who meets the HSD criteria for serious mental illness (SMI); or~~

~~**(2)** is under 21 years of age who meets the HSD criteria for serious emotional disturbance (SED).~~

~~**B.** In order for an eligible recipient to access CareLink NM services, there must be a designated health home provider agency in his or her county of residence; see the CareLink NM policy manual.~~] is 21 years of age and older who meets the HSD criteria for serious mental illness (SMI); or

B. is under 21 years of age who meets the HSD criteria for serious emotional disturbance (SED).

[8.310.10.12 NMAC - N, 4/1/2016; A, 5/1/2018]

8.310.10.13 COVERED SERVICES: Health home services through CareLink NM are coordinated with the eligible recipient and his or her family and a CareLink NM provider agency as appropriate. CareLink NM services identify available community-based resources and actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up post engagement. Common linkages include continuation of the eligible recipient's MAP category of eligibility, and his or her other disability benefits, housing assistance, legal services, educational and employment supports, and other personal needs consistent with his or her recovery goals and [~~treatment~~] CareLink NM care plan. CareLink NM staff make and follow-up on referrals to community services, link an eligible recipient with natural supports, and assure that these connections are solid and effective. Services are linked as appropriate and feasible by health information technology. CareLink NM services are comprised of [~~five~~] six unique categories (and further defined in the CareLink NM policy manual):

A. comprehensive care management;

B. care coordination [~~and health promotion~~];

C. health promotion;

[~~**C.**~~] **D.** comprehensive transitional care;

[~~**D.**~~] **E.** individual [~~eligible recipient~~] and family support services; and

[~~**E.**~~] **F.** referrals for the eligible recipient to community and social support services[~~and.~~

~~**F.** use of health information technology to link services.~~]

[8.310.10.13 NMAC - N, 4/1/2016; A, 5/1/2018]

8.310.10.14 GENERAL NON-COVERED SERVICES: Non-covered CareLink NM services are subject to the limitations and coverage restrictions that exist for other MAD services. See 8.310.2 and 8.321.2 NMAC for general non-covered services. Specific to CareLink NM services, the following apply:

A. CareLink NM services rendered during an eligible recipient's stay in an acute care or freestanding psychiatric hospital and a residential treatment facility (not to include foster care and treatment foster care placements), except when part of the eligible recipient's transition plan, are not covered

services.

B. Services which duplicate other MAD services, including [~~Care Coordination~~] care coordination activities that the MCO has not delegated to the provider agency, are not covered services. [8.310.10.14 NMAC - N, 4/1/2016; A, 5/1/2018]

8.310.10.15 PRIOR AUTHORIZATION (PA) AND UTILIZATION REVIEW (UR): All MAD services are subject to utilization review (UR) for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, before payment is made, or after payment is made. The provider agency must contact [~~HSD or its authorized agents~~] MAD or its designees to request UR instructions. It is the provider agency's responsibility to access these instructions or ask for hard copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider agency and practitioner must follow that contractor's instructions for authorization of services. A provider agency and practitioner rendering services to a member must comply with that MCO's prior authorization requirements.

A. Prior authorization: CareLink NM services do not require prior authorization, but are provided as approved by the CareLink provider agency. However, other procedures or services may require a prior authorization from MAD or its designee. Services for which a prior authorization is required remain subject to UR at any point in the payment process, including after payment has been made. It is the provider agency's responsibility to contact MAD or its designee and review documents and instructions available from MAD or its designee to determine when a prior authorization is necessary.

B. Timing of UR: A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD PPA, a provider agency agrees to cooperate fully with MAD or its designee in its performance of any review and agrees to comply with all review requirements. The following are examples of the reviews that may be performed:

(1) prior authorization review (review occurs before the service is furnished);

(2) concurrent review (review occurs while service is being furnished);

(3) pre-payment review (claims review occurring after service is furnished but before payment);

(4) retrospective review (review occurs after payment is made); and

(5) one or more reviews may be used by MAD to assess the medical necessity and program compliance of any service.

C. Denial of payment: If a service or procedure is not medically necessary or not a covered MAD service, MAD may deny a provider agency's claim for payment. If MAD determines that a service is not medically necessary before the claim payment, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

D. Review of decisions: A provider agency that disagrees with a prior authorization request denial or another review decision may request reconsideration from MAD or the MAD designee that performed the initial review and issued the initial decision; see 8.350.2 NMAC. A provider agency that is not satisfied with the reconsideration determination may request a HSD provider administrative hearing; see 8.352.3 NMAC. A provider agency that disagrees with the member's MCO decision is to follow the process detailed in 8.308.15 NMAC. [8.310.10.15 NMAC - N, 4/1/2016; A, 5/1/2018]

LIVESTOCK BOARD

This is an amendment to 21.30.6 NMAC, Section 11, effective 04/24/2018.

21.30.6.11 REGULATORY ACTION:

A. Commingled grazing. All non-virgin bulls commingling in grazing associations or multiple permittee allotments or leases, shall have the official *T. foetus* bull test conducted annually prior to turn out. A new official test will be required each time the bull(s) enter a different grazing association or multiple permittee allotment or lease.

(1) If a bull is found positive, the entire bull population present on the allotment or lease, regardless of ownership, will be required to have an official *T. foetus* test conducted. All positive bulls shall be identified with the official New Mexico livestock board "N" fire brand or NMLB approved method, and be sold for slaughter only. All test negative bulls belonging to the same owner(s) will be required to have a second negative test prior to turn out and a third negative official test after the bull(s) are removed from the grazing association or multiple permittee allotment or lease.

(2) Any stray non-virgin bull from an untested group that enters the grazing area of tested animals may be held under quarantine until the bull has one or more official *T. foetus* test(s) conducted. The test(s) shall be the responsibility of the bull's owner. The conditions of the quarantine and number of tests will be determined by the state veterinarian.

B. Positive *T. foetus* bull & herd. Any confirmed *T. foetus* bovine and its herd (as defined by state animal health officials) shall immediately be placed under quarantine and will continue under quarantine until the following rules are completed.

(1) Positive

T. foetus bulls shall be identified with the official New Mexico livestock board "N" fire brand or other NMLB approved method.

(2) Positive *T. foetus* bulls shall be quarantined and sent directly to slaughter or to public livestock market for slaughter only. [~~A quarantined feed period may be allowed under special conditions.~~] Positive bulls may be required to move on a NMLB approved method. Confined feeding may be allowed provided bulls are "N" branded.

(3) All other bulls in a positive *T. foetus* herd shall test negative to three consecutive official *T. foetus* tests at least seven days apart. The third *T. foetus* test will be completed within 12 months of *T. foetus* confirmation in the herd and will be conducted after the bulls have had breeding exposure to the cow herd. The bulls will be removed from the cow herd at least seven days prior to the official *T. foetus* test. If more than 12 months have passed since confirmation of *T. foetus* in the herd, the state veterinarian may require additional *T. foetus* testing prior to release of quarantine. The initial negative *T. foetus* test is included in the three negative tests.

(4) If a disease management plan has not been developed and activated within 30 days of confirmation of *T. foetus* infection in the herd, all bovids, except steers and spayed heifers, will be required to go directly to slaughter upon leaving the ranch.

(5) Any bull entering a quarantined premise will be required to test negative prior to re-introduction to its herd of origin.

C. Reproductive bovine females from a positive *T. foetus* herd.

(1) Females over 12 months of age (not known to be virgin heifers) from a positive *T. foetus* herd may be sold direct to slaughter or quarantined on the premises of origin. Individual females may be released from quarantine when either all requirements of Paragraph 3 of Subsection B of 21.30.6.11 NMAC have been met or the cow(s) has a calf at side with no exposure to other than known negative *T. foetus* bulls since parturition, has documented 120 days of sexual isolation or is determined by an accredited veterinarian to be at least 120 days pregnant. Heifers known to be virgin at the time of turnout or heifers exposed only to known negative *T. foetus* bulls and not yet 120 days pregnant are allowed unrestricted movement.

(2) Open females shall be sold to slaughter or held in isolation from all bulls for 120 days. Any female sold to slaughter through a livestock market shall be identified with an official New Mexico positive *T. foetus* tag or NMLB approved method during the quarantine period.

(3) Breeding by artificial insemination is allowed during the quarantine period and cows confirmed by an accredited veterinarian to be at least 120 days pregnant as well as cows documented to have 120 days sexual isolation will be released from quarantine.

(4) If a disease management plan has not been developed and activated within 30 days of confirmation of *T. foetus* infection in the herd, all bovids, except steers and spayed heifers, will be required to go directly to slaughter upon leaving the ranch.

D. Regulatory action.

(1) Any stray non-virgin bull from an untested group that enters the land of a negative *T. foetus* herd and commingles with that herd may be held under quarantine until the bull has one or more official *T. foetus* test(s) conducted.

(2) The test(s) shall be the responsibility of the bull(s) owner. The conditions of the quarantine and the number of tests will be determined by the state veterinarian.

E. Neighboring facilities of a positive *T. foetus* herd.

(1) All facilities that share a common boundary with a positive *T. foetus* herd will be notified by the NMLB and [~~may be required to test all of the bulls on the facility at their own expense.~~] may be quarantined based on results of the epidemiological investigation by the state veterinarian. Quarantine will remain in place until testing requirements are satisfied. [~~The decision to require such testing will be made by the state veterinarian based on results of epidemiological investigation.~~]

(2) Any exposed herds found positive upon testing will be designated as a positive *T. foetus* herd.

[21.30.6.11 NMAC - N, 7/15/05; A, 2/26/10; A, 07/15/14; A, 04/24/2018]

NURSING, BOARD OF

This is an amendment to 16.12.2 NMAC, Sections 10 and 12 through 15, effective 5/3/2018.

16.12.2.10 LICENSURE REQUIREMENTS FOR REGISTERED AND PRACTICAL NURSES: Licensure with the New Mexico board of nursing is mandatory and is the responsibility of the individual nurse, pursuant to the Nursing Practice Act. For states who are a part of the nurse licensure compact, licensure in New Mexico can only be issued to applicants who declare New Mexico as their primary state of residence.

A. Prerequisites for licensure of RNs and LPNs by examination in New Mexico.

(1) Completion of and eligible for graduation from a board approved course of study for the preparation of registered nurses or practical nurses, or an acceptable level of education as determined by the board or graduation from a program which is equivalent to an approved program of nursing in the United States:

(a) minimum acceptable level of education for LPN licensure by examination for candidates enrolled in RN programs with LPN programs embedded include:

(i)

minimum of 500 hours, 250 didactic, 250 (clinical and lab) which includes the minimum as follows; OB/Peds - 30 hours didactic/40 hours clinical; medical-surgical - 60 hours didactic/ 90 hours clinical; pharmacology - 45 hours didactic; and psych - 60 contact hours;

(ii) LPN transition course approved by the New Mexico board of nursing.

(b) request to New Mexico board of nursing for LPN licensure examination by acceptable level of education from an approved program of nursing should include:

(i) transcripts with minimum of 500 hours in nursing education and proof of successful completion of board approved LPN transition course;

(ii) written communication from the director of the approved nursing program requesting permission for nursing students to test for LPN licensure.

(c) certification of eligibility for LPN licensure examination by students enrolled in a nursing program with a LPN track will need to include:

(i) transcripts with minimum of 500 hours in nursing education and board approved LPN transition course passed successfully on completion of board approved LPN transition course;

(ii) written communication from the director of the approved nursing program requesting permission for nursing students to test for LPN licensure.

(2) RN and PN graduates from non-U.S. nursing programs:

(a) shall have an evaluation of their nursing education credentials sent to the New Mexico board directly from a board recognized educational credentialing agency;

(i) the credentialing agency must be a member of a national credentialing organization and must be monitored by an external committee of credentialing experts and nursing educators;

(ii) the credentialing agency must demonstrate the ability to accurately analyze academic and licensure credentials in terms of U.S. comparability, with course-by-course analysis of nursing academic records;

(iii) the credentialing agency must manage the translation of original documents into English;

(iv) the credentialing agency will inform the board of nursing in the event of fraudulent documents;

(v) the credentials report must state the language of nursing instruction and language of textbooks for nursing education; and

(vi) the credentialing agency must only use original source documents in evaluating nursing education and must compare the foreign education to the U.S. education standards.

(b) Puerto Rico applicants who are graduates of national league for nursing accrediting commission (NLNAC) accredited registered nurse program are eligible to sit national council licensure examination for registered nurses (NCLEX-RN) exam;

(c) successful completion of any one of the approved English competency examinations with:

(i) a minimum score of 540 (207 on computerized version) on the test of English as a foreign language (TOEFL) or test of English as a foreign language - internet based test (TOEFL IBT) minimal passing standard of 84 overall, with a minimum speaking score of 26, a minimum score of 725 on test of English for international communication test of English for international communication (TOEIC) or a minimum score of 6.5 overall with a 7.0 on the spoken portion on the academic version of international English language testing system international English language testing system (IELTS);

(ii) completion of a nursing program given in English in another country;

(iii) a passing score on a nursing licensure examination which is given in English.

(3) Completion of the required board of nursing application for licensure by examination according to instructions and including the required fee.

(4) Completion of NCLEX application for the testing service according to instructions.

(5) Graduates who have compact state addresses or who declare another compact state as their state of residence on their application will have their application for examination, and appropriate fees returned to them.

(6) The board shall not approve an application for a license until the applicant provides the following information:

(a) demographics, including race, ethnicity and primary and other languages spoken;

(b) practice status, including but not limited to: active practices in New Mexico and other locations; practice type, practice settings, such as hospital, clinic or other clinical settings;

(c) education, training and primary and secondary specialties;

(d) average hours worked per week and the average number of weeks worked per year in the licensed profession;

(e) percentage of practice engaged in direct patient care and in other activities, such as teaching, research and administration in the licensed profession;

(f) practice plans for the next five years, including retiring from the health care profession, moving out of state or

changing health care work hours.

B. Nationwide criminal background check. Applicants for licensure in New Mexico are subject to a state and national criminal background check at their cost.

(1) Applicants will follow the criminal background check process required by the New Mexico department of public safety or its agent.

(2) Applications for exam or endorsement will not be processed without results of a criminal background check.

(3) If the criminal background check reveals a felony or violation of the Nursing Practice Act, the applicant/licensee will be notified to submit copies of legal documents and other related information to the board that will make the determination if the applicant is eligible for licensure or if disciplinary action will be taken.

C. Complete application for licensure by examination, certification of eligibility for graduation completed by nursing education program or official transcript, and an approved criminal background check must be received by the board office prior to being granted permission to take the national licensing examination (NCLEX). Certification of eligibility for graduation completed by nursing education program or official transcript, indicating date requirements for graduation from the nursing program were met and certificate or degree awarded must be received in the board office directly from the registrar's office.

D. Results of the examination shall be reported to the individual applicant within four weeks following the applicant's examination date. Examination results shall be released to the applicant's nursing program and boards of nursing unless otherwise instructed, in writing, by applicant.

E. An initial license shall be valid until the last day of the applicants' birth month after the first anniversary of the initial license.

F. Applications containing fraudulent or misrepresented information could be the basis for denial or revocation of licensure.

G. If the licensure process is not completed, the application becomes null and void six months after date of the application being received at the board.

H. Permits-to-practice may be issued for employment at a specific institution(s) in New Mexico. Permits-to-practice can be emailed, faxed or mailed directly to the New Mexico employing institution(s).

(1) To be eligible for a permit-to-practice, the applicant must:

(a) complete the application process to take the NCLEX within 12 weeks of graduation; the permit to practice for RN and PN graduates of U.S. schools may be issued for a period not to exceed six months from the receipt date of application; permits to practice may not be issued by the New Mexico board of nursing for employment at specific institution(s) in compact states; permits-to-practice will not be issued for applicants who declare residency in other compact states;

(b) RN and PN graduates from non-U.S. nursing programs may be issued a permit-to-practice in New Mexico for a period not to exceed six months from the date of application when requirements are met according to Paragraph (2) of Subsection A of 16.12.2.10 NMAC;

(c) assure that prospective New Mexico employer(s) submit a letter of intent to employ to the board office, on agency letterhead, indicating the name of a specific New Mexico employer and name and nursing license number of the RN who is responsible for assuring direct supervision by a registered nurse;

(d) have an approved criminal background check results.

(2) Permits-to-practice cannot be transferred or renewed.

(3) Written notification from employer must be made to the board office in case of lost or stolen permit-to-practice.

(4) Permits-to-practice shall be valid until the examination results are disseminated but shall not exceed the expiration date on the permit.

(a) Applicants who fail the first or any subsequent examination shall not practice nursing until such time as the applicant passes a nursing licensing examination.

(b) Any applicant who is eligible to write the professional examination but elects to write the practical examination on the basis of practical nursing education equivalency and fails the practical examination shall not be granted graduate nurse status when the applicant applies to write the professional registered nurse examination.

(c) Any applicant who fails to appear for the first examination for which applicant is eligible shall not practice nursing until such time as the applicant passes a licensing examination.

(5) Candidates who were not successful on the *national licensure examination* will receive the results as soon as they are available.

(6) Applicants who hold a graduate permit-to-practice and do not become licensed prior to the expiration date of the permit may not continue to practice as a graduate nurse or graduate practical nurse.

I. Direct supervision for graduate permit holders:

(1) at a minimum, the RN responsible for direct supervision must be in the facility or on the unit with the graduate;

(2) the RN is responsible for observing, directing and evaluating the performance of the graduate;

(3) the RN supervisor must not be engaged in other activities that would

prevent them from providing direct supervision.

J. [~~Applicants educated in the United States who fail the examination may apply to retake the examination:~~

~~**(1)** Up to eight times in two years. The applicant must wait 45 days to retest after failing the exam.~~

~~**(2)** An application expires after six months and a new application and all the supporting documentation must be submitted.~~

~~**(3)** Applicants for re-examination must meet all NCLEX requirements for retaking the examination.~~

~~**(4)** If the applicant did not pass the exam in eight attempts or within two years of graduating, or did not attempt the exam within two years of graduating;~~

~~**(a)** the applicant must submit an individualized remediation plan within six months of the last date of taking the NCLEX to the nurse education advisory committee for consideration;~~

~~**(b)** the applicant has one year to fully execute the approved plan;~~

~~**(c)** upon full execution of the plan, the board's designee will authorize the applicant to take the exam four more times within one year before becoming indefinitely ineligible to sit NCLEX based on nursing program graduation. Subsequent graduations will reset the applicant's NCLEX eligibility;~~

~~**(d)** applicants educated outside of the United States who have practiced nursing for any time may petition the nursing education advisory committee for an alternative schedule for successful completion of the NCLEX not based on graduation date;~~

~~**(e)** graduates who have not passed the NCLEX within two years of graduation and who graduated prior to July 1, 2014 may submit a remediation plan by December 31, 2016.~~] NCLEX attempt limits:

(1) Applicants educated in the United States may take the examination a maximum of three times within three years of first being eligible for to sit for the examination.

(2) Applicants educated outside of the United States may take the examination a maximum of three times within three years of their initial New Mexico application for licensure through examination.

(3) The applicant must wait 45 days to retest after failing the exam.

(4) Applicants for re-examination must meet all NCLEX requirements for retaking the examination.

K. National council licensing examination.

(1) Applicants for licensure as registered nurses shall be required to pass the NCLEX-RN.

(2) Applicants for licensure as licensed practical nurses shall be required to pass the NCLEX-PN.

(3) Applicants observed giving or receiving unauthorized assistance during the taking of the national licensing examination shall be referred to the board by a sworn complaint.

L. Prerequisites for licensure of registered nurses and licensed practical nurses by endorsement.

(1) Verification *directly* from the licensing authority which shall include:

(a) graduation from an approved nursing program or an acceptable level of education as determined by the board or a nursing program which is equivalent to an approved program of nursing in the United States; and

(b) initial licensure by passing a national licensure examination in English or a state constructed licensure examination prior to October 1986.

(2) Applicants from licensing authorities which do not verify graduation from a nursing education program, must assure that a final transcript is sent to the board of nursing *directly* from the educational institution or custodian of records verifying graduation from an approved nursing program or equivalent, or

(3) Canadian applicants who have been endorsed by another state after passing the Canadian nursing exam in English or the NCLEX are eligible for endorsement into NM.

(4) Complete and submit the required application for licensure by endorsement in accordance with all instructions, including the required fee.

(5) The board shall not approve an application for endorsement until the applicant provides the following information:

(a) demographics, including race, ethnicity and primary and other languages, spoken;

(b) practice status, including but not limited to: active practices in New Mexico and other locations; practice type, practice settings, such as hospital, clinic or other clinical settings;

(c) education, training and primary and secondary specialties;

(d) average hours worked per week and the average number of weeks worked per year in the licensed profession;

(e) percentage of practice engaged in direct patient care and in other activities, such as teaching, research and administration in the licensed profession;

(f) practice plans for the next five years, including retiring from the health care profession, moving out of state or changing health care work hours.

(6) Applicants will follow the criminal background check process required by the New Mexico department of public safety or its agent and have a new criminal background check approved.

M. Qualifications for licensure as a RN or LPN are pursuant

to the Nursing Practice Act.

(1) LPN applicants initially licensed after July 1, 1969 must meet the educational requirements.

(2) Military personnel, licensed as LPNs by successful writing of the national licensing examination prior to July 1, 1977, may be licensed in New Mexico by endorsement providing their DD-214 shows the related civilian occupation to be "LPN".

(3) Continuing education (CE) is not required for initial licensure by endorsement. CE requirements must be met at the time of the first renewal. CE may be prorated to commensurate with the length of the renewal period.

(4) Disciplinary action taken or pending against a nursing license in another jurisdiction, or a conviction of a felony, may result in denial of a license.

N. A temporary license may be issued to an endorsee upon submission of:

(1) a completed endorsement application and required fee in accordance with all instructions;

(2) applicants will follow the criminal background check process required by the New Mexico department of public safety or its agent and have a criminal background check result approved.

(3) the board will issue the temporary license to the applicant;

(4) a temporary license is valid for a period not to exceed six months from the date of application, is non-renewable and becomes null and void upon issuance of a current license, expiration, or withdrawal by board action;

(5) applicant is responsible for assuring that all requirements have been met and all documents have been received prior to the expiration date of the temporary license;

(6) the discovery of inaccurate or false information, on the licensure application, may be subject to recall of the temporary license by the board and denial of licensure.

O. An initial license shall be valid until the last day of the applicants' birth month after the first anniversary of the initial license.

P. If the licensure process is not completed within six months after date application received by the board, the application becomes null and void.

Q. In case of a medical emergency (as defined in these rules), nurses currently licensed to practice as a RN or LPN in a jurisdiction of the United States may practice in New Mexico without making application for a New Mexico license for a period not to exceed 30 days.

R. Requirements for relicensure and reactivation. Applicants for relicensure and reactivation must meet CE requirements as stated in these rules, pursuant to the Nursing Practice Act Section 61-3-24 NMSA 1978. The CE may be prorated to commensurate with the length of the renewal period.

(1) Licensed nurses shall be required to complete the renewal process by the end of their renewal month every two years.

(2) A renewal notice shall be mailed to the licensee at least six weeks prior to the end of the renewal month.

(a) Renewal of license may be accepted no more than 60 days prior to the expiration date of the license.

(b) The board shall not approve an application for a renewal of license until the applicant provides the following information:

(i) demographics, including race, ethnicity and primary and other languages spoken;

(ii) practice status, including but not limited to: active practices in New Mexico and other locations; practice type, practice settings, such as hospital, clinic or other clinical settings;

(iii) education, training and primary and secondary specialties;

(iv) average hours worked per week and the average number of weeks worked per year in the licensed profession;

(v) percentage of practice engaged in direct patient care and in other activities, such as teaching, research and administration in the licensed profession;

(vi) practice plans for the next five years, including retiring from the health care profession, moving out of state or changing health care work hours.

(c) Failure to receive notice renewal shall not relieve the licensee of the responsibility of renewing the license by the expiration date.

(d) If the license is not renewed by the end of the renewal month, licensee does not hold a valid license and shall not practice nursing in New Mexico until the lapsed licensed has been reactivated.

(e) A reactivation fee will be charged when license has lapsed.

(f) **Exception**: if renewing, nurses who are mobilized for active duty are not required to renew their license while on active duty, other than training, during a military action. A copy of the mobilization orders must be submitted to the board office prior to expiration of the license. The license extension shall end one month after deployment is concluded. No reactivation fee will be charged when the license is renewed.

(3) 30 hours of approved CE must be accrued within the 24 months immediately preceding expiration of license. CE may be prorated to commensurate with the length of the renewal period.

(a) Certified nurse practitioners must complete a total of 50 hours of approved CE each renewal. CE may be prorated to commensurate with the length of the renewal period. A

copy of the specialty certification/ recertification card or certificate shall be presented at the time of each subsequent renewal.

(b) Certified registered nurse anesthetists must submit a copy of the recertification card issued by NBCRNA for renewal of the CRNA license.

(c) Clinical nurse specialist must complete a total of 50 hours of approved continuing education each renewal. CE may be prorated to commensurate with the length of the renewal period. A copy of the specialty certification/recertification card or certificate shall be presented at the time of each subsequent renewal.

(d) **Exception**: if renewing, nurses mobilized for military action are not required to meet the CE requirements while on active duty, other than training, during a military action. A copy of the mobilization order must be submitted along with the renewal application.

(4) Individuals who reside out-of-state who do not hold primary residence in a nurse licensure compact state, but wish to maintain a current, valid New Mexico license, must meet the same requirements for licensure as licensees residing within the state who have declared New Mexico as their primary residence.

(5) **Penalty**: failure of licensee to meet the CE requirement for licensure shall result in the license not being renewed, reinstated, or reactivated. When the CE requirement has been met, an application for licensure may be submitted for consideration.

(6) Licenses can be verified by phone verification, on the board website or www.nursys.com.

(7) Individuals who are reactivating a license which has been lapsed for four or more years must complete a refresher course that includes both a didactic and clinical component designed to prepare a nurse who has been out of practice to re-enter into practice.

(a) Applicants will follow the criminal background check process required by the New Mexico department of public safety or its agent and have a new criminal background check result approved.

(b) A temporary license will be issued not to exceed six months unless the board of nursing approves an extension to allow the individual to complete the refresher course clinical component. If documentation is not received by the board verifying successful completion of the refresher course prior to the temporary license expiration date, the individual will not be allowed to practice nursing.

(c) Advanced practice nurses who are reactivating an advanced practice license which has been lapsed for four or more years must also complete a refresher course or certification reactivation that is reflective of their specific advanced practice knowledge, skills and expertise. A temporary license will be issued not to exceed one year unless board of nursing approves an extension.

S. Requirements for name-address change:

(1) **Address change**: Immediate notification of address change *must be made* to the board office.

(2) **Name change**: Nurse must use name as it appears on current license until name change is in effect. Name change can be submitted with license renewal or at any given time. Submit a copy of the legal document required for name change (*only* recorded marriage certificate, divorce decree or court order accepted).

T. Reactivation/ reinstatement of a lapsed license must meet the requirements for re-licensure pursuant to the Nursing Practice Act and these rules. A reactivated or reinstated license shall be valid up to two years.

U. Inactive status. Licensee may request her/his license be placed on inactive status during the renewal cycle only; however, the licensee may not function in a nursing capacity as a New Mexico licensed nurse until the license is reactivated.

V. The board will collect a standardized core essential data set as required in regulation for examinations and renewals which will be entered into the internal licensing database at the board of nursing.

[16.12.2.10 NMAC - Rp, 16.12.2.10 NMAC, 10/1/2016; A, 9/12/2017; A, 5/3/2018]

16.12.2.12 STANDARDS OF NURSING PRACTICE:

A. The nurse shall maintain individual competence in nursing practice, recognizing and accepting responsibility for individual actions and judgments.

(1) Competent nursing practice requires that the nurse have the knowledge and skills to practice nursing safely and properly in accordance with his/her licensure status and to perform specific functions or procedures required in his/her particular area of practice. Competent nursing practice also requires that the nurse have the knowledge to recognize and respond to any complication(s) which may result from the function or procedure the nurse performs.

(2) To maintain the requisite knowledge and skills, the nurse shall engage in CE specific to his/her particular area of practice.

(3) The nurse shall use individual competence as a criterion in accepting assigned responsibilities.

(4) The nurse contributes to the formulation, interpretation, implementation and evaluation of the objectives and policies to nursing practice within his/her employing setting.

B. The nurse shall assign/delegate to licensed and unlicensed persons only those nursing actions which that person is prepared, qualified or licensed or certified to perform.

(1) The nurse is accountable for assessing

the situation and is responsible for the decision to delegate or make the assignment.

(2) The delegating nurse is accountable for each activity delegated, for supervising the delegated function or activity, and for assessing the outcome of the delegated function or activity.

(3) The nurse may not delegate the specific functions of nursing assessment, evaluation and nursing judgment to non-licensed persons.

(4) Registered nurses engaged in school nursing practice may delegate medication administration, including emergency medication, to adults affiliated with school operations.

C. The nurse shall have knowledge of the laws and rules governing nursing and function within the legal boundaries of nursing practice.

(1) The nurse must report incompetent and unprofessional conduct to the appropriate authorities.

(2) The nurse must report violations of the Nursing Practice Act and administrative rules of the board of nursing to the board of nursing.

D. The nurse acts to safeguard the patient/client when his care and safety are affected by incompetent, unethical, or illegal conduct of any person by reporting the conduct to the appropriate authorities.

E. The nurse shall recognize the dignity and rights of others regardless of social or economic status and personal attributes, shall conduct practice with respect for human dignity, unrestricted by considerations of age, race, religion, sex, sexual orientation, national origin, disability or nature of the patient/client's health problems.

F. The nurse safeguards the individual's right to privacy by judiciously protecting information of a confidential nature, sharing only that information relevant to his care.

G. The nurse shall identify herself/himself by name and licensure category and shall permit inspection of their license when requested.

H. Standards for professional registered nursing practice. Registered nurses practice in accordance with the definition of professional registered nursing in the NPA. Subsection J of Section 61-3-3 NMSA 1978.

(1) RNs may assume specific functions and perform specific procedures which are beyond basic nursing preparation for professional registered nursing Subsection J of Section 61-3-3 NMSA 1978 provided the knowledge and skills required to perform the function and procedure emanates from a recognized body of knowledge and practice of nursing, and the function or procedure is not prohibited by any law or statue.

(2) When assuming specific functions and performing specific procedures, which are beyond the nurse's basic educational preparation, the RN is responsible for obtaining the appropriate knowledge, skills and supervision to assure he/she can perform the function/procedure safely and competently.

(a) administration of medication for the purposes of procedural sedation and analgesia requires particular attention;

(b) a nurse shall possess specialized nursing knowledge, judgment, skill and current clinical competence to manage the nursing care of the patient receiving procedural sedation including:

(i) being currently trained with demonstrated proficiency in ACLS or PALS;

(ii) knowledge of anatomy, physiology, pharmacology, cardiac arrhythmia recognition, oxygen delivery, respiratory physiology, transport and uptake and the use of an oxygen mask, bag-valve mask, oral airway, nasal airway adjunct, or the maintenance of a supraglottic airway, or endotracheal tube;

(iii) ability to recognize emergency situations and institute emergency procedures as appropriate to the patient condition and circumstance.

(c) To perform procedural sedation a registered nurse:

(i) shall not have other responsibilities during or after the procedure that would compromise the nurse's ability to adequately monitor the patient during procedural sedation/analgesia;

(ii) shall assess the physical setting for safe administration of medications for sedation and proceed only if the resources needed for reasonable anticipated emergencies are available;

(iii) shall ensure that a qualified airway specialist is readily available during and after the procedure for respiratory emergencies. A qualified airway specialist is trained in and maintains a current competency in endotracheal intubation, such as but not limited to a CRNA, anesthesiologist, emergency physician, paramedic, respiratory therapist or a registered nurse;

(iv) shall decline to administer medications classified as sedatives or other medication if the registered nurse assesses the administration of sedatives or other medication would be unsafe under the circumstances;

(v) shall maintain adequate oxygenation and ventilation via an appropriate method.

I. Standards for licensed practical nursing practice. Licensed practical nurses practice in accordance with the definition of licensed practical nursing in the NPA Subsection G of Section 61-3-3 NMSA 1978.

(1) LPNs may assume specific functions and perform specific procedures which are beyond basic preparation for licensed practical nursing Subsection G of Section 61-3-3 NMSA 1978 provided the knowledge and skills

required to perform the function and procedure emanates from the recognized body of knowledge and practice of nursing, and the functions or procedure is not prohibited by any law or statute. LPNs who perform procedures which are beyond basic preparation for practical nursing must only perform these procedures under the supervision/direction of a RN.

(2) LPNs may perform intravenous therapy, including initiation of IV therapy, administration of intravenous fluids and medications, and may administer medications via the intraperitoneal route provided the LPN has the knowledge and skills to perform IV therapy safely and properly.

(3) When assuming specific functions and performing specific procedures which are beyond the LPN's basic educational preparation, the LPN is responsible for obtaining the appropriate knowledge, skills and supervision to assure he/she can perform the function/procedure safely and competently.

J. Educational program criteria. Educational programs preparing either RNs or LPNs to perform specific functions and procedures that are beyond basic educational preparations should:

(1) prepare the nurse to safely and properly perform the function and procedures;

(2) prepare the nurse to recognize and respond to any complication(s) which may result from the procedure, and;

(3) verify the nurse's knowledge and the ability to perform the specific functions and procedures.

K. Nursing practice advisory committee. Board of nursing may appoint a minimum of a seven-member advisory committee to assist the board in regulating the practice of nursing. The committee shall assist and advise the board in the review of issues related to the practice of nursing.

[16.12.2.12 NMAC - Rp, 16.12.2.12 NMAC, 10/1/2016; A, 5/3/2018]

16.12.2.13 ADVANCED PRACTICE REGISTERED NURSE (APRN) CERTIFIED NURSE PRACTITIONER (CNP):

A. Requirements for licensure of nurse practitioners.

(1) Hold a current, unencumbered RN license from New Mexico or hold a compact multi-state RN license.

(2) Successfully complete a graduate level nursing program designed for the education and preparation of nurse practitioners as providers of primary, or acute, or chronic, or long-term, or end of life health care.

(a) The program must be offered through an accredited institution of higher education or through the armed services.

(b) If the applicant is initially licensed by any board of nursing including the New Mexico board of nursing after January 1, 2001 the program must be at the master's in nursing level or higher. Applicants who do not hold a master's level or higher degree from a nurse practitioner program and were initially licensed by any board before January 1, 2001, must provide verification of NP licensure.

(c) The educational documentation shall verify the date of graduation, credentials conferred and number of supervised clinical hours as a nurse practitioner in the education program.

(3) Provide evidence of successful accomplishment of national certification as a nurse practitioner.

(4) It is the responsibility of the applicant to provide documented evidence of his/her qualifications for licensure.

(5) Applicants who meet the minimum didactic and pharmacology requirements, but lack the required preceptorship, may be considered for licensure in New Mexico if the applicant provides satisfactory evidence of two years nurse practitioner experience in another jurisdiction.

(6) Nurse practitioners who will be requesting prescriptive authority must also comply with the requirements for prescriptive authority as outlined in these rules.

B. Procedure for licensure as a graduate nurse practitioner. The applicant seeking licensure as a nurse practitioner shall be responsible for providing proof of meeting the requirements for licensure.

(1) The applicant shall complete the New Mexico nurse practitioner licensure application and submit it along with all required documents in accordance with the instructions.

(2) Upon acceptance of the completed application and receipt of all required supporting documents, the file is reviewed for qualifications and compliance with the requirements.

(3) Applicants who do not meet the requirements for licensure may request or be requested to meet with the board or its designee.

(4) Nurse practitioners are not eligible to practice in New Mexico as a certified nurse practitioner until so licensed in accordance with the licensure procedures.

(5) The board may appoint nurse practitioners to the advanced practice committee. These nurse practitioners will provide advice regarding licensure and practice of nurse practitioners.

C. Graduate nurse practitioners (GNP) permit-to-practice may be issued, upon written request, provided all requirements have been met except national nursing certification.

(1) GNPs must practice under the direct supervision of a physician or New Mexico Certified Nurse Practitioner (NCP) or Certified Nurse Specialist (CNS) in the specialty.

(2) GNPs may prescribe medications only under the direct supervision of a licensed CNP, CNS or a physician, in compliance with these rules. GNPs must fulfill the requirements in this section to

prescribe controlled substances.

(3) GNP permits will be issued to the employer.

(4) A letter of verification of intent to employ, on official letterhead including the name of the practice supervisor and the name of the prescription supervisor, is required from each employer. Upon change in employment, the new employer must send the board a letter of intent to employ. The board will then issue a permit to practice at the new place of employment. The permit will be issued directly to the new employing agency.

(5) The name of the employment institution and the name(s) of the supervisor(s) shall be indicated on the GNP permit.

(6) GNP permits cannot be transferred or renewed.

(7) GNP permits expire on the date specified on the permit. Permits shall be valid not to exceed six months after the date of the national certifying examination. Those who fail the national certifying examination are rendered ineligible to practice as a GNP. It is the responsibility of the GNP to request that the national certifying organization notify the board of nursing of the results of the examination.

D. An initial license to practice as a CNP shall be issued only after receipt by the board of proof of national certification. Such proof must be submitted to the board directly from the certifying agency prior to the expiration of the permit or temporary license.

E. Prerequisites for licensure of CNP by endorsement.

(1) Verification *directly* from the licensing authority, which shall include graduation from a nurse practitioner program.

(2) In lieu of verification of advanced practice licensure for the licensing authority the board will accept:

(a) documentation directly from that licensing authority that the state does not issue advanced practice licensure;

(b) a sworn affidavit from applicant that they practice as an advance practice nurse with the year practice began, and;

(c) if applicant was licensed by another board after January 1, 2001, submit a transcript from the program directly to the board documenting completion of a nurse practitioner program on the master's or higher level.

(3) Verification from applicant of national certification as a nurse practitioner.

(4) Nurse practitioners who are requesting prescriptive authority must comply with the requirements for prescriptive authority as outlined in these rules.

(5) Complete and submit the required application from licensure by endorsement in accordance with all instructions including the required fee.

(6) Continuing education is not required for initial CNP licensure by endorsement.

F. Qualifications for licensure as CNP are pursuant to the Nursing Practice Act.

(1) Refer to Subsection A of 16.12.2.13 NMAC for licensure requirements.

(2) [~~CE requirements must be met at the time of the first renewal;~~

~~**(a)** Advanced practice registered nurse (APRN) newly licensed in New Mexico may have their 20 CE requirements prorated at a ratio of five contact hours for each six months of licensure leading up to the expiration date;~~

~~**(b)** the five contact hours of the 15 currently required in pharmacology to include addressing management of non-cancer pain shall not be prorated. It shall be required for renewal periods of any length;~~

~~**(c)** APRNs with less than six months of licensure prior to renewal at the time of initial licensure shall complete at least five continuing education contact hours.~~

~~**(3)**~~] Disciplinary action taken or pending against a nursing license in another jurisdiction, or a conviction of a felony, may result in denial of a license.

G. A CNP temporary license may be issued to an endorsee awaiting results on successful completion of national certification.

H. A temporary nurse practitioner license may be issued to an endorsee who:

(1) submits a completed endorsement application and fee in accordance with all instructions;

(2) submits a copy of current national certification as a nurse practitioner; the following exceptions can be made;

(a) nurse practitioners who were licensed by any jurisdiction before December 2, 1985 are not required to hold national certification; or

(b) when the state of former advanced practice licensure does not require national certification; proof of national certification as a nurse practitioner must be submitted to the board before a license will be issued;

(3) the board will issue the temporary license to the applicant;

(4) a temporary license is valid for a period not to exceed six months from the date of application, is non-renewable and becomes null and void upon issuance of a current license, expiration, or withdrawal by board action;

(5) applicant is responsible for assuring that all requirements have been met and all documents have been received prior to the expiration date of the temporary license;

(6) the discovery of inaccurate or false information, on the licensure application, may be subject to recall of the temporary license by the board and denial of licensure.

I. An initial nurse

practitioner license shall be valid until the last day of the applicant's birth month after the first anniversary of the initial license. For nurses from compact states, an NM advanced practice license will be issued with the same expiration date as the RN compact license. A letter of authorization will be issued to NPs who have RN multi-state licensure privileges from another nurse licensure compact state. Official verification to practice is located on the board website.

J. If the licensure process is not completed, the application becomes null and void six months after the date of application being received at the board.

K. Authorization to expand scope of practice or who need recertification.

(1) A letter of authorization will be issued for the CNPs who through additional formal education have expanded their practice into another area of NP practice or who need practice hours to recertify provided all requirements have been met except national certification.

(2) A letter of verification of intent to provide a preceptorship, on official letterhead including the name of the practice preceptor and the name of the prescription preceptor must be submitted to the board of nursing.

(3) Practice must be under the direct supervision of a physician or licensed New Mexico CNP or CNS in the specialty.

(4) Prescribing may be done only under the direct supervision of a licensed CNP or CNS or a physician in compliance with these rules.

(5) A letter of authorization will be issued to the preceptor.

(6) A letter of authorization cannot be transferred, renewed or a duplicate issued.

(7) A letter of authorization will expire on the date specified.

(a)
A letter of authorization shall be valid not to exceed six months after the date of the national certifying examination. Those who fail the national certifying examination are rendered ineligible to practice in that area. It is the responsibility of the CNP to request that the national certifying organization notify the board of the results of the examination. A letter of authorization may be valid for a period not to exceed two years.

(b)
A letter of authorization shall be valid for six months for those applicants recertifying.

(c)
A letter of authorization shall be issued for the prescriptive authority preceptorship. This letter will only be valid for the duration of the preceptorship expansion of scope of practice or recertification required hours of practice.

L. Maintaining licensure as a nurse practitioner.

(1) National certification: NPs must maintain national certification. A copy of the specialty certification/recertification card shall be presented at the time of each subsequent renewal. Nurse practitioners licensed by the NM board, after December 2, 1985 are required to be nationally certified in their specialty.

(2) Continuing education.

(a)
The CNP shall accrue a [~~total~~] minimum of 50 contact hours of approved CE each renewal period. [~~National certification or recertification as a NP may not be used to fulfill any portion of the CE requirement:~~

~~(i)~~
~~30 contact hours shall meet the requirements for licensure as a RN, and~~

~~(ii)~~
~~an additional 20 contact hours, 15 of which must be pharmacology are required.~~

~~(iii)~~
~~[CNP's] CNPs with DEA registration and licensure that permits prescribing opioids shall obtain five contact hours addressing [of the 15 currently required in pharmacology to include] management of non-cancer pain in lieu of five of the 15 contact hours required in pharmacology.~~

~~(iv)~~
~~[CNP's] CNPs from compact states are only required to fulfill CE requirements listed under item (ii) and (iii) of this Subparagraph.~~

~~(v)~~
~~CE may be prorated to commensurate with the length of the renewal period.~~]

(b)
[~~The CE shall be in accordance with the requirements as set forth in these rules.~~] National certification or recertification as a CNP may not be used to fulfill any portion of the CE requirement.

(c)
All CEs shall be in accordance with the requirements set forth in 16.12.2.11 and 16.12.2.13 NMAC.

(d)
For renewal periods that are less than two years, CE may be prorated to commensurate with the length of the renewal period. When CE obligations are prorated the CNP must obtain all non-cancer pain management CEs and all pharmacology CEs.

(e)
CNPs with DEA registration at any time during their most recent renewal period shall obtain:

(i)
30 contact hours for licensure as an RN. CNPs with a compact RN license from another jurisdiction have the same obligation for these 30 contact hours as those holding an RN license from New Mexico;

(ii)
five contact hours related to the CNP's practice;

(iii)
10 contact hours in pharmacology related to the CNP's practice;

(iv)
five contact hours in the management of non-cancer pain.

(f)
CNPs without DEA registration for the entire most recent renewal period shall obtain:

(i)
30 contact hours for licensure as an RN. CNPs with a compact RN license

from another jurisdiction have the same obligation for these 30 contact hours as those holding an RN license from New Mexico.

(ii) 10 contact hours related to the CNP's practice;

(iii) 10 contact hours in pharmacology related to the CNP's practice.

M. Reactivation. To reactivate or reinstate licensure as a nurse practitioner, the nurse must provide evidence of meeting the CE requirements.

(1) NPs licensed by the board after December 2, 1985 must also provide evidence of current national certification.

(2) CNPs who are reactivating an advanced practice license which has been lapsed for four or more years must also complete a refresher course or certification reactivation that is reflective of their knowledge skills and expertise. A temporary license will be issued not to exceed one year, unless the board of nursing approves an extension.

N. Nurse practitioner practice.

(1) The CNP makes independent decisions regarding the health care needs of the client and also makes independent decisions in carrying out health care regimens.

(2) The CNP provides primary or acute, or chronic, or long-term, or end of life health care to meet the health care needs of individuals, families and communities in any health care setting.

(3) The CNP may assume specific functions or perform specific procedures which are beyond the advanced educational preparation and certification for the CNP provided the knowledge and skills required to perform the function or procedure emanates from a recognized body of knowledge or advanced practice of nursing and the function or procedure is not prohibited by any law or statute. When assuming specific functions and performing specific procedures, which are beyond the CNP's advanced educational preparation and certification, the CNP is responsible for obtaining the appropriate knowledge, skills and supervision to ensure he/she can perform the function/procedure safely and competently and recognize and respond to any complications that may arise.

(4) The CNP collaborates as necessary with other healthcare providers. Collaboration includes discussion of diagnosis and cooperation in managing and delivering healthcare.

(5) CNPs who have fulfilled requirements for prescriptive authority may prescribe and distribute dangerous drugs including controlled substances contained in Schedules II through V of the Controlled Substances Act within their clinical specialty and practice setting.

(a) Requirements for prescriptive authority: In accordance with applicable state and federal laws, the CNP who fulfills the following requirements may prescribe and distribute dangerous drugs including controlled substances included in Schedules II through V of the Controlled Substance Act.

(i) Verifies 400 hours of work experience in which prescribing dangerous drugs has occurred within the two years immediately preceding the date of the application. Individuals who have not fulfilled this requirement must provide documentation of successful completion of 400 hours of prescribing dangerous drugs in a preceptorship with a licensed CNP, CNS or physician. The preceptorship must be completed within six months and a letter of authorization will be issued for the duration of the preceptorship.

(ii) In order to prescribe controlled substances, the CNP must provide the board of nursing with verification of current state controlled substances registration and current DEA number, unless the CNP has met registration waiver criteria from the New Mexico board of pharmacy as provided under Subsection I of 16.19.20.8 NMAC. CNPs may not possess, prescribe or distribute controlled substances until they have both a current state controlled substances registration and a current DEA registration.

(iii) Once prescriptive authority requirements are met, the board will notify the board of pharmacy of completion of prescriptive authority requirements.

(b) Formulary. It is the CNP's responsibility to maintain a formulary of dangerous drugs and controlled substances that may be prescribed; the only drugs to be included in the formulary are those relevant to the CNP's specialty and practice setting. The board of nursing reserves the right to audit the formulary of the CNP. Licensees may be subject to disciplinary action by the board of nursing if non-compliant with the audit.

(c) Prescription records; written, verbal or electronic prescriptions and orders will comply with state board of pharmacy and federal requirements. All prescriptions will include the name, title, address, and phone number of the prescribing advanced practice registered nurse.

(d) Distributing: CNPs, who have fulfilled requirements for prescriptive authority as stated in these rules, and defined by the board of pharmacy may distribute to their patients dangerous drugs including controlled substances contained in Schedules II through V of the Controlled Substances Act, which have been prepared, packaged, or fabricated by the registered pharmacist or doses which have been pre-packaged by a pharmaceutical manufacturer in accordance with the Pharmacy Act Section 61-11-12 NMSA 1978 and the Drug, Device and Cosmetic Act for the benefit of the public good.

(e) Labeling: CNPs may label only those drugs which the CNP prescribes and distributes to patients under the

CNP's care. The medication shall be properly labeled with the patient's name, date of issue, drug name and strength, instructions for use, drug expiration date, number dispensed and name, address and telephone number of the CNP. Labeling may be handwritten or a pre-printed fill-in label may be used. All information shall be properly documented in the patient record.

(f) CNPs who do not plan to prescribe controlled substances but do plan to prescribe dangerous drugs must meet the requirements relative to prescriptive authority except those specifically required for controlled substances.

(g) CNPs may prescribe, provide samples of and dispense any dangerous drug to a patient where there is a valid practitioner-patient relationship as defined in 16.12.2.7 NMAC.

(6) Graduate nurse practitioner (GNP) practice.

(a) GNPs may not distribute medications.

(b) GNPs may practice or prescribe medications only under the direct supervision of a licensed CNP, CNS or physician in the specialty.

(7) To insure competency and safe practice in specific regard to prescription writing practices in the state of NM:

(a) a list of current CNPs and their status with regard to prescription writing shall be distributed at least annually and upon request to the board of pharmacy;

(b) violation of these rules or disciplinary action taken by the board of nursing with regard to controlled substances shall be reported to the board of pharmacy;

(c) the board of nursing shall appoint qualified CNPs in each specialty to serve on the board of pharmacy disciplinary panel as requested by the board of pharmacy.

[16.12.2.13 NMAC - Rp, 16.12.2.13 NMAC, 10/1/2016; A, 9/12/2017 A, 5/3/2018]

16.12.2.14 ADVANCED PRACTICE REGISTERED NURSE (APRN) CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA):

A. Requirements for licensure as a CRNA.

(1) Hold a current, unencumbered RN license from New Mexico or hold a compact multi-state RN license.

(2) Successfully complete a formal program designed for the education and preparation of certified registered nurse anesthetist. The COA *council on accreditation of nurse anesthesia educational programs* must accredit the program.

(3) If the applicant is initially licensed by any board of nursing including the New Mexico board of nursing after January 1, 2001, the program must be at the master's level or higher. Applicants who do not hold a master's or higher degree from a nurse anesthetist program and were initially licensed by any board before January 2, 2001, must provide verification of CRNA licensure.

(4) Provide evidence of successful completion of a national certification examination as described by the NBCRNA.

(5) It is the responsibility of the applicant to provide documented evidence of his/her qualification for licensure.

(6) Applicants who will be requesting prescriptive authority must also comply with the requirements for prescriptive authority as outlined in these rules.

B. Procedure for licensure as a graduate. The applicant seeking licensure as a certified registered nurse anesthetist shall be responsible for providing proof of meeting the requirements for licensure.

(1) The applicant shall complete the New Mexico certified registered nurse anesthetist licensure application and submit it along with all required documents, and fee in accordance with the instructions.

(2) Upon acceptance of the completed application and receipt of all required supporting documents, the file is reviewed for qualifications and compliance with the requirements.

(3) Applicants who do not meet the requirements for licensure may request or be requested to meet with the board or its designee.

(4) Certified registered nurse anesthetists are not eligible to practice in New Mexico as certified registered nurse anesthetist until so licensed in accordance with the licensure procedures.

(5) The board may appoint certified registered nurse anesthetists to the advanced practice committee. These nurse anesthetists will provide advice regarding licensure and practice of certified registered nurse anesthetists.

C. Graduate registered nurse anesthetist permit-to-practice may be issued, upon written request, provided all requirements have been met except NBCRNA certification.

(1) A permit may be issued following graduation from an approved school of nurse anesthesia to afford the applicant the opportunity for employment pending dissemination of the national qualifying examination results by the NBCRNA.

(2) GRNAs must function in an interdependent role as a member of a health care team and practice at the direction of and in collaboration with a physician, osteopathic physician, dentist or podiatrist.

(3) GRNAs may prescribe and administer medications only in collaboration with a physician, osteopathic physician, dentist or podiatrist in compliance with these rules.

(4) GRNAs permits will be issued to the employer(s).

(5) A letter of verification of intent to employ, on official letterhead including the name of the practice supervisor(s) and

name of prescription supervisor(s), is required from each employer. Upon change in employment, the new employer must send the board a letter of intent to employ. The board will then issue a permit to practice for the new place of employment. The permit will be issued directly to the new employing agency.

(6) The name of the employment institution and the name(s) of the supervisor(s) shall be indicated on the GRNA permit.

(7) GRNA permits cannot be transferred or renewed.

(8) GRNA permits expire on the date specified on the permit.

(a) Permits shall be valid for approximately 12 months subsequent to the date of graduation from the nurse anesthesia program.

(b) Written proof of application to write the national qualifying exam must be received in the board office within 12 weeks of graduation from the nurse anesthesia program.

(c) Verification that applicant wrote the national qualifying examination, must be received in the board office within three weeks subsequent to the date of the examination.

(d) Failure of applicant to write the scheduled qualifying examination or if the exam is failed, will render the applicant ineligible to practice anesthesia in New Mexico and the employer must immediately return the permit-to-permit to the board office. It is the responsibility of the GRNA to request that the national certifying organization notify the board of the results of the examination.

D. A license to practice as a CRNA shall be issued only after receipt by the board of proof of NBCRNA certification. Such proof must be submitted to the board by the certifying agency.

E. Prerequisites for licensure of CRNA by endorsement.

(1) Verification *directly* from the licensing authority, which shall include graduation from a COA *council on accreditation of nurse anesthesia educational program* and a graduate level degree after January 1, 2001.

(2) In lieu of verification of advanced practice licensure from the licensing authority, the board will accept documentation directly from that licensing authority that the state does not issue advanced practice licensure and a sworn affidavit from applicant that they practice as an advance practice nurse with year practice began.

(3) Verification by applicant of National board of certification and recertification for nurse anesthetists (NBCRNA) certification/recertification.

(4) Certified registered nurse anesthetists must comply with the requirements for prescriptive authority as outlined in these rules.

(5) Complete and submit the required application for licensure by endorsement in accordance with all instructions including the required fee.

(6) Continuing education is not required for initial certified registered nurse anesthetists (CRNA) licensure by endorsement.

F. Qualifications for licensure as CRNA are pursuant to the Nursing Practice Act.

(1) Refer to Subsection A of 16.12.2.14 NMAC for licensure requirements.

(2) [~~CE requirements must be met at the time of first renewal. Recertification by NBCRNA will meet the mandatory CE requirements for CRNA licensure. CRNA's with DEA registration and licensure that permits prescribing opioids shall obtain five contact hours to include the management of non-cancer pain.~~

~~(3)~~] Disciplinary action taken or pending against a nursing license in another jurisdiction, or a conviction of a felony, may result in denial of a license.

G. A CRNA temporary license may be issued, to an endorsee awaiting results on successful completion of NBCRNA certification.

H. A temporary certified registered nurse anesthetist license may be issued to an endorsee who:

(1) submits a completed endorsement application in accordance with instructions and fee;

(2) submits a copy of current NBCRNA council of recertification of nurse anesthetist;

(3) the board will mail the temporary license to the endorsee;

(4) a temporary license is valid for a period not to exceed six months from the date of application;

(5) a temporary license is not renewable and becomes null and void upon issuance of a current license, expiration, or withdrawal by board action;

(6) applicant is responsible for assuring that all requirements have been met and all documents have been received prior to the expiration date of the temporary license;

(7) the discovery of inaccurate or false information, on the licensure application, may be subject to recall of the temporary license by the board and denial of licensure.

I. An initial certified registered nurse anesthetist license shall be valid until the last day of the applicant's birth month after the first anniversary of the initial license. For nurses from compact states, a New Mexico advanced practice license will be issued with the same expiration date as the compact RN license. A letter of authorization will be issued to CRNAs who have RN multi-state licensure privileges from another nurse licensure compact states. Official verification of authorization to practice is available through the board website.

J. If the licensure process is not completed, the application becomes null and void six months after the date received at the board of nursing.

K. Maintaining licensure as a certified registered nurse anesthetist.

(1) National certification: CRNAs must maintain NBCRNA. A copy of the recertification card must be presented at the time of each subsequent renewal.

(2) Continuing education: recertification by NBCRNA is accepted for meeting mandatory CE requirement. CRNAs with DEA registration at any time during their most recent renewal period shall obtain five contact hours in the management of non-cancer pain.

L. Reactivation: to reactivate or reinstate licensure as a certified registered nurse anesthetist.

(1) The nurse must provide evidence of current recertification by the NBCRNA.

(2) CRNAs who are reactivating an advanced practice license which has been lapsed for four or more years must also complete a refresher course or certification reactivation that is reflective of their knowledge, skills and expertise. A temporary license will be issued not to exceed one year, unless board of nursing approves an extension.

M. Certified registered nurse anesthetist practice.

(1) The CRNA provides pre-operative, intra-operative and post-operative anesthesia care and related services, including ordering of diagnostic tests, in accordance with the current *American association of nurse anesthetists*' guidelines for nurse anesthesia practice.

(2) The CRNA functions in an interdependent role as a member of a health care team in which the medical care of the patient is directed by a licensed physician, osteopathic physician, dentist or podiatrist licensed in New Mexico.

(3) The CRNA may assume specific functions or perform specific procedures which are beyond the advanced educational preparation and certification for the CRNA provided the knowledge and skills required to perform the function or procedure emanates from a recognized body of knowledge or advanced practice of nursing and the function or procedure is not prohibited by any law or statute. When assuming specific functions or performing specific procedures, which are beyond the CRNA's advanced educational preparation and certification, the CRNA is responsible for obtaining the appropriate knowledge, skills and supervision to ensure he/she can perform the function/procedure safely and competently and recognize and respond to any complications that may arise.

(4) The CRNA collaborates as necessary with the licensed physician, osteopathic physician, dentist or podiatrist concerning the anesthesia care of the patient. Collaboration means the process in which each health care provider contributes his/her respective expertise. Collaboration includes systematic formal planning and evaluation between the health care professionals involved in the collaborative practice arrangement.

(5) CRNAs who have fulfilled requirements for prescriptive authority may prescribe and administer therapeutic measures, including dangerous drugs and controlled substances included in Schedules II through V of the Controlled Substances Act within the specialty of anesthesia and practice setting.

(a) Requirements for prescriptive authority: in accordance with applicable state and federal laws, the CRNA who fulfills the following requirements may prescribe and administer dangerous drugs including controlled substances included in Schedules II through V of the Controlled Substance Act.

(i) Verifies 400 hours of work experience in which prescribing and administering dangerous drugs has occurred within the two years immediately preceding the date of the application. Individuals who have not fulfilled this requirement must provide documentation of successful completion of 400 hours of prescribing dangerous drugs in a preceptorship with a CRNA or physician. The preceptorship must be completed within six months and a letter of authorization will be issued for the duration of the preceptorship.

(ii) In order to prescribe controlled substances, the CRNA must provide the board of nursing with verification of current state controlled substances registration and current drug enforcement administration (DEA) number, unless the CRNA has met registration waiver criteria from the New Mexico board of pharmacy (Subsection I of 16.19.20.8 NMAC). CRNAs may not possess or prescribe controlled substances until they have both a current state controlled substances registration and a current DEA registration.

(iii) Once prescriptive authority requirements are met, the board will notify the board of pharmacy of completion of prescriptive authority requirements.

(b) Formulary: the formulary will include agents related to the administration of anesthesia and Advanced Cardiac Life Support (ACLS) protocol agents.

(i) All CRNAs must adhere to the current formulary approved by the board of nursing.

(ii) The initial formulary or a formulary with changes will be submitted to the board of medical examiners for a review.

(c) Prescription records: written, verbal or electronic prescriptions and order will comply with state board of pharmacy and federal requirements. All prescriptions will include the name, title, address and phone number of the prescribing advanced practice registered nurse.

(d) Prescribing and administering: CRNAs who have fulfilled

requirements for prescriptive authority as stated in these rules as defined by the board of pharmacy may prescribe and administer to their patients dangerous drugs including controlled substances contained in Schedules II through V of the Controlled Substances Act, which have been prepared, packaged or fabricated by a registered pharmacist or doses or drugs that have been prepackaged by a pharmaceutical manufacturer in accordance with the Pharmacy Act Section 61-11-22 NMSA 1978 and the New Mexico Drug, Device and Cosmetic Act for the benefit of the public good.

(e) Distributing: CRNAs who have fulfilled requirements for prescriptive authority as stated in these rules may *not* distribute to their patients dangerous drugs including controlled substances contained in Schedules II through V of the Controlled Substances Act.

(f) CRNAs who do not plan to prescribe controlled substances but do plan to prescribe dangerous drugs must meet the requirements relative to prescriptive authority except those specifically required for controlled substances.

(6) Graduate registered nurse anesthetist practice.

(a) GRNAs may NOT distribute medications.

(b) GRNAs may practice or prescribe/ administer medications only in collaboration with a physician, osteopathic physician, dentist or podiatrist.

(7) To insure competency and safe practice in specific regard to prescription writing practices in the state of NM.

(a) A list of current CRNAs and their status with regard to prescription writing shall be distributed upon request to the board of pharmacy.

(b) Violation of these rules or disciplinary action taken by the board of nursing with regard to controlled substances shall be reported to the board of pharmacy.

(c) The board of nursing shall appoint as requested, qualified CRNAs to serve on the board of pharmacy disciplinary panel as requested by the board of pharmacy.

N. A CRNA business entity formed pursuant to the laws of the state of New Mexico is authorized to provide health care services in the state of New Mexico if the health care services are provided by persons who are duly licensed to engage in the practice of nursing pursuant to the provisions of the Nursing Practice Act.

[16.12.2.14 NMAC - Rp, 16.12.2.14 NMAC, 10/1/2016; A, 9/12/2017 A, 5/3/2018]

16.12.2.15 ADVANCED PRACTICE REGISTERED NURSE (APRN) CLINICAL NURSE SPECIALIST (CNS):

A. Requirements for licensure as a CNS:

(1) hold a current, unencumbered RN license from New Mexico or hold a compact multi-state RN license;

(2) successfully complete a clinical nurse specialist program at the master's or doctoral level in a defined clinical nursing specialty through an accredited institution of higher education; and

(3) provide evidence of successful accomplishment of certification by a national nursing organization, consistent with the defined clinical nursing specialty, which meets criteria as listed below:

(a) successfully complete a national certifying examination in the applicant's area of specialty;

(b) is certified by a national nursing organization;

(4) it is the responsibility of the applicant to provide documented evidence of his/ her qualifications for licensure;

(5) any CNS requesting prescriptive authority must also comply with the regulations for prescriptive authority as outlined in these rules.

B. Procedure for licensure as a graduate CNS: applicant seeking licensure as a CNS shall be responsible for providing proof of meeting the requirements for licensure.

(1) The applicant shall complete the New Mexico CNS application and submit it along with all requested documents in accordance with the instructions.

(2) Upon acceptance of the completed application and receipt of all required supporting documents, the file is reviewed for qualifications and compliance with the requirements.

(3) Applicants who do not meet the requirements for licensure may request or be requested to meet with the board or their designee.

(4) CNSs are not eligible to practice in New Mexico as a CNS until so licensed by the New Mexico board in accordance with licensure procedures.

(5) The board may appoint CNSs to the advanced practice committee. These CNSs will provide advice regarding the licensure and practice of the CNS.

C. Graduate clinical nurse specialist (GCNS) permit to practice.

(1) GCNS permits may be issued upon written request, provided all requirements have been met except certification by a national nursing organization.

(a) GCNSs practice under the direct supervision of another CNS, CNP or physician in the specialty.

(b) GCNSs may prescribe medications only under the direct supervision of a licensed CNS, CNP or physician in compliance with these rules.

(c) GCNS permits will be issued to the employer.

(d) A letter of verification of intent

to employ, on official letterhead including the name of the practice supervisor and the name of the prescription supervisor is required from each employer. Upon change in employment, the new employer must send the board a letter of intent to employ. The board will then issue a permit to practice at the new place of employment. The permit will be issued directly to the new employing agency.

(e) The name of the employment institution and the name(s) of the supervisor(s) shall be indicated on the GCNS permit.

(f) GCNS permits cannot be transferred or renewed.

(g) GCNS permits expire on the date specified on the permit. Permits shall be valid not to exceed six months after the date of the national certifying examination. Those who fail the national certifying examination are rendered ineligible to practice as a GCNS. It is the responsibility of the GCNS to request that the national certifying organization notify the board of the results of the examination.

(2) An initial license to practice as a CNS shall be issued only after receipt by the board of proof of certification by a national nursing organization. Such proof must be submitted to the board directly from the certifying agency prior to the expiration of the permit or temporary license.

D. Prerequisites for licensure of CNS by endorsement.

(1) Verification *directly* from the licensing authority which shall include graduation from a clinical nurse specialist program in a defined clinical nursing specialty.

(2) In lieu of verification of advanced practice licensure from the licensing authority, the board will accept:

(a) documentation directly from the licensing authority that the state does not issue advanced practice licensure; and

(b) a sworn affidavit from applicant that they practice as an advance practice nurse with year practice began.

(3) Verification by applicant of national certification in a clinical specialty area.

(4) Clinical nurse specialist must comply with requirements for prescriptive authority as outlined in these rules.

(5) Complete and submit the required application for licensure by endorsement in accordance with all instructions including the required fee.

(6) Continuing education is not required for initial CNS licensure by endorsement.

E. Qualifications for licensure as a CNS are pursuant to the Nursing Practice Act.

(1) Refer to Subsection A of 16.12.2.15 NMAC for licensure requirements.

(2) [~~CE requirements must be met at the time of the first renewal.~~

~~**(3)**~~] Disciplinary action taken or pending against a nursing license in another jurisdiction, or a conviction of a felony, may result in denial of a license.

F. A CNS temporary license may be issued to an endorsee awaiting results on successful completion of national certification.

G. A temporary clinical nurse specialist license may be issued to an endorsee who:

(1) submits a completed endorsement application in accordance with all instructions and fee;

(2) submits a copy of current national certification in a nursing specialty; when the state of former advanced practice licensure does not require national certification; national certification in a nursing specialty must be submitted to the board before a license will be issued;

(3) the board will mail the temporary license to the applicant;

(4) a temporary license is valid for a period not to exceed six months from the date of application, is non-renewable and becomes null and void upon issuance of a current license, expiration, or withdrawal by board action;

(5) applicant is responsible for assuring that all requirements have been met and all documents have been received prior to the expiration date of the temporary license;

(6) the discovery of inaccurate or false information, on the licensure application, may be subject to recall of the temporary license by the board and denial of licensure.

H. An initial clinical nurse specialist license shall be valid until the last day of the applicant's birth month after the first anniversary of the initial license. For nurses from compact states, a New Mexico advanced practice license will be issued with the same expiration date as the compact license. A letter of authorization will be issued to CNSs who have RN multi-state licensure privilege from another nurse licensure compact state. Official verification to practice is located on the board website.

I. If the licensure process is not completed, the application becomes null and void one year after the date of application being received at the board.

J. Authorization to expand scope of practice or who need recertification.

(1) A letter of authorization will be issued for the CNSs who through additional formal education have expanded their practice into another area of CNS practice or who need practice hours to recertify provided all requirements have been met except national certification.

(2) A letter of verification of intent to provide a preceptorship, on official letterhead including the name of the practice preceptor and the name of the prescription preceptor must be submitted to the board of nursing.

(3) Practice must be under the direct supervision of a New Mexico CNS or CNP or physician in the specialty.

(4) Prescribing may be done only under the direct supervision of a licensed CNP or CNS or a physician in compliance with these rules.

(5) A letter of authorization will be issued to the preceptor.

(6) A letter of authorization cannot be transferred, renewed or a duplicate issued.

(7) A letter of authorization will expire on the date specified.

(a) A letter of authorization shall be valid not to exceed six months after the date of the national certifying examination. Those who fail the national certifying examination are rendered ineligible to practice in that area. It is the responsibility of the CNS to request that the national certifying organization notify the board of the results of the examination. A letter of authorization may be valid for a period not to exceed two years.

(b) A letter of authorization will be valid for six months for those applicants recertifying.

(c) A letter of authorization shall be issued for the prescriptive authority preceptorship. This letter will only be valid for the duration of the preceptorship for expansion of scope of practice or recertification required hours of practice.

K. Maintaining licensure as a clinical nurse specialist.

(1) The CNS shall be nationally certified in the specialty by a nursing organization and maintain national certification. A copy of the specialty certification/ recertification card shall be presented at the time of each subsequent renewal.

(2) Continuing education.

(a) [~~The CNS shall accrue a total of 50 contact hours of approved CE each renewal period. National certification or recertification as a CNS may not be used to fulfill any portion of the CE requirement.~~

(b) ~~30 contact hours, shall meet the requirements for licensure as an RN, and~~

(c) ~~An additional 20 contact hours, 15 of which must be pharmacology are required.~~

(d) ~~CNSs with DEA registration and licensure that permits prescribing opioids shall obtain five contact hours addressing of the 15 currently required in pharmacology to include management of non-cancer pain in lieu of five of the 15 contact hours required in pharmacology.~~

(e) ~~CNSs from compact states are only required to fulfill CE requirement listed under (c) and (d).~~

(f) ~~The CE shall be in accordance with the requirements as set forth in these rules.~~

(g) ~~CE may be prorated to commensurate with the length of the renewal period.~~] The CNS shall accrue a minimum of 50 contact hours of approved CE each two year renewal period.

(b) National Certification or recertification as a CNS may not be used to fulfill any portion of the CE requirement.

(c) All CEs shall be in accordance with the requirements set forth in 16.12.2.11 and 16.12.2.15 NMAC

(d) For renewal periods that are less than two years, CE may be prorated to commensurate with the length of the renewal period. When CE obligations are prorated the CNP must obtain all non-cancer pain management CEs and all pharmacology CEs.

(e) CNSs with DEA registration at any time during their most recent renewal period shall obtain:

(i) 30 contact hours for licensure as an RN. CNSs with a compact RN license from another jurisdiction have the same obligation for these 30 contact hours as those holding an RN license from New Mexico;

(ii) five contact hours related to the CNS's practice;

(iii) 10 contact hours in pharmacology related to the CNS's practice;

(iv) five contact hours in the management of non-cancer pain.

(f) CNSs without DEA registration for the entire most recent renewal period shall obtain:

(i) 30 contact hours for licensure as an RN. CNSs with a compact RN license from another jurisdiction have the same obligation for these 30 contact hours as those holding an RN license from New Mexico;

(ii) 10 contact hours related to the CNS's practice;

(iii) 10 contact hours in pharmacology related to the CNS's practice.

(3) Reactivation.

(a) To reactivate or reinstate licensure as a CNS, the nurse must provide evidence of meeting the CE requirements: evidence of current national certification must also be provided.

(b) CNSs who are reactivating an advanced practice license which has been lapsed for four or more years must also complete a refresher course or certification reactivation that is reflective of their knowledge, skills and expertise. A temporary license will be issued not to exceed one year, unless the board of nursing approves an extension.

L. Clinical nurse specialist practice.

(1) The CNS is a nurse who through graduate level preparation has become an expert in a defined area of knowledge and practice in a selected clinical area of

nursing.

(2) The CNS makes independent decisions in a specialized area of nursing practice, using knowledge about the health care needs of the individual, family and community. The CNS collaborates as necessary with other members of the health care team, when the needs are beyond the scope of practice of the CNS.

(3) The CNS may assume specific functions or perform specific procedures which are beyond the advanced educational preparation and certification for the CNS provided the knowledge and skills required to perform the function or procedure emanates from a recognized body of knowledge or advanced practice of nursing and the function or procedure is not prohibited by any law or statute. When assuming specific functions or performing specific procedures, which are beyond the CNS's advanced educational preparation and certification, the CNS is responsible for obtaining the appropriate knowledge, skills and supervision to assure he/she can perform the function/procedure safely and competently and recognize and respond to any complications that may arise.

(4) Carries out therapeutic regimens in the area of the specialty.

(5) The CNS who has fulfilled the requirements for prescriptive authority in the specialty area may prescribe and distribute therapeutic measures including dangerous drugs and controlled substances contained in Schedules II through V of the Controlled Substance Act within the scope of the specialty practice and setting.

(a) Requirements for prescriptive authority: In accordance with applicable state and federal laws, the CNS who fulfills the following requirements may prescribe and distribute dangerous drugs including controlled substances included in Schedules II through V of the Controlled Substance Act:

(i) verifies 400 hours of work experience in which prescribing dangerous drugs has occurred within the two years immediately preceding the date of application and provide a copy of a transcript documenting successful completion of the a three credit hour pharmacology course, a three credit hour assessment course and a three credit hour pathophysiology course included as part of a graduate level advanced practice nursing education program; 45 contact hours of advanced level pharmacology continuing education course may be substituted for the academic pharmacology; a certificate of completion must be provided that verifies continuing education; or

(ii) if 400 hours of work experience in which prescribing dangerous drugs cannot be verified, provide a copy of a transcript documenting successful completion of a three credit hour pharmacology course that is included as part of a graduate level advanced practice nursing education program within five years immediately prior to the date of application to the board; 45 contact hours of advanced level pharmacology continuing education course may be substituted for the academic pharmacology; a certificate of completion must be provided that verifies continuing education; the course must be related to the specialty and contain content in pharmacokinetics, pharmacodynamics, pharmacology of current/commonly used medications and application of drug therapy to the treatment of disease or the promotion of health; and

(iii) provide a copy of a transcript documenting successful completion of a three credit hour assessment course that is included as part of a graduate level advanced practice nursing education program; the course must be related to the specialty and include content supported by related clinical experience such that students gain knowledge and skills needed to perform comprehensive assessments to acquire date, make diagnoses of health status and formulate effective clinical management plans; and

(iv) provide a copy of a transcript documenting successful completion of a three credit hour pathophysiology course that is included as part of a graduate level advanced practice nursing education program; the course must be related to the specialty and include content in physiology and pathophysiology;

(v) provide a copy of a transcript documenting successful completion of a 400 hour university/college associated preceptor experience in the prescription of dangerous drugs within the two years immediately prior to the date of application to the board; or

(vi) after fulfilling ii, iii, and iv above, upon application to the board, a letter of authorization for a prescriptive authority preceptorship will be issued to complete a preceptorship, which must be completed within six months;

(vii) in order to prescribe controlled substances, the CNS must provide the board of nursing with verification of current state controlled substances registration and current DEA number, unless the CNS with prescriptive authority has met registration waiver criteria from the New Mexico board of pharmacy; CNSs may not possess, prescribe or distribute controlled substances until they have both a current state controlled substances registration and a current DEA registration;

(viii) once prescriptive authority requirements are met, the board will notify the board of pharmacy of completion of prescriptive authority requirements.

(b) Formulary. It is the CNS's responsibility to maintain a formulary of dangerous drugs and controlled substances that may be prescribed. The only drugs to be included in the formulary are those relevant to the CNS's area of specialty practice, scope of practice

and clinical setting. The board of nursing reserves the right to audit the formulary. Licensees may be subject to disciplinary action by the board of nursing if non-compliant with the audit.

(c) Prescription records: written, verbal or electronic prescriptions and orders will comply with state board of pharmacy and federal requirements. All prescriptions will include the name, title, address and phone number of the prescribing advanced practice registered nurse.

(d) Distributing: CNSs who have fulfilled requirements for prescriptive authority as stated in these rules, may distribute to their patients dangerous drugs including controlled substances contained in Schedules II through V of the Controlled Substance Act, which have been prepared, packaged, or fabricated by the registered pharmacist or doses which have been pre-packaged by a pharmaceutical manufacturer in accordance with the Pharmacy Act and the Drug, Device and Cosmetic Act for the benefit of the public good.

(e) Labeling: CNSs may label only those drugs which the CNS prescribes and distributes to patients under the CNS's care. The medication shall be properly labeled with the patient's name, date of issue, drug name and strength, instructions for use, drug expiration date, telephone number of the CNS. Labeling may be handwritten or a pre-printed fill-in label may be used. All information shall be properly documented in the patient record.

(f) CNSs who do not plan to prescribe controlled substances but do plan to prescribe dangerous drugs must meet the requirements relative to prescriptive authority except those specifically required for controlled substances.

(6) Graduate clinical nurse specialist (GCNS) practice.

(a) GCNSs may not distribute medications.

(b) GCNSs may practice or prescribe medications only under the direct supervision of a licensed CNS, CNP or physician in the specialty.

(7) To insure competency and safe practice in specific regard to prescription writing practices in the state of NM:

(a) a list of current CNSs and their status with regard to prescription writing shall be distributed upon request to the board of pharmacy;

(b) violation of these rules or disciplinary action taken by the board of nursing with regard to controlled substances shall be reported to the board of pharmacy;

(c) the board of nursing shall appoint qualified CNSs in each specialty to serve on the board of pharmacy disciplinary panel as requested by the board of pharmacy.

M. Advanced practice committee.

(1) The board may appoint a minimum of a six member advisory committee to assist the board in regulating the advanced practice of nursing.

(2) The committee shall assist and advise the board in the review of issues related to the advanced practice of nursing.

(3) The committee shall be composed of representatives from each advanced practice area regulated by the board.

[16.12.2.15 NMAC - Rp, 16.12.2.15 NMAC, 10/1/2016; A, 5/3/2018]

NURSING, BOARD OF

This is an amendment to 16.12.9 NMAC, Section 10, effective 5/3/2018.

16.12.9.10 NON-CANCER PAIN MANAGEMENT CONTINUING EDUCATION: Any advanced practice registered nurse (APRN) with a drug enforcement agency (DEA) registration and licensure that permits prescribing opioids, shall obtain continuing education on the management of non-cancer pain. These practitioners shall be required to obtain five [~~CE of the 15 CE currently required every two years in pharmacology~~] contact hours every renewal period to include a review of these rules 16.12.9 NMAC for management of non-cancer pain, an understanding of the pharmacology and risks of controlled substances, a basic awareness of the problems of abuse, addiction and diversion, and awareness of state and federal regulations for the prescription of controlled substances.

[16.12.9.10 NMAC - N, 11/20/2012; A, 9/12/2017; A, 5/3/2018]

SECRETARY OF STATE

The Office of the Secretary of State repeals its rule entitled Ballot Position; Supreme Court or Court of Appeals, 1.10.10 NMAC, filed 11/23/2009, effective 4/24/2018.

The New Mexico Secretary of State's Office, after a rule hearing conducted on 03/18/2018, has approved a repeal to its rule 1.10.12 NMAC, Absentee Voting (filed 03/31/2000) and replaced it with 1.10.12 NMAC, Absentee Voting. The rule was adopted on 04/02/2018 and will be effective 04/24/2018.

The New Mexico Secretary of State's Office, after a rule hearing conducted on 03/30/2018, has approved a repeal to its rule 1.10.22 NMAC, Provisional Voting (filed 04/28/2006) and replaced it with 1.10.22 NMAC, Provisional Voting. The rule was adopted on 04/02/2018 and will be effective 04/24/2018.

SECRETARY OF STATE

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 10 ELECTIONS AND ELECTED OFFICIALS
PART 12 ABSENTEE VOTING

1.10.12.1 ISSUING AGENCY: Office of the Secretary of State, 325 Don Gaspar, Suite 300, Santa Fe, New Mexico 87501.
[1.10.12.1 NMAC - Rp, 1.10.12.1 NMAC, 4/24/2018]

1.10.12.2 SCOPE: This rule applies to any election covered under the Election Code, Section 1-1-19, NMSA 1978 and the Special Election Act, NMSA 1978.
[1.10.12.2 NMAC - Rp, 1.10.12.2 NMAC, 4/24/2018]

1.10.12.3 STATUTORY AUTHORITY: Election Code, Section 1-2-1; Section 1-6-5.4; Section 1-6-5.6; Section 1-6-16.1; and Section 1-9-7.1 NMSA 1978.
[1.10.12.3 NMAC - Rp, 1.10.12.3 NMAC, 4/24/2018]

1.10.12.4 DURATION: Permanent.
[1.10.12.4 NMAC - Rp, 1.10.12.4 NMAC, 4/24/2018]

1.10.12.5 EFFECTIVE DATE: April 24, 2018 unless a later date is cited at the end of a section.
[1.10.12.5 NMAC - Rp, 1.10.12.5 NMAC, 4/24/2018]

1.10.12.6 OBJECTIVE: The objective of this rule is to establish procedures for protecting the integrity, security and secrecy of the absentee ballot, to establish procedures for establishing mobile alternate voting locations in rural areas of the state, and to establish procedures for electronic ballot delivery of absentee ballots for visually impaired voters.
[1.10.12.6 NMAC - Rp, 1.10.12.6 NMAC, 4/24/2018]

1.10.12.7 DEFINITIONS:

A. "Absentee ballot" means a method of voting by mail, accomplished by a voter who is absent from the voter's polling place on election day.

B. "Absentee ballot register" means a listing kept by the county clerk for each election with the information specified in the Election Code, Section 1-6-6 NMSA 1978.

C. "Adjudicate" means a decision made by a precinct board, in accordance with the Election Code, of a ballot signifying a voter's intent to mark their selection for a candidate contest or ballot question.

D. "Alternate voting location" means a location outside the office of the county clerk, established by the county clerk, where a voter may cast an early in person ballot on voting tabulator. This includes mobile alternate voting locations.

E. "Application" means an absentee ballot application, prescribed by the secretary of state pursuant to the Election Code, Section 1-6-4 NMSA 1978.

F. "Ballot markers" means the grid pattern around the voting response area on the ballot face used by the voting tabulator to distinguish the ballot style and voter's selection of alternatives allowed in any candidate contest or ballot question to record, count and produce a tabulation of votes cast.

G. "Blank ballot" means a paper ballot on which the voter has not selected any of the alternatives allowed in any candidate contest or ballot question.

H. "Challenger" means a voter of a precinct located in that county to which the voter is appointed in conformance with the Election Code, Section 1-2-21 to 1-2-22 NMSA 1978 for the purpose of carrying out such duties as prescribed in the Election Code, Section 1-2-23 to 1-2-26 NMSA 1978.

I. "County canvassing board" means the board of county commissioners in each county, convened for the purposes of conducting the county canvass.

J. "Early voter" means a voter who votes in person before election day, and not by mail.

K. "Early voting daily report" means a form used to certify the daily early voting activity at the office of the county clerk, alternate voting location and mobile alternate voting location; the form shall be prescribed by the office of the secretary of state to be completed and filed daily during early voting, consisting of the voting tabulator serial number, beginning public counter number, ending public counter number, total number of ballots cast early per tabulator and those to be hand tallied.

L. "Electronically transmitted ballot" means a ballot provided through an electronic transmission system to federal qualified electors pursuant to Section 1-6B-7 or to blind or visually impaired voters as provided in Section 1-9-7.1 NMSA 1978.

M. "Immediate family member" means a person's spouse, children, parents, brothers and sisters.

N. "Inner envelope" means the official envelope, prescribed by the secretary of state, given to the voter along with an absentee or provisional ballot into which the voter places the ballot after it is voted and which is used to preserve the secrecy of the voter's ballot.

O. "Official transmittal envelope" means the official envelope used by the county clerk to mail absentee ballot materials, to include the inner and outer envelopes.

P. "Outer envelope" means the official envelope, prescribed by the secretary of state, which has information that will identify the voter and contains a sworn affidavit, into which the voter places the inner envelope, containing an absentee ballot.

Q. "Overvoted ballot" means a ballot on which the voter has selected more than the number of candidates to be elected for that contest, or in both the affirmative and negative on a ballot question.

R. "Provisional

ballot envelope" means the official envelope, prescribed by the secretary of state, which has information that will identify the provisional voter, purpose the provisional ballot was issued and contains a sworn affidavit and a blank voter registration certificate, into which the provisional voter places the inner envelope.

S. "Replacement absentee ballot" means a ballot that is processed as a provisional ballot, provided to a voter whose name appears on the absentee ballot register or signature roster as having been issued an absentee ballot and who has affirmed that the ballot was not received or voted on pursuant to the Election Code, Section 1-6-16 NMSA 1978. The ballot shall be placed in a provisional ballot envelope prescribed by the secretary of state and processed within the time frame specified in the Election Code, Section 1-6-16 NMSA 1978.

T. "Undervoted ballot" means a ballot that is not a blank ballot and on which the voter has selected at least one candidate or answered at least one ballot question in accordance with the instructions for that ballot type, but on which the voter has selected fewer than the number of alternatives allowed in a candidate contest or on a ballot question.

U. "Voting response area" means the place on a ballot the voter is instructed to mark the voter's selection for a candidate or question.
[1.10.12.7 NMAC - Rp, 1.10.12.7 NMAC, 4/24/2018]

1.10.12.8 APPLICATION:

A. An application for an absentee ballot may be made on a blank form prescribed by the secretary of state, either on paper with an original signature or through the official electronic absentee application portal. The form may not be altered, to include the pre-population of voter information, without prior approval from the secretary of state. Completed applications shall require the information specified in the Election Code, Section 1-6-4 NMSA 1978.

B. Upon receipt of an absentee ballot application, the county clerk shall review it for completeness in accordance with the Election Code, Section 1-6-5 NMSA 1978. When it is determined that the applicant does not have a valid certificate of registration on file in that county or the application is not completed or has incorrect information, the application shall be marked "rejected". The county clerk shall notify the applicant in writing of the reasons for rejection and include the internet address for the official electronic absentee application portal and may also include the paper form absentee application.

C. An application by a federal qualified elector as defined in the Election Code, Section 1-1-4.1 NMSA 1978, consists of one of the methods listed in the Election Code Section 1-6B-3 NMSA 1978.

(1) The county clerk, shall review each application by a federal qualified elector for completeness and compliance with the voter registration requirements prescribed in the Election Code, Section 1-6B-5 NMSA 1978 and determine whether the requirements are met. The county clerk shall immediately notify the federal qualified elector if the application is rejected, to include the reasons for rejection, according to the applicant's preferred method of communication, pursuant to the Election Code, Section 1-6B-7 NMSA 1978.

(2) An application for an absentee ballot or a military overseas ballot received by the office of the county clerk or secretary of state for a voter registered in a differing county shall be forwarded within 24 hours of receiving the application, or if received less than five days before the election, shall be electronically transmitted to the appropriate county clerk.
[1.10.12.8 NMAC - Rp, 1.10.12.8 NMAC, 4/24/2018]

1.10.12.9 ABSENTEE VOTING:

A. A voter shall have the right to vote by absentee ballot for all candidate contests and ballot questions as if the voter were casting the ballot in person at their election day polling place. Absentee ballots are provided as follows:

(1) By mail - by completing and signing an application as provided in the Election Code, Section 1-6-5 NMSA 1978 and received by the office of the county clerk, pursuant to the Election Code, Section 1-6-10 NMSA 1978 during the regular hours and days of business.

(a) A voter who is required to present identification and has not done so at the time the voter's ballot is to be mailed to them, shall be sent a ballot that is processed as a provisional ballot, along with a provisional ballot envelope prescribed by the secretary of state, and shall include instructions on how to provide the required identification pursuant to the Election Code, Section 1-4-5.1 NMSA 1978.

(b) A blind or visually impaired voter pursuant to the Election Code, Section 1-9-7.1 NMSA 1978, may request an electronically transmitted ballot by completing an absentee application and executing a statement certifying blindness. The county clerk shall provide an absentee ballot through electronic transmission, enabling the use of one's personal nonvisual or low vision access technology to independently mark the ballot. The electronic transmission shall also include instructions on how the voter accesses the ballot, marks their selections, returns the ballot, as well as, the voter certificate as required in the Election Code, Subsections C and D of Section 1-6-8 NMSA 1978, which shall be completed, signed and included with the returned ballot, in the outer envelope.

(i) The secretary of state shall prescribe an official transmittal envelope such that the blind or visually impaired voter can distinguish it for the purposes of returning the absentee ballot.

(ii)

Delivery of electronically transmitted ballots shall be by a computer system secured by intrusion detection and protection systems.

(2) Early - by completing and signing an application at the office of the county clerk beginning 28 days before the election, or 20 days prior to the election at an alternate voting location or mobile alternate voting location in accordance with the Election Code, Section 1-6-5 NMSA 1978.

(a) Each county clerk shall ensure that the employee issuing ballots at the office of the county clerk and precinct board members at the alternate voting location or mobile alternate voting location are trained on the accessible voting device of the voting tabulator so that any voter may mark a ballot independently.

(b) A voter who is required to present a physical form of identification and does not submit it upon requesting to vote early shall be issued a provisional ballot in accordance with the Election Code, Section 1-12-7.1 NMSA 1978.

(3) A federal qualified elector or emergency response provider may apply for an absentee ballot in accordance with the Uniform Military and Overseas Voter Act.

B. A voter who has been issued an absentee ballot by mail or via electronic delivery shall not be allowed to vote in person, other than under the following conditions:

(1) In accordance with the Election Code, Section 1-6-16 NMSA 1978, a voter who has not received, or if received, has not voted the ballot, will be issued a replacement absentee ballot that is processed as a provisional ballot. The replacement absentee ballot may be mailed to the voter, to include express mail, if the county clerk deems necessary, or issued in person at the office of the county clerk, alternate voting location or mobile alternate voting location. Once voted, the voter shall place the replacement absentee ballot in an outer envelope and shall complete and sign the attached sworn affidavit.

(2) The voter, by executing a sworn affidavit at their election day polling place affirms that they have not received, or if received, have not voted the ballot, will be issued a replacement absentee ballot that is processed as a provisional ballot, along with a provisional ballot envelope prescribed by the secretary of state.

(3) A replacement absentee ballot issued at the office of the county clerk, alternate voting location, mobile alternate voting location or election day polling place must be voted on prior to the voter leaving the premises, provided however, that the ballot shall be not be cast in the voting tabulator, but placed and sealed in a provisional ballot envelope prescribed by the secretary of state to undergo the subsequent provisional qualification process by the county clerk.

[1.10.12.9 NMAC - Rp, 1.10.12.9 NMAC, 4/24/2018]

1.10.12.10 ABSENTEE PAPER BALLOTS: Except as otherwise provided in the Election Code, there shall be one uniform paper ballot.

[1.10.12.10 NMAC - Rp, 1.10.12.10 NMAC, 4/24/2018]

1.10.12.11 ALTERNATE VOTING LOCATIONS AND MOBILE ALTERNATE VOTING LOCATIONS:

A. Alternate voting locations are established by the county clerk for early voting and shall meet the standards set out in the Election Code, Sections 1-6-5.6 to 1-6-5.8 NMSA 1978. Reimbursement to the county for the cost of voting equipment and personnel on Indian nation, tribal area or pueblo land shall only be provided for those invoices received by the office of the secretary of state no later than the fifth week after the date of the election.

(1) 90 days prior to the beginning of early voting, the county clerk shall notify the secretary of state of the dates, times of operations, and addresses of the established alternate voting locations or mobile alternate voting locations and shall publicize the information using media outlets directed to, and appropriate for, the voters of that area.

(2) Alternate voting locations and mobile alternate voting locations shall be staffed in accordance with the Election Code, Section 1-2-12 NMSA 1978 and may not be staffed by the county clerk if the county clerk's name appears on the ballot.

(3) The county clerk shall prepare a list of authorized individuals who have access to each alternate voting location or mobile alternate voting location, to include authorized custodians of the voting tabulator or ballot box keys. Access to each alternate voting location or mobile alternate voting location for those authorized shall not be controlled by any third party. A copy of the list shall be provided to the office of the secretary of state and, in a primary, general or special election for U.S. representative, the chairs of each county's political parties.

B. Lawfully appointed challengers, watchers and observers shall be allowed in an alternate voting location or mobile alternate voting location as provided in the Election Code. An interposed challenge shall be handled in accordance with the Election Code, Section 1-12-20 to 1-12-22 NMSA 1978.

[1.10.12.11 NMAC - N, 4/24/2018]

1.10.12.12 VOTING TABULATOR PROGRAMMING, CERTIFICATION, CUSTODY AND SECURITY:

A. Each certified voting tabulator designated for use during an election, shall be programmed, tested for accuracy and used for the tabulation of ballots in accordance the Election Code, Section 1-9-1 to 1-9-22 NMSA 1978.

(1) Official tabulator envelopes for each voting tabulator shall be prepared and shall contain the tabulator serial number, seal number, a printed and signed

results reporting tape indicating the clearing of any votes recorded on the tabulator's removable storage media device cartridge and set at zero, and any keys or tokens needed to access, operate and secure the tabulator. Such envelopes shall be provided to the presiding judge of the alternate voting location or mobile alternate voting location.

(2) At least one day before each voting tabulator is deployed for absentee by-mail ballot tabulation and early voting, the county clerk shall provide the voting tabulator type and serial number to the secretary of state and the county chair of each political party represented on the ballot.

(a) Each certified voting tabulator deployed to an alternate voting location or mobile alternate voting location shall be transported with the care and custody set out in the Election Code, Section 1-9-12 NMSA 1978, delivered in accordance with the Election Code, Section 1-11-11 NMSA 1978 and shall be secured by a lock, key and seal.

(b) The placement of each voting tabulator used for absentee or early voting shall safeguard the secrecy of each voted ballot, protect the security of the voting tabulator and shall be compliant with accessibility requirements of the Americans with Disabilities Act.

(3) Each day during the early voting period, the county clerk or precinct board member shall, in the presence of one other county clerk employee or precinct board member, unlock the office where the voting tabulator, ballot box, preprinted paper ballots or voting systems needed to issue ballots are located and unlock the voting tabulator, ballot box or other container securing preprinted paper ballots or voting systems needed to issue ballots.

(4) Each day upon close of the early voting location, the above procedure shall be followed to lock and secure the voting tabulator, ballot box or other container securing preprinted paper ballots or voting systems needed to issue ballots.

(5) Assigned user names and passwords needed to access voting systems used to issue ballots or the voting tabulator shall not be shared or disclosed to any person other than the intended user.

(6) Immediately after unlocking or locking the early voting location, the county clerk or precinct board member present shall complete and sign the early voting daily report and shall submit it to the office of the secretary of state for the previous day's activity. Any discrepancy between the daily number of ballots issued and the number of ballots cast shall be reconciled prior to the submission of the early voting daily report.

B. A voting tabulator shall be used for the entire early voting period for the casting of ballots. The tabulator shall remain in open status and the result reporting tape shall be prompted only by the absentee precinct board, when convened, for the counting and recording of absentee by-mail and early voted ballots.

(1) If a voting tabulator is inadvertently prompted to close, the presiding judge shall notify the county clerk immediately. The county clerk, after determining that the tabulator should be reopened, shall dispatch a voting technician, who in the presence of the presiding judge and two election judges, one of a differing party than the presiding judge, shall enable the reopen polls function and verify the number of ballots counted on the tabulator screen. An audit log of the reopen polls transaction will be recorded by the voting tabulator and will be visible on the results reporting tapes. The results reporting tapes shall be signed by the presiding judge and two election judges, one of a differing party than the presiding judge, and remain connected to the voting tabulator.

(a) If the number of ballots counted does not match the number of ballots cast prior to the inadvertent close of the voting tabulator, the county clerk shall instruct the voting technician, who in the presence of the presiding judge and two election judges, one of a differing party than the presiding judge, to clear the removable storage media device cartridge, removing all previously recorded votes and reopen the polls of the voting tabulator. The presiding judge and two election judges, one of a differing party than the presiding judge, will inspect the generated results reporting tapes to ensure the ballots cast number and all candidate contests and ballot questions are cleared and set to zero. The presiding judge and two election judges, one of a differing party than the presiding judge shall sign the certificate at the end of the generated results reporting tapes, affirming their inspection and reinsert the ballots from within the bin into the voting tabulator. The results reporting tapes shall remain connected to the voting tabulator. Once complete, the presiding judge and two election judges, one of a differing party than the presiding judge will verify the ballots cast on the public counter of the voting tabulator matches the total ballots cast on the voting tabulator prior to the inadvertent close.

(b) The voting tabulator may then be put back into use and the county clerk shall immediately notify the office of the secretary of state, in writing, of the occurrence. The presiding judge will provide the results reporting tapes from the inadvertent tabulator closure to the voting technician, who will deliver the results reporting tapes directly to the county clerk to be filed and kept confidential.

(2) If a voting tabulator is inadvertently closed, generating the results reporting tapes during the days and hours of operation of early voting, the presiding judge shall immediately notify the county clerk and ensure the voting tabulator, ballots within the bin and results reporting tapes are not tampered with.

(a) The county clerk shall dispatch a

voting technician, who in the presence of the presiding judge and two election judges, one of a differing party than the presiding judge, will instruct the presiding judge to verify the total number of ballots cast on the voting tabulator before it was inadvertently closed. The voting technician will clear the removable storage media device cartridge, removing all previously recorded votes and reopen the polls of the voting tabulator. The presiding judge and two election judges, one of a differing party than the presiding judge, will inspect the generated results reporting tapes to ensure the ballots cast number and all candidate contests and ballot questions are cleared and set to zero. The presiding judge and two election judges, one of a differing party than the presiding judge shall sign the certificate at the end of the generated results reporting tapes, affirming their inspection and reinsert the ballots from within the bin into the voting tabulator. The results reporting tapes shall remain connected to the voting tabulator. Once complete, the presiding judge and two election judges, one of a differing party than the presiding judge will verify the ballots cast on the public counter of the voting tabulator matches the total ballots cast on the voting tabulator prior to the inadvertent close.

(b) The voting tabulator may then be put back into use and the county clerk shall immediately notify the office of the secretary of state, in writing, of the occurrence. The presiding judge will provide the results reporting tapes from the inadvertent tabulator closure to the voting technician, who will deliver the results reporting tapes directly to the county clerk to be filed and kept confidential.

[1.10.12.12 NMAC - N, 4/24/2018]

1.10.12.13 VOTE TABULATION:

A. Ballots shall be tabulated for the reporting of votes pursuant to the Election Code, Section 1-12-70 NMSA 1978.

(1) Early voted ballots, not by mail, cast on a voting tabulator shall be counted separately from absentee by-mail ballots in accordance with the Election Code, Section 1-6-5.4 NMSA 1978 and recorded in the early vote by machine counting group.

(a) If an early voted ballot is returned by the voting tabulator as overvoted or blank, the ballot shall be accepted by the voting tabulator only after requesting and receiving a declaration by the voter of their intent to cast the overvoted or blank ballot as is.

(b) An early voter who declares their intent to cast the overvoted or blank ballot, shall have their ballot cast on the voting tabulator. For overvoted ballots, only those contests receiving no more than the allotted selections for the number of candidates to be elected or ballot questions where there is one selection for either the affirmative or negative will be tabulated; for blank ballots, no votes will be tabulated.

(c) An early voter who declares their intent to not cast the overvoted or blank ballot shall have their ballot rejected by the voting tabulator without the tabulation of votes. The overvoted ballot shall be spoiled in conjunction with Section 1-12-62 NMSA 1978. The county clerk or precinct board member shall instruct the voter to insert the spoiled ballot into a spoiled ballot envelope and return the spoiled ballot envelope to the county clerk. The voter shall then be issued a new ballot, be instructed how to mark their selection of alternatives allowed in any candidate contest or ballot question in the voting response area and how to personally feed the ballot into the voting tabulator.

(i) In the event the voter does not wish to spoil their voted ballot and declines a new ballot, the overvoted ballot shall be delivered to the absentee precinct board, after the close of early voting, to be hand tallied in accordance with 1.10.23 NMAC. The ballot will be counted and recorded in the early vote by hand tally counting group; or,

(ii) If deemed necessary by the county clerk, a high speed central cast tabulator may be designated, programmed and certified for the tabulation of such ballots. The absentee precinct board will adjudicate the overvoted or blank ballot and count and record it in the early vote by hand tally counting group.

(d) If an early voted ballot cast is misread after being fed into the voting tabulator, the voter shall be instructed to insert the ballot in a different orientation. If the ballot is misread again, the ballot will be spoiled, and the county clerk or precinct board member shall instruct the voter to insert the spoiled ballot into a spoiled ballot envelope and return it to the county clerk in conjunction with the Election Code, Section 1-12-62 NMSA 1978. The voter shall then be issued a new ballot, be instructed how to mark their selection of alternatives allowed in any candidate contest or ballot question in the voting response area and how to personally feed the ballot into the voting tabulator. In the event the voter does not wish to spoil their voted ballot and declines a new ballot, the misread ballot shall be delivered to the absentee precinct board, after the close of the early voting period, by the precinct board, to be hand tallied in accordance with 1.10.23 NMAC. The ballot will be counted and recorded in the early vote by hand tally counting group.

(2) Absentee by-mail ballots, either returned by mail or hand-delivered, shall be fed into a voting tabulator by an absentee precinct board member in accordance with the Election Code, Sections 1-6-11 and 1-6-14 NMSA 1978 as follows:

(a) An overvoted or blank absentee by-mail ballot shall be accepted by the voting tabulator after it has been adjudicated by the absentee precinct board. The ballot will be counted and recorded in the absentee by machine counting group.

(b) If an absentee by-mail ballot is misread after being fed into a voting tabulator, an absentee precinct board member shall feed it into the voting tabulator a second time. An absentee by-mail ballot that is rejected after two attempts shall be adjudicated by the absentee precinct board, hand tallied by precinct as provided in 1.10.23 NMAC and counted and recorded in the absentee by hand tally counting group.

(c) Returned absentee ballots that were issued via electronic transmission to a blind or visually impaired voter will not contain programmed ballot markers necessary for tabulation by the voting tabulator. These ballots shall be hand tallied by the absentee precinct board, by precinct and shall be counted and recorded in the absentee by hand tally counting group.

(3) Returned military-overseas ballots, either mailed back or electronically submitted shall be counted separately from all other absentee by-mail or early voted ballots. The county clerk shall determine whether returned military-overseas ballots are to be hand-tallied, or if necessary, to designate, program and certify a voting tabulator for the tabulation of such ballots.

(a) Returned military-overseas ballots that do not contain programmed ballot markers necessary for tabulation by a voting tabulator, shall be hand tallied by the absentee precinct board, by precinct and shall be counted and recorded in the federal overseas hand tally counting group.

(b) When a voting tabulator is used for the tabulation of military-overseas ballots that contain programmed ballot markers, the ballots shall be fed into the voting tabulator by an absentee precinct board member and the votes shall be counted and recorded in the federal overseas by machine counting group.

(c) An overvoted or blank military-overseas ballot shall be accepted by the voting tabulator after it has been adjudicated by the absentee precinct board. The ballot will be counted and recorded in the federal overseas by machine counting group.

(d) If a military-overseas ballot is misread after being fed into a voting tabulator, an absentee precinct board member shall feed it into the voting tabulator a second time. A military-overseas ballot that is rejected after two attempts shall be adjudicated by the absentee precinct board, hand tallied by precinct as provided in 1.10.23 NMAC and counted and recorded in the federal overseas hand tally counting group.

(4) Undervoted ballots shall be accepted by the voting tabulator, regardless of either being cast early at the county clerk's office, an alternate voting location or mobile alternate voting location or absentee by-mail ballot and only those contests or ballot questions receiving a selection by the voter will be tabulated.

B. The public counter number of the voting tabulator will not increase in the above scenarios involving an overvoted or blank ballot, unless the ballot is accepted by the voting tabulator after requesting and receiving a declaration by the voter of their intent to cast the overvoted or blank ballot as is or by adjudication of the absentee precinct board. An undervoted ballot fed into the voting tabulator will increase the public counter number.

C. Overvoted, blank, undervoted or misread ballots required to be hand tallied shall be recorded on the prescribed hand tally sheet, by precinct, as follows:

(1) Each ballot shall increase the ballots cast count by one;

(2) On an overvoted ballot, only those contests receiving no more than the allotted selections for the number of candidates to be elected or ballot questions where there is one selection for either the affirmative or negative will be hand tallied;

(3) No votes for either candidate contests or ballot questions will be hand tallied on a blank ballot;

(4) On an undervoted ballot, only those contests or ballot questions receiving a selection by the voter will be hand tallied; and,

(5) Only those contests receiving no fewer, nor more than the allotted selections for the number of candidates to be elected or ballot questions where there is one selection for either the affirmative or negative will be hand tallied on a misread ballot.

D. An overvoted, blank or undervoted ballot cast by a voter, after going through the above process shall be recorded as a "ballot cast" and proper voting credit shall be given on the respective voter registration record on file with the county clerk.

E. In accordance with the Election Code, Section 1-12-70 NMSA 1978, the reporting of vote totals by precinct and voting method shall be combined to the extent necessary to protect the secrecy of each voter's ballot.

[1.10.12.13 NMAC - Rp, 1.10.12.13 NMAC and 1.10.12.14 NMAC, 4/24/2018]

1.10.12.14 [RESERVED]

1.10.12.15 ABSENTEE PRECINCT BOARD, COUNTY CLERK AND COUNTY CANVASS BOARD DUTIES:

A. An absentee precinct board shall be created for the purpose of determining voter eligibility, counting and tabulating absentee by-mail and early voted ballots cast. The board shall be comprised of precinct board members in accordance with the Election Code, Section 1-2-12 NMSA 1978 provided that the counting and tabulation of absentee by-mail ballots shall remain separate from early voted ballots.

(1) Pursuant to the Election Code, Section 1-6-11 NMSA 1978, the absentee by-mail ballots shall be delivered along with

all necessary supplies, including red pencils or red pens, to be used as a writing instrument, for absentee precinct board members. Only the presiding judge shall be issued a black or blue ink pen for signing and filling out required documents.

(2) The processing of absentee by-mail ballots shall be in accordance with the Election Code, Section 1-6-14 NMSA 1978.

(a) An absentee by-mail ballot inner envelope containing two ballots shall be counted if the determination can be made that the outer envelope is signed by both voters, the absentee ballot register confirms the issuance of absentee by-mail ballots to the voters who signed, and it has been determined that the voters have not already voted in the election. Absentee ballot envelopes not in compliance with one or more of the above requirements shall be changed to "rejected" in the absentee ballot register, with the reason for rejection.

(b) An absentee by-mail ballot inner envelope containing no ballot shall be "accepted" if the outer envelope is signed by the voter, the absentee ballot register confirms the issuance of the ballot to the voter who signed the outer envelope, and the voter has not voted in any other manner during the election. Absentee ballot envelopes not in compliance with one or more of the above requirements shall be changed to "rejected" in the absentee ballot register, with the reason for rejection.

(3) Pursuant to the Election Code, Subsections C and D of Section 1-6-14 NMSA 1978, an absentee by-mail ballot envelope may be challenged by a lawfully appointed challenger. A voter who satisfies the reason for the affirmed challenge before the conclusion of the county canvass shall have their ballot accepted and counted. The voter's record on the absentee ballot register shall be changed from "rejected" to "accepted", and the notation "challenged-affirmed" on the absentee by-mail ballot envelope shall be crossed out, signed and dated by either the presiding judge of the absentee precinct board or a member of the county canvassing board, dependent upon when the voter satisfies the reason for the affirmed challenge. If the ballot is hand tallied it shall be recorded in the absentee by-mail hand tally counting group. If the ballot is tabulated by a voting tabulator, it shall be recorded in the absentee by-mail machine counting group.

(4) An absentee by-mail ballot, processed as a provisional ballot, in a provisional ballot envelope, prescribed by the secretary of state because the first-time voter did not provide the required form of physical identification prior to the ballot issuance, shall be separated from all other absentee by-mail ballots and provided to the county clerk. The county clerk shall perform the required provisional qualification process to the ballots in accordance with the Election Code, Section 1-6-14 NMSA 1978 and with 1.10.22 NMAC.

B. Upon the last day to early vote, all early voted ballots shall be delivered to the county clerk, who will transfer custody to the absentee precinct board. A receipt containing the serial number and public counter number indicating the votes recorded on the voting tabulator, number of ballot boxes, number of provisional ballots, number of ballots to be hand tallied and the signature of the respective alternate or mobile alternate voting location presiding judge shall be provided. After verifying the information for accuracy, the county clerk or absentee precinct board presiding judge shall sign the receipt indicating custody of the early voting returns, voting tabulator and ballot boxes. Keys to the alternate or mobile alternate voting location and the key or security token to access the voting tabulator shall also be transferred to the county clerk. The receipt shall be maintained on file with the county clerk.

(1) The absentee precinct board shall process early voted ballots cast by closing the polls and running the results reporting tapes for each voting tabulator used during the early voting period. The absentee precinct board shall be responsible for hand tallying any early voted ballot not tabulated by the voting tabulator in accordance with the Election Code, Section 1-1-5.2 NMSA 1978.

(2) Provisional ballots issued during early voting in the office of the county clerk, alternate voting location or mobile alternate voting location for the reasons set out in the Election Code, shall be provided to the county clerk.

C. The county canvassing board shall canvass the election returns and ascertain whether any discrepancies, omissions or errors appear on the face of the election returns, in accordance with the Election Code, Section 1-13-1 to 1-13-22 NMSA 1978.

D. All provisional ballots issued to absent or early voters are subject to requalification in the event of a recount or contest as prescribed in the Election Code, Section 1-14-22 NMSA, 1978.
[1.10.12.15 NMAC - Rp, 1.10.12.15 NMAC, 4/24/2018]

1.10.12.16 [RESERVED]

1.10.12.17 PAPER BALLOT TRANSFER:

A. Paper ballots cast in a voting tabulator for early voting shall remain in the custody of the precinct board assigned to the alternate voting location or mobile alternate voting location in either the ballot holding bin of the voting tabulator, or if deemed necessary, in a locked ballot box with two padlocks or numbered seals, designated for the specific tabulator.

B. Paper ballots removed from the ballot holding bin of the voting tabulator on a daily basis shall only be removed after voting hours by the presiding judge and two election judges, one of a differing political party than the presiding judge. The ballots shall be placed into a locked ballot box,

with two padlocks or numbered seals designated for the specific tabulator.

(1) Those ballots diverted to the write-in holding bin and those ballots placed in the hand tally bin shall also be removed daily. Tabulated, write-in and hand tally ballots shall be kept separate from each other, but shall be retained by date and specific to the tabulator.

(2) The presiding judge and two election judges, one of a differing party than the presiding judge must execute a certificate containing the date and voting tabulator serial number for each ballot type, after the transfer of ballots on a daily basis.

(3) The locked ballot box shall be placed in a locked room at the county clerk's office, alternate voting location or mobile alternate voting location. If a location does not have a locked room, the county clerk shall either provide a cabinet with a locking device to be placed at the location for the presiding judge to place the ballot box, or the county clerk shall take possession of the locked ballot box and store it at the county clerk's office until it is transferred to the absentee precinct board. The presiding judge or county clerk shall have sole possession of the key to the locked room.

C. Paper ballots that remain in the ballot holding bin of the voting tabulator for the duration of voting, shall be checked daily before voting hours begin by two election judges, one of a differing party than the presiding judge, and in the presence of the presiding judge. If the ballots are touching or near the diverter device, they shall be laid down in a stack, as to avoid a jam in the diverter.

(1) If the ballot holding bin of the voting tabulator becomes full during voting hours, the presiding judge and two election judges, one of a differing party than the presiding judge, shall unlock the bin and transfer the ballots to a locked ballot box, with two padlocks or numbered seals, specific to the tabulator. The presiding judge shall, in an audible tone, explain the reason for the removal and transfer of ballots.

(2) The presiding judge and two election judges, one of a differing party than the presiding judge must execute a certificate containing the date and voting tabulator serial number for each ballot type, after the transfer of the ballots. Those ballots diverted to the write-in holding bin and those ballots placed in the hand tally bin shall also be removed, kept separate from each other and specific to the tabulator.

(3) The locked ballot box shall be placed in a locked room at the county clerk's office, alternate voting location or mobile alternate voting location. If a location does not have a locked room, the county clerk shall either provide a cabinet with a locking device to be placed at the location for the presiding judge to place the ballot box or shall take possession of the locked ballot box and stored at the county clerk's office until transferred to the absentee precinct board. The presiding judge or county clerk shall have sole possession of the key to the locked room.

D. After the transfer, recording and securing of ballots in accordance with this section, the voting tabulator will remain in open polls status, put back into use for the duration of the voting period and the removable storage media device cartridge will not be cleared out. [1.10.12.17 NMAC - Rp, 1.10.12.17 NMAC, 4/24/2018]

1.10.12.18 SECURITY FOR UNVOTED PRE-PRINTED BALLOTS AT ALTERNATE VOTING LOCATION:

A. No sooner than one day, nor later than one hour before the first day of voting at the alternate voting location or mobile alternate voting location, the county clerk shall provide the presiding judge pre-printed paper ballots, in a locked box with two padlocks or numbered seals.

(1) The county clerk shall open the ballot box, and together with the presiding judge, shall complete an affidavit verifying the number of ballots by style or precinct to be issued. The affidavit shall be signed by the county clerk and the presiding judge and shall be retained on file with the county clerk.

(2) The county clerk shall instruct the presiding judge to distribute one key for each padlock on the ballot box to two election judges, one of differing party than the presiding judge. One key shall be for one padlock and the other key for the other padlock. The keys shall remain in the assigned election judge's custody until the early voting period ends and must be returned to the county clerk, as instructed.

B. At the end of each day of early voting at the alternate voting location or mobile alternate voting location, the presiding judge and the two election judges, one of a differing party than the presiding judge, shall verify and document the number of the unvoted ballots and place them in the ballot box. The ballot box shall be locked with the two padlocks or numbered seals by the two election judges, one of a differing party than the presiding judge and placed in a locked room at the alternate voting location or mobile alternate voting location. The presiding judge or county clerk shall have sole possession of the key to the locked room. If a location does not have a locked room, the county clerk shall provide a cabinet with a locking device to be placed on at the location for the presiding judge to place the ballot box.

(1) At the beginning of each day until the final day of early voting at the alternate voting location or mobile alternate voting location, the presiding judge shall unlock the room. The presiding judge, and the two election judges, one of a differing party than the presiding judge shall open the padlocks or numbered seals on the ballot box to retrieve the unvoted ballots to be used.

(2) The beginning ballot number for that day must match the ending ballot number from the prior day. If it does

not match, the county clerk must be notified immediately. No voting at that alternate voting location or mobile alternate voting location shall be allowed until the discrepancy has been resolved to the satisfaction of the county clerk.
[1.10.12.18 NMAC - Rp, 1.10.12.18 NMAC, 4/24/2018]

1.10.12.19 [RESERVED]
1.10.12.20 [RESERVED]

History of 1.10.12 NMAC: 1.10.12 NMAC - Absentee Voting, filed 03/31/2000 was repealed and replaced by 1.10.12 NMAC - Absentee Voting, effective 4/24/2018.

SECRETARY OF STATE

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 10 ELECTIONS AND ELECTED OFFICIALS
PART 22 PROVISIONAL VOTING

1.10.22.1 ISSUING AGENCY: Office of the Secretary of State, 325 Don Gaspar, Suite 300, Santa Fe, New Mexico, 87501.
[1.10.22.1 NMAC - Rp, 1.10.22.1 NMAC, 4/24/2018]

1.10.22.2 SCOPE: This rule applies to any election covered under the Election Code, Section 1-1-19 NMSA 1978 and the Special Election Act, NMSA 1978.
[1.10.22.2 NMAC - Rp, 1.10.22.2 NMAC, 4/24/2018]

1.10.22.3 STATUTORY AUTHORITY: Election Code, Section 1-2-1; Section 1-6-5; Section 1-6-16; Section 1-6-16.1; 1-12-25.2; Section 1-12-25.3; Section 1-12-25.4; 1-12-27.1 NMSA 1978 and Public Law 107-252, The Help America Vote Act of 2002.
[1.10.22.3 NMAC - Rp, 1.10.22.3 NMAC, 4/24/2018]

1.10.22.4 DURATION: Permanent.
[1.10.22.4 NMAC - Rp, 1.10.22.4 NMAC, 4/24/2018]

1.10.22.5 EFFECTIVE DATE: April 24, 2018 unless a later date is cited at the end of a section.
[1.10.22.5 NMAC - Rp, 1.10.22.5 NMAC, 4/24/2018]

1.10.22.6 OBJECTIVE: The Help America Vote Act, PL 107-252, effective October 29, 2002, requires the casting of a provisional ballot in the following circumstances; a voter whose name does not appear on the roster at the polling place, on the county voter file, or a new voter who has not provided the required identification to vote. The Election Code also provides for the use of a provisional ballot qualification process in the instance of an affirmed challenge or when a replacement ballot for an absent voter is required or in the event of an emergency, as defined in Section 1-6-16.2 NMSA 1978. This rule creates uniform criteria for the issuance and reporting of all provisional ballots and offers consistency in the qualification process and for the counting and canvassing of provisional ballots. The rule also provides for the secrecy of a provisional voter's ballot during each stage of the election process, extending through a recount or contest of the election and the ensuing requalification of the provisional ballots.
[1.10.22.6 NMAC - Rp, 1.10.22.6 NMAC, 4/24/2018]

1.10.22.7 DEFINITIONS:

A. "Adjudicate" means a decision made by a precinct board, in accordance with the Election Code, of a ballot signifying a voter's intent to mark their selection for a candidate contest or ballot question.

B. "Alternate voting location" means a location outside the office of the county clerk, established by the county clerk, where a voter may cast an early in person ballot on voting tabulator. This includes mobile alternate voting locations.

C. "Blank ballot" means a paper ballot on which the voter has not selected any of the alternatives allowed in any candidate contest or ballot question.

D. "Canvass" means the process of qualifying and verifying paper ballots and counting and tallying votes for each precinct beginning upon the closing of the polls and ending with the certification and announcement of the results by the county canvassing board pursuant to Subsection F of Section 1-2-31 NMSA 1978.

E. "Challenger" means a voter of a precinct located in that county to which the voter is appointed in conformance with the Election Code, Section 1-2-21 to 1-2-22 NMSA 1978 for the purpose of carrying out such duties as prescribed in the Election Code, Section 1-2-23 to 1-2-26 NMSA 1978.

F. "Contest" means court litigation that seeks to overturn the outcome of an election pursuant to the Election Code, Section 1-14-1 NMSA 1978.

G. "County canvass observer" a voter of the county to which they are appointed, in accordance with the Election Code, Section 1-2-31 NMSA 1978, and permitted to be present at any time from the time the county canvassing begins until the completion of the canvass, and strictly limited to observing and documenting the canvassing process.

H. "County canvassing board" means the board of county commissioners in each county, convened for the purposes of conducting the county canvass.

I. "County voter file" means the computerized version of the county register, comprising a portion of the statewide voter file.

J. "Health care provider" means an individual licensed, certified or permitted by law to provide health care in the ordinary course of business or practice of a profession.

K. "Inner envelope" means the official envelope, prescribed by the secretary of state, given to the voter along with an

absentee or provisional ballot into which the voter places the ballot after it is voted and which is used to preserve the secrecy of the voter's ballot.

L. "Naked ballot" means a provisional or absentee ballot that has not been placed in the inner envelope by the voter.

M. "Overvoted ballot" means a ballot on which the voter has selected more than the number of candidates to be elected for that contest, or has voted in both the affirmative and negative on a ballot question.

N. "Precinct" means a part of a county with definite boundaries established for electoral administrative functions.

O. "Provisional ballot envelope" means the official envelope, prescribed by the secretary of state, which has information that will identify the provisional voter, purpose the provisional ballot was issued and contains a sworn affidavit and a blank voter registration certificate, into which the provisional voter places the inner envelope.

P. "Provisional ballot transmission envelope" means a sealed envelope or pouch marked and designated by the county clerk to transmit provisional ballots from the polling place or alternate location to the office of the county clerk.

Q. "Qualification process" means the process used by a county clerk to determine the qualifications of a voter who voted on a provisional ballot.

R. "Replacement absentee ballot" means a ballot that is processed as a provisional ballot, that is provided to a voter whose name appears on the absentee ballot register or signature roster as having been issued an absentee ballot, and who has affirmed that the ballot was not received or voted on pursuant to the Election Code, Section 1-6-16 NMSA 1978. The ballot shall be placed in a provisional ballot envelope prescribed by the secretary of state and processed within the time frame specified in the Election Code, Section 1-6-16 NMSA 1978.

S. "Signature roster" means the certified list of voters at a polling place, which is signed by a voter or county voter file at a consolidated polling place.

T. "Tally sheet" means a document prescribed by the secretary of state used for the counting and tallying of votes cast on a ballot that has not been fed into a voting tabulator.

U. "Undervoted ballot" means a paper ballot that is not a blank ballot, and on which the voter has selected at least one candidate or answered at least one ballot question in accordance with the instructions for that ballot type, but on which the voter has selected fewer than the number of alternatives allowed in a candidate contest or on a ballot question.

[1.10.22.7 NMAC - Rp, 1.10.22.7 NMAC, 4/24/2018]

1.10.22.8 PROVISIONAL BALLOT ISSUANCE AND PRECINCT BOARD PROCEDURES:

A. A person offering to vote shall be allowed to vote on a provisional ballot in accordance with the Election Code.

B. When issuing a provisional ballot, the precinct board shall ensure the following:

(1) a provisional voter places the ballot in the inner envelope and provisional ballot envelope prescribed by the secretary of state and shall fill out all required information on the provisional ballot envelope;

(2) the name of a provisional voter is entered in the signature roster on the line immediately following the last entered voter's name, or in its electronic equivalent when consolidated precincts are used, pursuant to the Election Code;

(3) a provisional voter completes the certificate of voter registration attached to the provisional ballot envelope, and that the certificate of registration remains attached to the provisional ballot envelope and returned to the county clerk;

(4) a provisional voter is not permitted to place the voted ballot into the voting tabulator;

(5) a provisional voter is not subject to a challenge at the time of voting under the procedures provided in the Election Code;

(6) the required physical form of identification provided by a provisional voter who returned to the alternate voting location, mobile alternate voting location or election day polling place, after already casting a provisional ballot, shall be placed with the provisional ballot envelope to be used by the county clerk during the provisional ballot qualification process, in accordance with the Election Code, Section 1-12-7.1 NMSA 1978; and,

(7) a provisional ballot shall not be placed in the ballot box designed for tabulated ballots, but rather, shall be deposited in a special sealed provisional ballot transmission envelope, pouch or ballot box designated by the county clerk for the sole use of securing provisional ballots.

C. After the period allowed for voting at the office of the county clerk, alternate voting location, mobile alternate voting location, or, upon close of the election day polling place, all provisional ballots shall be delivered and transferred to the county clerk. A receipt indicating the date and time, the total number of provisional ballots, the name of the alternate voting location, mobile alternate voting location or election day polling place, and the signature of the presiding judge shall be prepared. After verification of the total number of provisional ballots received, the county clerk shall sign the receipt indicating custody of the ballots.

[1.10.22.8 NMAC - Rp, 1.10.22.8 NMAC, 4/24/2018]

1.10.22.9 COUNTY CLERK PROCEDURES:

A. The county clerk

is charged with, and authorized to, determine the qualification of provisional ballots issued for the election, and must notify provisional voters of the qualification determination and count and record qualified provisional ballots.

(1) The provisional ballots shall be kept separate by each voting method - absentee, early or election day, as well as, by the name of the alternative voting location, mobile alternate voting location or election day polling place. The provisional ballot envelopes shall not be opened until the county clerk has completed the qualification process.

(2) A provisional ballot shall be qualified if the voter has provided all the information under the Election Code, Section 1-12-25.3 NMSA 1978, and the provisions set out in the Election Code, Section 1-12-25.4 NMSA 1978 have been met.

B. The provisional ballot qualification process shall be conducted by the county clerk, as follows:

(1) read aloud the name and address on the provisional ballot envelope;

(2) determine, by use of the statewide voter file, the registration status, county of registration and correct precinct of the provisional voter, or if the required physical form of identification is attached; and,

(3) publicly announce whether the provisional ballot is qualified or disqualified and the reasons for that determination.

C. A county canvass observer, pursuant to the Election Code, Section 1-2-31 NMSA 1978 may be present during the provisional ballot qualification and canvass.

(1) During the provisional ballot qualification process and canvass, the observer shall wear a self-made badge designating the observer as an authorized observer of a candidate or organization.

(2) The observer shall not wear any other form of identification and all campaign and electioneering materials are prohibited.

(3) The observer shall not perform any duty of the county clerk, handle any material, or interfere with the orderly conduct of the provisional ballot qualification or canvass.

(4) The observer shall not be in the view of the provisional ballot envelope, so as to maintain the privacy of the voter's social security number or full date of birth, nor shall the use of cell phones or electronic recording equipment be allowed while observing.

(5) Observers are permitted to take written memoranda for later reference.

D. The determination of the provisional ballot disposition, along with the research done by the county clerk, shall be noted on the provisional ballot envelope by the county clerk to include the following:

(1) notation of qualified or disqualified status;

(2) the voter's correct voting precinct, if registered;

(3) the voter's correct party designation, if registered;

(4) if the voter is registered in a different party than that of the issued ballot, a notation of "Different Party" shall be made;

(5) if the voter is registered in a different county within the state, a notation of "Out of County" shall be made;

(6) if the voter is not registered in the state, a notation of "Not Registered" shall be made;

(7) if the voter's record shows that a ballot for the election has already been received, a notation of "Already Voted" shall be made;

(8) if the voter's record shows it has been cancelled in accordance with the Election Code, a notation of "Cancelled" along with the reason for cancellation shall be made; and,

(9) when consolidated precincts are not used, the relevant districts in which the voter is registered shall be listed so that only the votes for those candidate contests or ballot questions for which the voter is eligible to vote shall be counted.

E. The county clerk, after the qualification process, shall separate qualified provisional ballot envelopes from unqualified provisional ballot envelopes, while keeping them arranged by voting method - absentee, early or election day - and sorted by each alternative voting location, mobile alternate voting location or election day polling place. Unqualified provisional ballot envelopes shall not be opened and shall be deposited in an envelope or ballot box marked "unqualified provisional ballots" and retained pursuant to the Election Code, Section 1-12-69 NMSA 1978.

(1) The provisional ballot envelope for qualified provisional paper ballots shall be opened and attached to the inner envelope and ballot, until the time period for an election recount or contest has expired, pursuant to the Election Code, Section 1-14-1 to 1-14-25 NMSA 1978. The county clerk shall place naked ballots in an individual envelope to replace the inner envelope.

(2) After the counting of qualified provisional ballots, the county clerk shall deposit the provisional ballots with attached outer and inner envelopes in an envelope or ballot box marked "counted provisional ballots". The provisional ballots shall be retained pursuant to the Election Code, Section 1-12-69 NMSA 1978.

(3) At no time shall the county clerk or members of the canvassing board disclose the votes of a provisional voter.

[1.10.22.9 NMAC - Rp, 1.10.22.9 NMAC, 4/24/2018]

1.10.22.10 TABULATION AND CANVASSING OF QUALIFIED PROVISIONAL BALLOT PROCEDURES:

A. Qualified provisional ballots shall be counted

for the reporting of votes by precinct and voting method for each candidate contest or ballot question, as specified in the Election Code, Section 1-12-70 NMSA 1978. Only the votes for those candidate contests or ballot questions for which the voter is eligible to vote shall be counted, as follows:

(1) A qualified absentee by-mail ballot, processed as a provisional ballot, in a provisional ballot envelope prescribed by the secretary of state because the first time voter did not provide the required form of physical identification prior to the ballot issuance, shall be hand tallied and recorded in the absentee provisional by hand tally counting group, or tabulated by a voting tabulator designated, programmed and certified for such specific use, and recorded in the absentee provisional by machine counting group.

(2) A qualified absentee replacement ballot, processed as a provisional ballot, in a provisional ballot envelope prescribed by the secretary of state because the absentee voter did not receive, or if received, did not vote the absentee by-mail ballot, shall be hand tallied and recorded in the absentee provisional by hand tally counting group, or tabulated by a voting tabulator designated, programmed and certified for such specific use, and recorded in the absentee provisional by machine counting group.

(3) A qualified provisional ballot issued during early voting in the office of the county clerk, alternate voting location or mobile alternate voting location shall be hand tallied and recorded in the early voting provisional by hand tally counting group, or tabulated by a voting tabulator designated, programmed and certified for such specific use, and recorded in the early voting provisional by machine counting group.

(4) A qualified provisional ballot issued on election day shall be hand tallied and recorded in the election day provisional by hand tally counting group, or tabulated by a voting tabulator designated, programmed and certified for such use, and recorded in the election day provisional by machine counting group.

(5) A qualified federal write-in absentee ballot shall be hand tallied and shall be counted and recorded in the federal overseas hand tally counting group.

(6) The hand tally of votes from qualified provisional ballots shall be conducted in accordance with 1.10.23 NMAC by a team of at least two persons. The team shall consist of one reader and one marker, not of the same political party, if possible. The reader shall read the ballot to the marker and the marker shall observe whether the reader has correctly read each vote from the ballot; the marker shall then mark the tally sheet of the precinct, voting method and voting location where the ballot was cast, and the reader shall observe whether the marker correctly marked the tally sheet. The hand tally team shall observe the following:

(a) Only the votes for the candidates or ballot questions from the precinct the voter is eligible to vote for shall be counted;

(b) Each ballot shall increase the ballots cast count by one;

(c) Only those contests receiving no more than the allotted selections for the number of candidates to be elected or ballot questions where there is one selection for either the affirmative or negative will be hand tallied on overvoted ballots;

(d) No votes for either candidate contests or ballot questions will be hand tallied for blank ballots;

(e) Only those candidate contests or ballot questions receiving a selection by the voter will be hand tallied on an undervoted ballot; and,

(f) Overvoted, blank or undervoted ballots cast by voters, after going through the above process shall be recorded as a "ballot cast" and proper voting credit shall be given on the respective voter registration record on file with the county clerk.

(7) When a voting tabulator is used for the counting and recording of qualified provisional ballots of voters who were issued a ballot for their correct voting precinct, a member of the county canvassing board shall feed the ballots into the voting tabulator.

(a) An overvoted or blank provisional ballot shall be accepted by the voting tabulator after it has been adjudicated by the county canvassing board. The ballot will be counted and recorded in the appropriate machine counting group, as detailed above.

(b) If a provisional ballot is misread after being fed into a voting tabulator, a county canvass board member shall feed it into the voting tabulator a second time. A provisional ballot that is rejected after two attempts shall be adjudicated by the county canvass board, hand tallied, counted and recorded in the appropriate hand tally counting group, as detailed above.

B. During the counting of qualified provisional ballots, the county clerk shall ensure that observers are not permitted to see the identity of any voter whose ballot is being tallied. If, in the instance of only one provisional ballot cast in an alternate voting location, mobile voting location or election day polling place, the observer may know the identity of the voter, but may not observe the tally of the ballot.

C. Upon the conclusion of the county canvass, the county clerk shall transmit the provisional ballot results to the office of the secretary of state in accordance with the Election Code, Subsection H of Section 1-12-25.4 NMSA 1978, and the county canvassing board shall direct the county clerk to prepare the required provisional ballot report.

D. If there is a discrepancy in the number of provisional ballots returned based on the number of provisional ballots issued, the county canvassing board

shall follow the procedures set out in the Election Code, Section 1-13-1 to 1-13-22 NMSA 1978.
[1.10.22.10 NMAC - N, 4/24/2018]

1.10.22.11 PROVISIONAL VOTER NOTIFICATION AND HEARING PROCESS:

A. In accordance with Subsection A of Section 1-12-12.2 NMSA 1978, the county clerk shall notify each provisional voter whose provisional ballot was rejected and inform the voter of their ability to appeal such rejection, by requesting a hearing. The appeal process shall be conducted as follows:

(1) the county clerk shall select a hearing officer(s) from staff or a person who is not affiliated with any candidate to be voted for at the election and knowledgeable of election law;

(2) the county clerk shall provide a disability accessible room for the appeal hearing to be held;

(3) the voter shall schedule an appointment time for an appeal by calling the county clerk's office and shall appear under oath and show by a preponderance of the evidence that the vote should be counted;

(4) the voter may appear with an advocate;

(5) the appeal hearing shall be a public meeting, but the voter's date of birth and social security number shall not be stated out loud and the public shall not be in the line of sight or view or make notes of the voter's personal information;

(6) the county clerk and the public may make a brief public comment and offer relevant exhibits but only the hearing officer shall be permitted to cross examine the witness;

(7) the hearing officer shall not be bound by the rules of civil procedure, but may use them for guidance and shall make an immediate oral decision explaining the decision by citing a provision of the Election Code;

(8) there is no statutory right of appeal; and

(9) if the voter prevails, the hearing officer shall direct the county clerk to handle the ballot as a qualified provisional ballot.

B. The county clerk shall notify the county canvassing board of the completion and results of the appeals process.
[1.10.22.11 NMAC - N, 4/24/2018]

1.10.22.12 SECRETARY OF STATE PROCEDURES:

A. Provisional voters wishing to determine the disposition of their provisional ballot may call the office of the secretary of state 14 days after the election. The secretary of state shall make the agency toll free number available to county clerks for the purpose of determining the status of provisional ballots, and shall establish a web-based computer program for the same purpose. The secretary of state, prior to providing information to a voter on the disposition of the voter's ballot, shall verify the identity of the voter.

B. The secretary of state shall not discuss the disposition of any provisional ballot with any person other than the provisional voter
[1.10.22.12 NMAC - Rp, 1.10.22.10 NMAC, 4/24/2018]

1.10.22.13 [RESERVED]

HISTORY OF 1.10.22 NMAC:
1.10.22 NMAC - Provisional Voting was Repealed and Replaced by 1.10.22 NMAC - Provisional Voting effective 4/24/2018.

History of Repealed Material:
1.10.22 NMAC - Provisional Voting Security (filed 8/1/2003) - Repealed effective 4/28/2006.
1.10.22 NMAC - Provisional Voting (filed 4/28/2006) - Repealed effective 4/24/2018.

SECRETARY OF STATE

This is an amendment to 1.10.11 NMAC, Sections 8 and 10, effective 4/24/2018.

1.10.11.8 ORDER OF OFFICES ON THE STATEWIDE BALLOT:

A. The ballot used in the primary and general elections shall contain, when applicable, the offices to be voted on in the following order:

(1) president and vice president;

(2) United States senator;

(3) United States representative;

B. Non-judicial state offices, when applicable, shall be in the following order on the primary election ballot. The order of the non-judicial state offices on the general election ballot shall be the same as in the primary election except, per New Mexico state constitution Article 5, Section 1, the governor and lieutenant governor shall be elected jointly by the casting by each voter of a single vote applicable to both offices.

(1) Governor;

(2) lieutenant governor;

(3) secretary of state;

(4) state auditor;

(5) state treasurer;

(6) attorney general;

(7) commissioner of public lands.

C. When applicable, the ballot used in the primary and general elections shall continue in the following order:

(1) state senator;

(2) state representative.

D. When applicable, other districted offices shall be in the following order on the primary and general election ballot:

(1) public regulation commissioner;

(2) public education commissioner;

(3) district attorney.

E. Judicial offices in

partisan contests, when applicable, shall be in the following order on the primary and general election ballot:

(1) supreme court justice in the order in which the position became vacant designated for purposes of ballot order by numerical position (Position 1, Position 2, Position 3, etc.);

(2) court of appeals judge in the order in which the position became vacant designated for purposes of ballot order by numerical position (Position 1, Position 2, Position 3, etc.);

(3) district court judge, in numerical order by division;

(4) magistrate or metropolitan court judge, when applicable, in numerical order by division.

F. When applicable, the ballot used in the primary and general elections shall continue in the following order:

(1) county commissioners or county councilors, in numerical order by district;

(2) county clerk;

(3) county treasurer;

(4) county assessor;

(5) county sheriff;

(6) probate judge.

G. When applicable, the ballot used in the general elections shall continue with other questions. At least 63 days before each general election, the SOS shall determine the order of each category of other questions, taking into account the need for a common back side for ballots in certain counties to reduce costs and to increase the efficiency of the check-in procedure for voters when using on demand ballot printing systems. The categories of other questions are:

(1) statewide judicial offices in retention elections, including supreme court and court of appeals, when applicable, in the order of seniority of each judicial officer;

(2) district court retention elections, when applicable, in numerical order by division;

(3) metropolitan court retention elections, when applicable, in numerical order by division;

(4) constitutional amendments, in the order passed by the legislature;

(5) general obligation bonds, in the order described in the chaptered General Obligation Bond Act;

(6) other statewide questions, otherwise authorized by law for placement on the ballot;

(7) local government ballot questions, in the order prescribed by the applicable county commission or county council.

[1.10.11.8 NMAC - N, 2/12/2016; A, 04/24/2018]

1.10.11.10 CANDIDATES FOR GOVERNOR AND LIEUTENANT GOVERNOR ON THE BALLOT: Pursuant to the New Mexico state constitution Article 5, Section 1, the governor and lieutenant governor shall be elected jointly by the casting by each voter of a single vote applicable to both offices.

A. Primary Election Ballot. In the event that at least one candidate of the same major party fails to file or does not qualify for both the office of governor and lieutenant governor, then no candidate for either position shall appear on the primary election ballot for that party in order to comply with the New Mexico state constitution Article 5, Section 1.

B. General Election Ballot. In the event that at least one independent candidate or candidate for the same minor party fails to file for or does not qualify for both the office of governor and lieutenant governor, then no candidate for either position shall appear on the general election ballot for that party in order to comply with the New Mexico state constitution Article 5, Section 1. For example, if an independent candidate for governor files and otherwise qualifies for appearance on the ballot but no independent candidate files for lieutenant governor, then the candidate for governor shall not appear on the ballot.

C. If an odd number of independent candidates for governor and lieutenant governor file and otherwise qualify to appear on the general election ballot, the qualifying candidates may choose to designate one another, on a form prescribed by the secretary of state, in order to determine which candidates will appear on the general ballot in compliance with the New Mexico state constitution Article 5, Section 1. For example, if two independent candidates for governor file and otherwise qualify for appearance on the ballot and only one independent candidate for lieutenant governor files and otherwise qualifies for appearance on the ballot, two of the candidates would complete the prescribed form in order to designate one another to determine which one of the two candidates for governor will appear with the candidate for lieutenant governor on the general election ballot. Failure to designate, will result in the drawing by lot as described in subsection D.

D. As an alternative to subsection C, if the independent candidates for governor and lieutenant governor fail to designate one another, a drawing by lot will be conducted by the secretary of state to determine the candidates to appear on the general ballot. The drawing by lot will be conducted on the first Wednesday in the month of September in the year in which a general election is to be held.

[1.10.11.10 NMAC - N, 04/24/2018]

SECRETARY OF STATE

This is an amendment to 1.10.13 NMAC, Section 27, effective 4/24/2018.

1.10.13.27 PRIMARY AND GENERAL ELECTION CYCLES FOR PURPOSES OF CONTRIBUTION LIMITS

A. For state representatives and any other two year office holders and for political committees, the primary election cycle begins the day after each general election and ends at midnight on the day of the primary election. The general election cycle begins on the day after each primary election and ends at midnight on the day of the general election.

B. For statewide office holders and any other four year office holders [~~and for political committees~~], the primary election cycle begins on the day after the general election in which the office is on the ballot, or included in governor's primary election proclamation, and ends at midnight on the day of the primary election in which the office appears on the ballot. The general election cycle begins on the day after the applicable primary election and ends at midnight on the day of the general election.

C. Transferring funds to a different primary or general election cycle in CFIS: Within CFIS, the secretary of state shall move funds, including debts, from an existing candidate campaign account to a new candidate campaign account pursuant to Section I of 1.10.13.8 NMAC, including for a candidate campaign committee that reports on a different election cycle. This transfer is applicable to all current and former candidates and elected officials who have an open CFIS account including candidates who chose to run for a different office.

(1) Each time a candidate runs for office, a new candidate campaign committee registration form is required. If a candidate has previously run for an office covered by the CRA, the secretary of state will create a new campaign in CFIS for the election year listed on the registration form in the candidate's existing CFIS account.

(2) Upon submitting the candidate campaign committee registration form for the new campaign year, the candidate is eligible to collect contributions in accordance with the contribution limits and the election cycle applicable to the campaign year and office listed on the form.

(3) Candidate withdrawal or loss of a primary election: If a candidate withdraws from candidacy or loses an election, the candidate may move funds collected to a future election campaign by submitting a new candidate campaign committee registration form.

(4) If contributions collected under the previous campaign cycle exceed what is allowable for the office associated with the new campaign, the candidate must take one of the following actions:

(a) Refund excessive funds to the original contributor;

(b) Allocate excessive funds received in a primary election cycle to the general election cycle to ensure limits are met; or

(c) Turn excess funds over to the SOS to deposit within the public election fund pursuant to Section 1-19-34.7 NMSA 1978.

[1.10.13.27 NMAC - N, 10/10/2017; A, 04/24/2018]

End of Adopted Rules

Other Material Related to Administrative Law

ATTORNEY GENERAL, OFFICE OF THE

NOTICE OF MINOR, NONSUBSTANTIVE CORRECTION

The New Mexico Office of the Attorney General, hereby gives certain notice of minor, non-substantive correction ("Notice").

The following correction was identified and amended:

Due to lack of a Subsection "B," Subsection "A" of 1.24.25.11 NMAC was deleted and the section was properly re-formatted.

This correction clarifies that for the above rule and pursuant to the authority granted under State Rules Act, Paragraph D of Section 14-4-5 NMSA, the following minor, non-substantive corrections to spelling, grammar or format has been made to all published and electronic copies of the above rules.

A copy of the Notice was filed with the official version of each of the above rule.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

NOTICE OF MINOR, NON-SUBSTANTIVE CORRECTION

Pursuant to the authority granted under State Rules Act, Subsection D of Section 14-4-5 NMSA, please note the following minor, non-substantive corrections to the formatting of 8.302.3 NMAC - "Third Party Liability Provider Responsibilities", 8.308.7 NMAC - "Enrollment and Disenrollment", 8.308.8 NMAC - "Members Rights, Responsibilities and Education" and 8.308.13 NMAC - "Member Rewards" filed on April 12, 2018, published and effective on May 1, 2018:

8.302.3 NMAC - "Third Party Liability Provider Responsibilities"- Subparagraph (e) of Paragraph (1) of Subsection C of 8.302.3.12 NMAC, corrected spelling "eligible".

8.308.7 NMAC - "Enrollment and Disenrollment" - Added Paragraph (2) to Subsection C of 8.308.7.9 NMAC (see below):

C. Auto assignment:

(1) HSD will auto-assign an eligible recipient to a MCO in specific circumstances, including but not limited to:

(a) the eligible recipient is not exempt from managed care and does not select a MCO at the time of his or her application for MAD eligibility;

(b) the eligible recipient cannot be enrolled in the requested MCO pursuant to the terms of this rule (e.g., the MCO is subject to and has reached its enrollment limit). HSD may modify the auto-assignment algorithm, at its discretion, when it determines it is in the best interest of the program, including but not limited to, sanctions imposed on the MCO, consideration of quality measures, cost or utilization management performance criteria.

(2) The HSD auto-assignment process will consider the following:

(a) if the eligible recipient was previously enrolled with a MCO and lost his or her eligibility for a period of six months or less, he or she will be re-enrolled with that MCO;

(b) if the eligible recipient has a family member enrolled in a specific MCO, he or she will be enrolled with that MCO;

(c) if the eligible recipient is a newborn, he or she will be assigned to the mother's MCO; see Subsection A of 8.308.6.10 NMAC; or

(d) if none of the above applies, the eligible recipient will be assigned using the default logic that assigns an eligible recipient to a MCO.

8.308.8 NMAC - "Members Rights, Responsibilities and Education" - Deleted Open Bracket before Section 8.308.8.9 NMAC.

8.308.13 NMAC - "Member Rewards" - Added Repealed to history notes.

8.310.10 NMAC - " Health Home Services" - Added Repealed to history notes.

A copy of this *Notification* will be filed with the official version of the above rule.

End of Other Material Related to Administrative Law

2018 New Mexico Register

Submittal Deadlines and Publication Dates
Volume XXIV, Issues 1-24

Issue	Submittal Deadline	Publication Date
Issue 1	January 4	January 16
Issue 2	January 18	January 30
Issue 3	February 1	February 13
Issue 4	February 15	February 27
Issue 5	March 1	March 13
Issue 6	March 15	March 27
Issue 7	March 29	April 10
Issue 8	April 12	April 24
Issue 9	April 26	May 15
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Issue 13	June 28	July 10
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Issue 16	August 16	August 28
Issue 17	August 30	September 11
Issue 18	September 13	September 25
Issue 19	September 27	October 16
Issue 20	October 18	October 30
Issue 21	November 1	November 13
Issue 22	November 15	November 27
Issue 23	November 29	December 11
Issue 24	December 13	December 27

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