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State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT

NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT

AMENDMENT OF HSD RULES TO ALIGN WITH HEALTH CARE AUTHORITY

III. PROGRAM AFFECTED

ALL HSD PROGRAMS

IV. ACTION

FINAL RULE AMENDMENTS

V. BACKGROUND SUMMARY

The Human Services Department (HSD) is finalizing amendments to regulations that were proposed in Human Register (HSR) Vol. 47 No. 11. By statute, Department will become the New Mexico Health Care Authority (HCA) on July 1, 2024. The Department proposed amending the rules listed at the end of this notice to bring the New Mexico Administrative Code (NMAC) into full alignment with this change.

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.

VI. CONCISE EXPLANATORY STATEMENT

The hearing for these rules was held on June 7, 2024. Matt Ortiz of the State Records Center and Archives (SRCA) provided a statement that requested HSD to enter a finding that SRCA staff may make non-substantive, style changes to the rules and that such changes be within the scope of the rulemaking. HSD so finds and SRCA is authorized to make such changes.

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The hearing officer read the following statement into the record, explaining that during the process of updating the rules the Department made some additional style and formatting updates to the rules:

> Consistent with all other rules converted from the Human Services Department to the Health Care Authority, throughout this rule, if found: "department" is changed to "authority" or "HCA"; "HSD" is changed to "HCA" and that acronym is generally first introduced in the third section of the rule; "alien" is changed to "non-citizen"; "child support enforcement division" is changed to "child support services division"; "CSED" is changed to "CSSD"; and style and formatting have been updated to conform with current NM State Records Center guidelines.

No other public comment was received. Therefore the involved rules are repealed and new versions are adopted as proposed.

VII. RULE

The final register and rule language is available on the HSD website at: https://www.hsd.state.nm.us/lookingforinformation/registers/. If you do not have internet access, a copy of the final register and rules may be requested by contacting HSD Office of the Secretary at (505) 827-7750.

VIII. PUBLICATION DATE

June 25, 2024

IX. EFFECTIVE DATE

July 1, 2024.

X. PUBLICATION

Publication of this rule is approved by:

DocuSigned by:
Kari Armijo
1BA9EB5EAD00499...

KARI ARMIJO, SECRETARY
HUMAN SERVICES DEPARTMENT

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HSD Rules Amended:

Rule number	Rule name
8.1.2 NMAC	GENERAL OPERATING PROCEDURE FOR THE OFFICE OF THE INSPECTOR GENERAL
8.50.100 NMAC	GENERAL PROVISIONS
8.50.108 NMAC	ESTABLISHMENT AND MODIFICATION OF SUPPORT ORDER
8.50.109 NMAC	MEDICAL SUPPORT
8.50.110 NMAC	INCOME WITHHOLDING
8.50.111 NMAC	GENERAL ENFORCEMENT OF SUPPORT OBLIGATIONS
8.50.112 NMAC	ADMINISTRATIVE ENFORCEMENT OF SUPPORT OBLIGATIONS
8.50.113 NMAC	ENFORCEMENT OF SUPPORT OBLIGATIONS FROM FEDERAL EMPLOYEES INCLUDING MEMBERS OF THE ARMED SERVICES
8.50.114 NMAC	FINANCIAL INSTITUTION DATA MATCH (FIDM)
8.50.115 NMAC	EXPEDITED PROCESSES AND ADMINISTRATIVE EXPEDITED PROCESS
8.50.117 NMAC	INTERNATIONAL CHILD SUPPORT ENFORCEMENT
8.50.124 NMAC	INTERSTATE CASES
8.50.125 NMAC	FEES, PAYMENTS, AND DISTRIBUTIONS
8.50.129 NMAC	CASE MANAGEMENT
8.50.130 NMAC	ADMINISTRATIVE HEARINGS
8.50.131 NMAC	PENALTIES
8.50.132 NMAC	UNCLAIMED CHILD, SPOUSAL OR MEDICAL SUPPORT
8.100.140 NMAC	GENERAL OPERATING POLICIES CASE FILES
8.100.640 NMAC	RESTORATION AND CLAIMS
8.102.100 NMAC	RECIPIENT POLICIES – DEFINITIONS AND ACRONYMS
8.102.460 NMAC	RECIPIENT POLICIES – COMPLIANCE REQUIREMENTS
8.102.461 NMAC	WORK PROGRAM ACTIVITIES
8.102.462 NMAC	NEW MEXICO WAGE SUBSIDY PROGRAM
8.106.100 NMAC	RECIPIENT POLICIES – DEFINITIONS AND ACRONYMS
8.106.400 NMAC	RECIPIENT POLICIES – DEFINING THE BENEFIT GROUP
8.106.410 NMAC	RECIPIENT POLICIES – GENERAL RECIPIENT REQUIREMENTS
8.106.420 NMAC	RECIPIENT POLICIES – REQUIREMENTS FOR DETERMINING DISABILITY
8.106.430 NMAC	RECIPIENT POLICIES – REQUIREMENTS FOR DEPENDENT CHILDREN
8.106.431 NMAC	PRE CERTIFIED VICTIMS OF HUMAN TRAFFICKING
8.106.500 NMAC	ELIGIBILITY POLICY – GENERAL INFORMATION
8.106.502 NMAC	GENERAL INFORMATION – BURIAL ASSISTANCE
8.106.510 NMAC	ELIGIBILITY POLICY- RESOURCES/PROPERTY

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8.106.520 NMAC	ELIGIBILITY POLICY – INCOME
8.106.610 NMAC	DESCRIPTION OF PROGRAM/BENEFITS – BENEFIT DELIVERY
8.106.620 NMAC	DESCRIPTION OF PROGRAM BENEFITS – BENEFIT DETERMINATION/GENERAL
8.106.630 NMAC	DESCRIPTION OF PROGRAM/BENEFITS – CHANGES IN ELIGIBILITY
8.106.631 NMAC	HEAT AND EAT PROGRAM
8.119.100 NMAC	RECIPIENT POLICIES-DEFINITIONS AND ACRONYMS
8.139.410 NMAC	GENERAL RECIPIENT REQUIREMENTS – NONFINANCIAL ELIGIBILITY CRITERIA
8.139.501 NMAC	TRANSITIONAL FOOD STAMP BENEFIT ELIGIBILITY
8.139.502 NMAC	STATE FOOD STAMP SUPPLEMENT
8.139.503 NMAC	NEW MEXICO MODIFIED COMBINED APPLICATION PROJECT
8.139.504 NMAC	NEW MEXICO EXTRA HELP SNAP
8.139.520 NMAC	ELIGIBILITY POLICY – INCOME AND DEDUCTIONS
8.139.527 NMAC	FOOD STAMP PROGRAM – INCOME AND RESOURCES EXCLUDED BY FEDERAL LAW
8.200.410 NMAC	GENERAL RECIPIENT REQUIREMENTS
8.200.420 NMAC	SPECIAL RECIPIENT REQUIREMENTS
8.201.400 NMAC	RECIPIENT POLICIES
8.201.600 NMAC	BENEFIT DESCRIPTION
8.206.400 NMAC	RECIPIENT REQUIREMENTS
8.215.400 NMAC	RECIPIENT POLICIES
8.215.500 NMAC	INCOME AND RESOURCE STANDARDS
8.215.600 NMAC	BENEFIT DESCRIPTION
8.231.400 NMAC	RECIPIENT POLICIES
8.231.500 NMAC	INCOME AND RESOURCE STANDARDS
8.231.600 NMAC	BENEFIT DESCRIPTION
8.234.400 NMAC	RECIPIENT REQUIREMENTS
8.234.500 NMAC	INCOME AND RESOURCE STANDARDS
8.234.600 NMAC	BENEFIT DESCRIPTION
8.242.400 NMAC	RECIPIENT REQUIREMENTS
8.242.500 NMAC	INCOME AND RESOURCE STANDARDS
8.242.600 NMAC	BENEFIT DESCRIPTION
8.243.400 NMAC	RECIPIENT POLICIES
8.243.500 NMAC	INCOME AND RESOURCE STANDARDS
8.243.600 NMAC	BENEFIT DESCRIPTION
8.245.600 NMAC	BENEFIT DESCRIPTION

DocuSign Envelope ID: C981798E-58C7-4141-A646-27EDA1FE4B4E

8.249.400 NMAC	RECIPIENT REQUIREMENTS
8.249.500 NMAC	INCOME AND RESOURCE STANDARDS
8.249.600 NMAC	BENEFIT DESCRIPTION
8.250.400 NMAC	RECIPIENT REQUIREMENTS
8.250.500 NMAC	INCOME AND RESOURCE STANDARDS
8.250.600 NMAC	BENEFIT DESCRIPTION
8.252.500 NMAC	INCOME AND RESOURCE STANDARDS
8.252.600 NMAC	BENEFIT DESCRIPTION
8.259.400 NMAC	RECIPIENT REQUIREMENTS
8.259.500 NMAC	INCOME AND RESOURCE STANDARDS
8.259.600 NMAC	BENEFIT DESCRIPTION
8.280.400 NMAC	RECIPIENT POLICIES
8.280.600 NMAC	BENEFIT DESCRIPTION
8.281.400 NMAC	RECIPIENT POLICIES
8.281.500 NMAC	INCOME AND RESOURCE STANDARDS
8.281.510 NMAC	TRUST STANDARDS
8.281.600 NMAC	BENEFIT DESCRIPTION
8.285.400 NMAC	RECIPIENT REQUIREMENTS
8.290.400 NMAC	RECIPIENT POLICIES
8.290.600 NMAC	BENEFIT DESCRIPTION
8.291.400 NMAC	ELIGIBILITY REQUIREMENTS
8.291.410 NMAC	GENERAL RECIPIENT REQUIREMENTS
8.291.420 NMAC	RECIPIENT RIGHTS AND RESPONSIBILITIES
8.292.400 NMAC	RECIPIENT REQUIREMENTS
8.292.500 NMAC	INCOME AND RESOURCE STANDARDS
8.292.600 NMAC	BENEFIT DESCRIPTION
8.293.400 NMAC	RECIPIENT REQUIREMENTS
8.293.500 NMAC	INCOME AND RESOURCE STANDARDS
8.293.600 NMAC	BENEFIT DESCRIPTION
8.294.400 NMAC	RECIPIENT REQUIREMENTS
8.294.500 NMAC	INCOME AND RESOURCE STANDARDS
8.294.600 NMAC	BENEFIT DESCRIPTION
8.295.400 NMAC	RECIPIENT REQUIREMENTS
8.295.500 NMAC	INCOME AND RESOURCE STANDARDS
8.295.600 NMAC	BENEFIT DESCRIPTION
8.296.400 NMAC	RECIPIENT REQUIREMENTS
8.296.500 NMAC	INCOME AND RESOURCE STANDARDS

DocuSign Envelope ID: C981798E-58C7-4141-A646-27EDA1FE4B4E

8.296.600 NMAC	BENEFIT DESCRIPTION
8.297.400 NMAC	RECIPIENT REQUIREMENTS
8.297.500 NMAC	INCOME AND RESOURCE STANDARDS
8.297.600 NMAC	BENEFIT DESCRIPTION
8.298.400 NMAC	RECIPIENT REQUIREMENTS
8.298.500 NMAC	INCOME AND RESOURCE STANDARDS
8.298.600 NMAC	BENEFIT DESCRIPTION
8.299.400 NMAC	RECIPIENT REQUIREMENTS
8.299.500 NMAC	INCOME AND RESOURCE STANDARDS
8.299.600 NMAC	BENEFIT DESCRIPTION
8.300.22 NMAC	ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM
8.302.2 NMAC	BILLING FOR MEDICAID SERVICES
8.302.3 NMAC	THIRD PARTY LIABILITY PROVIDER RESPONSIBILITIES
8.308.2 NMAC	PROVIDER NETWORK
8.308.6 NMAC	ELIGIBILITY
8.308.7 NMAC	ENROLLMENT AND DISENROLLMENT
8.308.8 NMAC	MEMBER EDUCATION
8.308.9 NMAC	BENEFIT PACKAGE
8.308.10 NMAC	CARE COORDINATION
8.308.11 NMAC	TRANSITION OF CARE
8.308.12 NMAC	COMMUNITY BENEFIT
8.308.13 NMAC	MEMBER REWARDS
8.308.14 NMAC	CO-PAYMENTS
8.308.15 NMAC	GRIEVANCES AND APPEALS
8.308.20 NMAC	REIMBURSEMENT
8.308.21 NMAC	QUALITY MANAGEMENT
8.308.22 NMAC	FRAUD, WASTE AND ABUSE
8.309.4 NMAC	MAD ADMINISTERED BENEFITS AND LIMITATION OF SERVICES
8.310.2 NMAC	GENERAL BENEFIT DESCRIPTION
8.310.3 NMAC	PROFESSIONAL PROVIDERS, SERVICES AND REIMBURSEMENT
8.310.9 NMAC	RURAL HEALTH CLINIC SERVICES
8.310.12 NMAC	INDIAN HEALTH SERVICE AND TRIBAL 638 FACILITIES
8.311.3 NMAC	METHODS AND STANDARDS FOR ESTABLISHING PAYMENT – INPATIENT HOSPITAL SERVICES
8.311.5 NMAC	SWING BED HOSPITAL SERVICES
8.312.2 NMAC	NURSING FACILITIES
8.312.3 NMAC	COST RELATED REIMBURSEMENT OF NURSING FACILITIES

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8.314.3 NMAC	MEDICALLY FRAGILE HOME AND COMMUNITY-BASED SERVICES WAIVER
8.314.5 NMAC	DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER
8.314.6 NMAC	MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER
8.314.7 NMAC	SUPPORT WAIVER
8.320.2 NMAC	EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES
8.320.6 NMAC	SCHOOL-BASED SERVICES FOR MAP ELIGIBLE RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE
8.324.4 NMAC	PHARMACY SERVICES, PRESCRIBING, AND PRACTITIONER ADMINISTERED DRUG ITEMS
8.324.5 NMAC	VISION APPLIANCES, HEARING APPLIANCES, DURABLE MEDICAL EQUIPMENT, OXYGEN, MEDICAL SUPPLIES, PROSTHETICS AND ORTHOTICS
8.324.7 NMAC	TRANSPORTATION SERVICES AND LODGING
8.325.8 NMAC	REHABILITATION SERVICE PROVIDERS
8.326.3 NMAC	CASE MANAGEMENT SERVICES FOR PREGNANT WOMEN AND THEIR INFANTS
8.326.4 NMAC	CASE MANAGEMENT SERVICES FOR THE CHRONICALLY MENTALLY ILL
8.326.5 NMAC	CASE MANAGEMENT SERVICES FOR TRAUMATICALLY BRAIN INJURED ADULTS
8.326.6 NMAC	CASE MANAGEMENT SERVICES FOR CHILDREN UP TO AGE THREE
8.326.7 NMAC	ADULT PROTECTIVE SERVICES CASE MANAGEMENT
8.326.8 NMAC	CASE MANAGEMENT SERVICES FOR CHILDREN PROVIDED BY JUVENILE PROBATION AND PAROLE OFFICERS
8.326.10 NMAC	TRAUMATIC BRAIN INJURY TRUST FUND PROGRAM
8.350.2 NMAC	RECONSIDERATION OF UTILIZATION REVIEW DECISIONS
8.350.3 NMAC	ABSTRACT SUBMISSION FOR LEVEL OF CARE DETERMINATIONS
8.350.4 NMAC	RECONSIDERATION OF AUDIT SETTLEMENTS
8.351.2 NMAC	SANCTIONS AND REMEDIES
8.352.2 NMAC	CLAIMANT HEARINGS
8.352.3 NMAC	PROVIDER HEARINGS
8.354.2 NMAC	PASRR AND PATIENT STATUS HEARINGS

TITLE 8 SOCIAL SERVICES
CHAPTER 1 SOCIAL SERVICES GENERAL PROVISIONS
PART 2 GENERAL OPERATING PROCEDURE FOR THE OFFICE OF INSPECTOR GENERAL

8.1.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.1.2.1 NMAC - N, 11/01/2018; A, 7/1/2024]

8.1.2.2 SCOPE: The rule applies to the general public.
[8.1.2.2 NMAC - N, 11/01/2018]

8.1.2.3 STATUTORY AUTHORITY:

A. Chapter 27, Articles 1 and 2 NMSA 1978 provide for the department to "adopt, amend and repeal bylaws, rules and regulations." They also provide for administration of public assistance programs.

B. The Office of Inspector General (OIG) of the health care authority was created by the secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

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

[8.1.2.3 NMAC - N, 11/01/2018; A, 7/1/2024]

8.1.2.4 DURATION: Permanent.
[8.1.2.4 NMAC - N, 11/01/2018]

8.1.2.5 EFFECTIVE DATE: November 1, 2018, unless a later date is cited at the end of a section.
[8.1.2.5 NMAC - N, 11/01/2018]

8.1.2.6 OBJECTIVE: The objective of these regulations is to provide general operating policy for the Office of Inspector General (OIG).
[8.1.2.6 NMAC - N, 11/01/2018]

8.1.2.7 DEFINITIONS: The following words and terms, when used in this section, shall have the following meanings, unless the text clearly indicates otherwise:

A. **"Abuse"** means to make excessive or improper use of a thing, or to employ it in a manner contrary to the material or legal rules for its use; to make an extravagant or excessive use, as to abuse one's authority. Abuse may also occur through expressive carelessness in following written instructions or policy or in failing to take proper action that results in improper payments for public assistance, food benefits, vendor payments, or claims processing. Abuse through expressive carelessness may occur in eligibility determination, supervision review, data processing, claims processing, or program interpretation.

B. **"Fraud"** is an intentional misappropriation, deception or misrepresentation made by a person(s) or entities with knowledge that the deception could result in some unauthorized benefit to the person(s), entity, other entity or some other person(s). The term includes any act that constitutes fraud under applicable federal or state laws, regulations, or rules.

C. **"Waste"** means not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by person(s) or entities with control over or access to government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse and does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.

[8.1.2.7 NMAC - N, 11/01/2018]

8.1.2.8 MISSION STATEMENT: [**RESERVED**]
[8.1.2.8 NMAC - N, 11/01/2018]

8.1.2.9 RESPONSIBILITIES: Generally, the OIG, is responsible for conducting independent audits, reviews, and investigations of HCA programs and operations, while detecting and preventing fraud, waste, and abuse. Through audits and reviews, the OIG promotes accountability, efficiency, economy, and integrity through

research and analysis, and by providing recommendations for improvement to HCA's secretary, leadership and management. The OIG conducts investigations into public assistance, i.e. medicaid, supplemental nutrition assistance program (SNAP), temporary assistance for needy families (TANF), etc., fraud, and HCA contractor and internal employee fraud. If potential fraud is identified, the OIG, when appropriate, will pursue prosecutive remedies and, in coordination with HCA, administrative remedies. Nothing in this section shall prohibit law enforcement agencies from pursuing claims for alleged violations of criminal conduct or other governmental entities from seeking all rights and remedies as permitted by law and regulations.
[8.1.2.9 NMAC - N, 11/01/2018]

8.1.2.10 **Authority:** In conjunction with federal and state law, rules and regulations that apply to HCA programs, the OIG is authorized:

A. To audit, review, inspect, evaluate, and investigate activities, records, electronic media, and individuals affiliated with contracts and procurements undertaken by HCA and any other official act or function of HCA.

B. To have access to all records, reports, audits, reviews, documents, papers, electronic media, recommendations, or other material available to the individual or entity which relate to HCA's programs and operations with respect to which the OIG has responsibility.

C. To conduct criminal, civil, and administrative investigations.

D. To engage in prevention activities, including but not limited to; review of legislation; review of rules, regulations, policies; procedures, and transactions; training and education.

E. To refer matters for further civil, criminal, and administrative action to appropriate administrative and prosecutorial agencies.

F. To refer matters to other law enforcement agencies, when appropriate.

G. To conduct joint investigations and projects with other oversight or law enforcement agencies.

H. To establish guidelines and procedures to guide functions and processes conducted by the OIG.

I. To recoup the cost of investigations from nongovernmental entities as permitted by law.

J. To administer to or take from any person an oath, affirmation, affidavit or sworn statement, whenever necessary in the performance of the OIG functions assigned by this code.

K. To request such information or assistance as may be necessary for carrying out the duties and responsibilities provided by this code from any federal, state, or local governmental agency or unit thereof.

L. Access to HCA's secretary, leadership and management when necessary for any purpose pertaining to the OIG's responsibilities.
[8.1.2.10 NMAC - N, 11/01/2018]

8.1.2.11 **Powers:** The OIG is granted the following powers:

A. Access to all records maintained by or available to any governmental entity relating in any way to the OIG's duties and responsibilities.

B. Access to testimony or documents from any individual, firm, or nongovernmental entity relating to the duties and responsibilities of the OIG.

C. Require HCA employees to report to the OIG information regarding fraud, waste, corruption, illegal acts, and abuse.
[8.1.2.11 NMAC - N, 11/01/2018]

8.1.2.12 **Confidentiality:** The OIG shall maintain confidentiality of records and, to the extent practicable, the identities of individuals who provide information to the OIG, except as authorized or required by law.
[8.1.2.12 NMAC - N, 11/01/2018]

8.1.2.13 **Cooperation:** In accordance with federal and state laws and regulations and, if applicable, collective bargaining agreements, all HCA employees shall cooperate fully and promptly with requests from the OIG for information and data relating to HCA programs and operations. All HCA employees shall also comply with requests for interviews and briefings and must provide affidavits or sworn statements, if so requested by an employee of the OIG so designated to take affidavits or sworn statements. The OIG is not required to give advanced notice before conducting audits, reviews or investigations. When possible, supervisors will be informed in advance if their areas of responsibility that are to be audited. Because some OIG investigations may involve allegations of criminal misconduct, circumstances will dictate whether, and what type of, notice will be given, if any. HCA employees must not impede or hinder other employees' cooperation with the OIG. In accordance with Act 10-16C-

1 through 10-16C-6 NMSA 1978, HCA managers shall prohibit reprisals against employees who cooperate with or disclose information to the OIG or other lawfully appropriate authority. HCA will also take administrative action against employees who take reprisals against employees who have cooperated with the OIG or other lawful appropriate authority to include, but is not limited to, counsel, reprimand, suspension, or termination. 8.1.2.13 NMAC must be applied to all HCA contracts, replacing "HCA" with "contractor", where applicable.
[8.1.2.13 NMAC - N, 11/01/2018]

HISTORY OF 8.1.2 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 100 GENERAL PROVISIONS

8.50.100.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.100.1 NMAC - Rp, 8.50.100.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.100.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.
[8.50.100.2 NMAC - Rp, 8.50.100.2 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.100.3 NMAC - Rp, 8.50.100.3 NMAC, 12/30/2010; A, 1/1/2022; A, 7/1/2024]

8.50.100.4 DURATION: Permanent.
[8.50.100.4 NMAC - Rp, 8.50.100.4 NMAC, 12/30/2010]

8.50.100.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.100.5 NMAC - Rp, 8.50.100.5 NMAC, 12/30/2010]

8.50.100.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.100.6 NMAC - Rp, 8.50.100.6 NMAC, 12/30/2010]

8.50.100.7 DEFINITIONS: Unless otherwise apparent from the context, the following definitions shall apply throughout these regulations.

A. "Account" means a demand deposit account checking or negotiable withdrawal order account, savings account, time deposit account, or money-market mutual fund account.

B. "Arrearage" means the amount of support owed that was unpaid and has been consolidated into a judgment. Also referred to as arrears or past-due support.

C. "AFDC" means aid to families with dependent children. AFDC is now replaced by the TANF/ NM works program. Where TANF/ NM works is referenced in these regulations, the provisions apply to AFDC cases.

D. "Authorized representative" means a person acting under the authority of a valid power of attorney (with a general or specific designation regarding a child support case), a guardian ad litem, an attorney representing a person, or the parent of a minor having a child support case. The person will be required to produce documentation of their authorized status.

E. "Business day" means a day on which state offices are open for regular business.

F. "CP" means custodial party or custodial parent.

G. "CSSD" means the child support services division of the health care authority that is the New Mexico Title IV-D agency, designated by Section 27-2-27 et seq., NMSA 1978, as the single state agency for the enforcement of child, medical, and spousal support obligations pursuant to Title IV-D of the Social Security Act.

H. "CSES" means the child support enforcement system (the computer system for CSSD).

I. "Delinquency" means any payment under an order for support that has become due and is unpaid and has not been consolidated into a judgment. This may also be known as overdue support.

J. "Department" means the New Mexico health care authority department.

K. "Department's records" means all physical and automated records maintained by the department on any person, as well as access to automated and physical records maintained by other persons.

L. "Dependent" means a minor who has not emancipated by age or by court order. This is the same as a "minor child."

M. "DMSH" means data match specification handbook.

N. "Distribution" means the act of collecting child support payments and disbursing those payments to the proper individual or agency.

O. **"District court"** means the judicial district courts, family courts, and child support hearing officers having jurisdiction over child support matters in the state of New Mexico.

P. **"Employer"** means the same as the term in Section 3401(d) of the Internal Revenue Code of 1986 and includes any governmental entity and any labor organization.

Q. **"FIDM"** means financial institution data match.

R. **"Financial institution"** is defined in Section 27-1-13 et seq., NMSA 1978.

S. **"Family violence"** means the family violence indicator or non-disclosure indicator on the child support computer system.

T. **"Genetic testing"** means any testing methodology used to determine parent and child relationship as described in Section 40-11A-503 et seq., NMSA 1978.

U. **"HCA"** means the health care authority.

V. **"Hearing officer"** means the Title IV-D administrative hearings officer or administrative law judge.

W. **"Hearings bureau"** means the Title IV-D hearings bureau.

X. **"Location"** means information concerning the physical whereabouts of a person or the person's employer(s), other sources of income, or assets as appropriate, which is sufficient and necessary to take the next appropriate action in a case.

Y. **"NCP"** means non-custodial party or non-custodial parent.

Z. **"Obligee"** means any person who is entitled to receive support under an order for support or that person's legal representative or assignee pursuant to Subsection F Section 27-2-28 et seq., NMSA 1978.

AA. **"Obligor"** means the person who owes a duty to make payments under an order for support.

BB. **"Order for support"** means any order that has been issued by any judicial, quasi-judicial or administrative entity of competent jurisdiction of any state, territory, or nation that has entered into a reciprocal agreement for the establishment and enforcement of orders for support with the United States and which order provides for:

(1) periodic payment of funds for the support of a child or a spouse;

(2) modification or resumption of payment of support;

(3) payment of delinquency; or

(4) reimbursement of support.

CC. **"Payor"** means any person or entity who provides income to an obligor.

DD. **"Person"** means an individual, corporation, partnership, governmental agency, public office or other entity.

EE. **"Physical or emotional harm"** means being subjected to: physical acts that resulted in, or threatened to result in, physical injury; sexual abuse; sexual activity involving a dependent child; being forced as the caretaker relative of a dependent child to engage in non-consensual sexual acts or activities; threats of, or attempts at, physical or sexual abuse; mental abuse; being subject to a pattern of emotional or psychological attacks that may include embarrassment, isolation, blaming, name-calling, humiliation, threats, shaming, extreme jealousy, gaslighting, intimidation, and manipulation resulting in a range of emotional trauma that may include: confusion, fear, difficulty concentrating, anxiety, social withdrawal, sleep disruption, and depression; or neglect or deprivation of medical care.

FF. **"Proof of service"** means the completed document demonstrating that service has been completed in accordance with the New Mexico rules of civil procedure at Rule 1-004 NMRA. The documents include, but are not limited to: an affidavit of mailing, acceptance of service, certificate of service, or return of service.

GG. **"Secretary"** means the secretary of the health care authority.

HH. **"SDU"** means the state disbursement unit that collects and disburses payments in all Title IV-D cases.

II. **"Service of process"** means:

(1) service has been accepted by the person signing an acceptance of service; or

(2) service performed pursuant to Rule 1-004 NMRA.

JJ. **"Support order"** means a judgment, decree, or order, whether temporary, final, or subject to modification, issued by a court or an administrative agency of competent jurisdiction, for the support and maintenance of a child or children, including a child who has attained the age of majority under the law of the issuing state, or a child and the parent with whom the child is living, which provides for monetary support, medical support, or arrearages.

KK. **"TANF/NM works"** means federally funded temporary assistance to needy families / New Mexico works (see AFDC).

LL. **"Title IV"** programs mean the various programs operated under the Social Security Act (42 USC Chapter 7, Title IV). IV-A refers to TANF and IV-B or IV-E refers to foster care. See definition below for "IV-D".

MM. **"Title IV-D"** or **"Title IV-D agency"** or **"IV-D agency"** means the single and separate state agency authorized by Title IV, Subsection D of the Social Security Act (42 USC 651 et seq.) to operate a child support program. Both states and tribes may administer a Title IV-D program. The New Mexico "Title IV-D" agency is authorized by Section 27-2-27 et seq., NMSA 1978.

NN. **"Title IV-D agency director"** or **"division director"** means the director of the child support services division of the New Mexico health care authority.

OO. **"Title IV-D staff"** or **"IV-D staff"** means employees of the state of New Mexico assigned to operate a child support program to also include any contractors with the IV-D agency.

PP. **"Title XIX"** means medicaid programs that are operated under Title XIX of the Social Security Act.

QQ. **"UIFSA"** means Uniform Interstate Family Support Act (replaces the former Uniform Reciprocal Enforcement of Support Act). A case from another jurisdiction that has not yet adopted UIFSA shall be treated as a New Mexico UIFSA case. (See Section 40-6A-101 et seq., NMSA 1978).

[8.50.100.7 NMAC - Rp, 8.50.100.7 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.8 GENERAL PROGRAM DESCRIPTION: Child support enforcement services include establishing paternity, obtaining enforceable orders of support, collection and distribution of on-going support and arrears, and medical support, as appropriate. Any case with an enforceable order is an enforcement case, although some intake functions, such as non-custodial party locate may be required in order to enforce the order.

[8.50.100.8 NMAC - Rp, 8.50.100.8 NMAC, 12/30/2010]

8.50.100.9 PROGRAM SERVICES:

A. There are six major program services in child support enforcement, of which one or more may be appropriate for a particular case:

(1) non-custodial parent location;

(2) establishment of paternity;

(3) establishment of a support obligation (including medical support);

(4) collection and distribution of support payments (including spousal and medical support);

(5) enforcement of support obligation, (including medical and spousal support); and

(6) review and adjustment of support obligation.

B. Spousal support: The IV-D agency does not take any action to establish an order for spousal support. It remains the obligee's responsibility to establish such an order. The responsibility of the IV-D agency is limited to enforcing existing spousal support orders. The IV-D agency may enforce spousal support when:

(1) the payee has a previously established order for spousal support or the payee subsequently obtains an order for spousal support, and

(2) the minor child and the payee are living in the same household, and

(3) the child support obligation established will be enforced by the IV-D agency; existing spousal support orders must be enforced even if the spousal support and child support are in separate orders.

C. Parental kidnapping and child custody cases: Federal and state parent locate services may be used to locate parents involved in parental kidnapping and custody cases pursuant to 42 USC 663 and 45 CFR 303.15. Any information obtained through the state or federal parent locate service shall be treated as confidential and shall be used solely for the purpose for which it was obtained and shall be safeguarded. A fee may be charged to cover the costs of processing requests for information. A separate fee may be charged to cover costs of searching for a social security number before processing a request for location information.

D. Mandatory and optional services: As a condition of eligibility, IV-A and IV-E applicants are mandated to receive full services, including medical support, and do not have the option to refuse any IV-D services. Medicaid only referrals that include an assignment of rights, including SSI referrals, are mandated to receive medical support services, but have the option of receiving full service. The custodial party must cooperate in establishing paternity and medical support. Non-IV-A, non-medicaid applicants may receive child support services, subject to service and the actual cost of fees.

[8.50.100.9 NMAC - Rp, 8.50.100.9 NMAC, 12/30/2010; A, 7/1/2019]

8.50.100.10 RESPONSIBILITY AND DELEGATION OF AUTHORITY: Pursuant to Section 27-2-27 et seq., NMSA 1978, the New Mexico health care authority's child support services division (CSSD) is the single and

separate organizational unit designated to administer Title IV-D of the Social Security Act. It is responsible and accountable for the operation of the child support enforcement program insuring that its functions are being carried out in accordance with the relevant federal and state laws and regulations.
[8.50.100.10 NMAC - Rp, 8.50.100.10 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.11 ATTORNEY REPRESENTATION: Per Subsection E of Section 27-2-27 et seq., NMSA 1978, the Title IV-D attorneys only represent the health care authority. There is no express or implied attorney-client relationship between IV-D attorneys and applicants or recipients of IV-D services. Although applicants and recipients of IV-D services may interact with IV-D attorneys regarding their cases, the interaction with the IV-D attorneys does not indicate any confidential relationship that the person would have with a private attorney. All IV-D applicants and recipients are on notice that information provided to the IV-D agency (either to IV-D staff or attorneys) will not be disclosed to the general public, but may be used to collect support from either parent. The IV-D agency reserves the right to invoke the attorney work product privilege as it pertains to its attorneys and their work for the IV-D agency.
[8.50.100.11 NMAC - Rp, 8.50.100.11 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.12 PRIVATE COUNSEL: Applicants for Title IV-D child support services may hire private legal counsel to represent their interests. The IV-D agency will cooperate with private attorneys, to the extent that such cooperation does not compromise the interests of the state. Applicants and their attorneys shall keep the IV-D agency fully informed of any private proceedings. If applicants or their legal representatives engage in conduct that is deemed to be non-cooperative, the case shall be eligible for closure. The IV-D agency is under no obligation to litigate any matters filed pro se by the custodial party or filed by a private attorney.
[8.50.100.12 NMAC - Rp, 8.50.100.13 NMAC, 12/30/2010]

8.50.100.13 CONFIDENTIALITY:

A. The Title IV-D agency has access to the entire Title IV-A case file and to material in the medicaid case file. Information contained in the Title IV-A and Title IV-D records is subject to federal and state confidentiality requirements. Federal and state law restrict the use or disclosure of information concerning applicants or recipients of program services to purposes directly connected with the administration of the Title IV-D program. No unauthorized use, dissemination or disclosure of information in the possession of the Title IV-D agency will be made or permitted. (See 42 USC 654 (a) (26) and 45 CFR 303.21). Department records are confidential and may not be released to third parties without a court order or as otherwise provided by federal or state law. Department records include, but are not limited to: address/locate information, audits, correspondence with other state agencies, payment records, distribution records, and employer information.

B. Unless authorized by federal law, no release of information concerning the whereabouts of persons subject to a protective order or about whom the state has reasonable evidence of domestic violence or child abuse shall be made.

C. A non-disclosure indicator will be entered on the child support enforcement system (CSES) and on the physical case file if a protective order or family violence affidavit is submitted. A court order for unsupervised visitation is not generally compatible with a non-disclosure indicator. A non-disclosure indicator will not be entered if a support order or divorce decree provides for unsupervised visitation, unless there is a specific court protective order.

D. The federal government may disclose confidential information on a New Mexico Title IV-D case in accordance with 42 USC 653.

E. All state and local staff and contractors who may have access to or be required to use confidential program data in the computerized support system will:

(1) be informed of applicable requirements and penalties, including those in section 6103 of the Internal Revenue Service Code (26 USC 6103);

(2) be adequately trained in security procedures; and

(3) be subject to have administrative penalties, including dismissal from employment, for unauthorized access to, disclosure, or use of confidential information.

F. The Title IV-D agency will redact personal identifying information to include social security numbers and dates of birth when releasing documents pursuant to a request for information, unless that information is being released pursuant to a specific program operation (i.e. court required information or administrative enforcement).
[8.50.100.13 NMAC - Rp, 8.50.100.14 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.14 AUTHORIZED RELEASE OF INFORMATION: Some information must be released to persons outside the agency. IV-D staff will exercise caution in releasing information on a Title IV-D case. Information should be released only after the identity of the requestor and the right to receive the information is clearly established. The burden of proving the legitimacy of a request is on the requestor.

A. Information may be released to the following parties:

(1) Applicants or recipients of Title IV-D services: Custodial and non-custodial parties of Title IV-D cases, their respective attorney of record, guardian, or power of attorney may obtain information concerning the receipt and distribution of payments, copies of legal documents filed in court on their case, public assistance benefits history, payment records, official notifications for a fee established by HCA, and correspondence from either the custodial or non-custodial party. They are not entitled to receive information that relates to the state's legal strategy or is otherwise protected by federal and state laws.

(2) Information may be released per the operational requirements of the program, subject to federal and state laws on confidentiality. Other agencies/requesters include, but are not limited to: district courts, credit reporting agencies, tax intercept programs, financial institutions, other Title IV agencies, medicaid agencies, authorized government agents (both federal and state authorized government agents must present adequate identification and permission from the individual concerned unless otherwise authorized to receive information), the federal office of child support enforcement and other state governmental bodies that are responsible for issuing licenses or holding money that is collectible by the Title IV-D agency.

(3) Congressional, executive or legislative inquiries - Congressional, executive and legislative inquiries are subject to all regulations governing confidentiality.

(4) Other individuals - Other individuals may obtain information through legal discovery procedures or from the custodial or non-custodial party.

B. Requests for information:

(1) Phone inquiries - Title IV-D staff will not release information on the telephone to anyone other than the custodial party, the non-custodial party, or their authorized representative. Requests by a third party for information must be submitted in writing.

(2) Written requests - Written requests for case information shall be screened by the Title IV-D agency to determine what information, if any, will be released.

(3) Walk-in requests - The same precautions applying to phone inquiries shall be used in dealing with walk-in requests for information. If uncertainty exists as to the identity of the requestor, the worker will ask to see identification before providing case information.

(4) Third party requests - The Title IV-D agency will not honor a request for information from a third party without a notarized release from either the custodial party or non-custodial party that specifies the information to be released. A third party may not obtain information pursuant to an authorized release unless the party consenting to the release is entitled to receive the information. The information provided will be in accordance with authorized releases according to federal and state law. The Title IV-D agency reserves the right to provide the requested information directly to either the custodial party or non-custodial party rather than the third party requestor or to redact personal or confidential information, as appropriate. An attorney of record for a custodial or non-custodial party is not considered a third party requestor.

[8.50.100.14 NMAC - Rp, 8.50.100.15 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.15 WRITTEN STATEMENTS OF COLLECTION PROVIDED TO RECIPIENTS OF IV-D SERVICES:

A. General written communication regarding collections: Upon a request from a recipient of Title IV-D services, the Title IV-D agency will make available a written statement, no more than twice a year, of payments made to the obligee by the obligor through the Title IV-D agency pursuant to an order for support, and the amount of any delinquency still owed to the obligee by the obligor.

B. Notice of collection of assigned support: The IV-D agency provides notice to recipients of benefits under Title IV-A of the Social Security Act of the amount of support payments collected for each quarter. No notice will be sent if:

(1) no collection is made in the quarter;

(2) the assignment is no longer in effect; and

(3) there are no assigned arrearages.

[8.50.100.15 NMAC - Rp, 8.50.100.16 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.16 CONTROLS AND REPORTING: The Title IV-D agency maintains records necessary for the proper and efficient operation of the state plan and for the reporting accountability required by the federal office of child support enforcement including records regarding the following:

A. application for support services available under the state plan;

B. location of non-custodial parties, action to establish paternity, and obtain and enforce support and the costs incurred in such action;

C. amount and sources of support collections and the distribution of these collections;

D. any fees charged or paid for support enforcement services;

E. administrative costs; and

F. statistical, fiscal, and other records necessary to the reporting required.

[8.50.100.16 NMAC - Rp, 8.50.100.18 NMAC, 12/30/2010; A, 1/1/2022]

8.50.100.17 CHANGE OF ADDRESS: The Title IV-D agency and its representatives must verify an individual's identity prior to changing the address and phone number in agency records. The failure of a custodial party or non-custodial party to maintain a valid address on file with the Title IV-D agency may result in one of the following, as appropriate for that party: further enforcement actions, closure of the Title IV-D case, or the surrender of support that has been determined to be unclaimed property pursuant to 8.50.132 NMAC.
[8.50.100.17 NMAC - N, 12/30/2010; A, 1/1/2022]

History of 8.50.100 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD SCEB 512.0000, Conditions Under Which Confidential Information May Be Released, 6/23/1980.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.100 NMAC, General Provisions, filed 5/14/2001 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 108 ESTABLISHMENT AND MODIFICATION OF SUPPORT ORDER

8.50.108.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.108.1 NMAC - Rp, 8.50.108.1 NMAC, 1/1/2024; A, 7/1/2024]

8.50.108.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of IV-D services.
[8.50.108.2 NMAC - Rp, 8.50.108.2 NMAC, 1/1/2024]

8.50.108.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.108.3 NMAC - Rp, 8.50.108.3 NMAC, 1/1/2024; A, 7/1/2024]

8.50.108.4 DURATION: Permanent.
[8.50.108.4 NMAC - Rp, 8.50.108.4 NMAC, 1/1/2024]

8.50.108.5 EFFECTIVE DATE: January 1, 2024, unless a later date is cited at the end of a section.
[8.50.108.5 NMAC - Rp, 8.50.108.5 NMAC, 1/1/2024]

8.50.108.6 OBJECTIVE: To provide regulations in accordance with federal and state law and regulations.
[8.50.108.6 NMAC - Rp, 8.50.108.6 NMAC, 1/1/2024]

8.50.108.7 DEFINITIONS: The following definition applies to this part. "Self-support reserve" means the support calculation ensures the payer parent has sufficient income to maintain a minimum standard of living. The self-support reserve is $1,200 per month for one person which is slightly higher than one hundred percent of the federal poverty guideline. Additional definitions may be found under the general provisions at 8.50.100.7 NMAC.
[8.50.108.7 NMAC - N, 1/1/2024]

8.50.108.8 ESTABLISHMENT OF SUPPORT ORDER: If parentage has been legally established, and there is no support order in existence, the IV-D agency will pursue the establishment of a support order, as appropriate, pursuant to the requirements under 45 CFR §303.4(b)(1-4). All support orders obtained by the IV-D agency shall include a provision requiring the parties to keep the IV-D agency informed of their current addresses and, if the party is a parent, to also provide the name and address of their current employer, whether the parent has access to medical insurance coverage at reasonable cost, including health care coverage through a public entity and, if so, the medical insurance policy information.

A. Immediate income withholding: The IV-D agency will request an income withholding provision in accordance with the Support Enforcement Act, Section 40-4A-1 et seq., NMSA 1978. The IV-D agency will not agree to an exception to wage withholding, but will honor any court or administrative order that waives or excepts wage withholding. All payments on Title IV-D cases, whether paid through income withholding, direct withdrawal, or direct payment by the non-custodial parent shall be paid through the IV-D agency. If the custodial party obtains an order in a IV-D case for direct payments to them, the IV-D agency will begin non-cooperation procedures in active IV-A cases and close cases with no public assistance history.

B. Persons and agencies the IV-D agency will assist to establish a support order:

(1) parent;
(2) legal guardian by court or administrative order;
(3) legal custodian by court or administrative order;
(4) IV-B or IV-E agency;
(5) another IV-D agency, state, U.S. territory or country pursuant to the Uniform Interstate Family Support Act, Section 40-6A-101 et seq., NMSA 1978, or reciprocal international agreements.

C. Public assistance: If a dependent child receives public assistance, the IV-D agency will pursue a support order against the non-custodial parent, unless the IV-D agency determines that the case involves rape, incest,

or it would not be in the best interest of the child(ren). If neither parent has custody of the child, the IV-D agency will pursue a support order against both parents. If the custodian of the child(ren) receiving public assistance does not have legal standing to pursue support, the IV-D agency will seek to establish a support order solely in favor of the state as reimbursement for public assistance benefits expended on behalf of the child(ren) in accordance with the child support guidelines.
[8.50.108.8 NMAC - Rp, 8.50.108.8 NMAC, 1/1/2024]

8.50.108.9 CHILD SUPPORT AWARD GUIDELINES: The IV-D agency uses income information provided to the agency by the parties or other sources to apply the child support guidelines in Section 40-4-11.1., NMSA 1978 and the basic child support schedule now incorporated here as Appendix 1. If exact income information is unavailable, or if a party's earnings history is below minimum wage, the IV-D agency may seek to impute income to a party, provided that the amount of support is established based on consideration of the required factors under 45 CFR §302.56(a-c). Many low wage jobs offer less than 40 hours per week, so local labor market data shall be considered when imputing income. A request for retroactive support by the IV-D agency will only be for the minimal period in accordance with New Mexico law. The custodial party may seek a longer retroactive period in accordance with the law and is solely responsible for providing all documentation, presenting all evidence, and making all arguments at any hearing or during negotiations in support for the additional time period. The amount of retroactive support requested by the IV-D agency on behalf of the state or for a custodial party will be in accordance with the child support guidelines established pursuant to 45 CFR Section302.56(f-h), or as otherwise stipulated to by the parties. Incarceration may not be treated as voluntary unemployment when a support order is being established, 45 CFR §302.56 (c)(3). Any deviations from the guidelines will contain a statement of the reason for deviation and shall be in accordance with Section 40-4-11.2 NMSA 1978.
[8.50.108.9 NMAC - Rp, 8.50.108.9 NMAC, 1/1/2024]

8.50.108.10 BASIC CHILD SUPPORT SCHEDULE AND THE SELF-SUPPORT RESERVE:

A. In any action to establish or modify child support, the child support guidelines schedule as set forth in this section shall be applied to determine the child support due and shall be a rebuttable presumption for the amount of such child support. The basic child support schedule is reviewed quadrennially by the child support guideline commission pursuant to Section 40-4-11.3 NMSA.

B. Effective January 1, 2024, the basic child support schedule incorporates a self-support reserve (SSR). The SSR is demonstrated in the shaded area of the basic child support schedule and provides that if the payer parent's income and number of children fall into the shaded area, only the payer-parent's income is considered in the child support calculation. As a result, the payer-parent is one hundred percent responsible for SSR adjusted child support obligation from the schedule. This ensures that the SSR is effective at considering basic subsistence needs of the payer-parent who has a limited ability to pay, even if the other parent has significantly more income and their combined income is above the SSR adjusted area of the schedule. Support calculation using the SSR method is reliant on using a worksheet A only and should not take into consideration childcare cost, medical expenses to include insurance premiums, and other appropriate expenses that are otherwise considered by the child support guidelines pursuant to Subparagraph (b) of Paragraph (2) of Subsection M of Section 40-4-11.1 NMSA, 1978.

C. For shared responsibility arrangements, the basic child support obligation shall be calculated using the basic child support schedule, worksheet B and instructions contained in Subsection M of Section 40-4-11.1 NMSA 1978. Support calculations using worksheet B are not subject to the SSR method.
[8.50.108.10 NMAC - N, 1/1/2024]

8.50.108.11 DEFAULT JUDGMENT: The IV-D agency may seek entry of a default order by the court or administrative authority according to state law and rules of procedure regarding default orders.
[8.50.108.10 NMAC - Rp, 8.50.108.10 NMAC, 1/1/2024]

8.50.108.12 MODIFICATION OF CHILD SUPPORT ORDERS: Either party may request the IV-D agency to provide the service of seeking the modification of a support order. Applicable fees will be charged to the requesting party in compliance with 8.50.125.10 NMAC. The IV-D agency may seek a modification if the non-custodial parent will be incarcerated for more than 180 calendar days. The IV-D agency will not review a support order for modification without request by a party, unless the custodial party is currently receiving public assistance. In accordance with federal and state laws, a modification of a support order is retroactive only to the time period that a petition or motion was filed with a court and was pending a decision.
[8.50.108.12 NMAC - Rp, 8.50.108.12 NMAC, 1/1/2024]

8.50.108.13 REVIEW AND ADJUSTMENT OF SUPPORT ORDERS: The IV-D agency conducts a review for modification of support orders in the IV-D caseload three years from the effective date of the last support order. At the time of review, if the case is actively receiving public assistance, the IV-D agency must pursue a modification either upward or downward if its review indicates that there will be at least a twenty percent change from the current obligation of support. The review is conducted based on information provided by the parties and other sources that report income. Both parties are sent notice at the time of review to request current information from them regarding income, childcare costs, medical expenses to include insurance premiums, and any other appropriate expenses that are considered by the child support guidelines. Both parties are notified of the result of the review conducted by the IV-D agency. If the IV-D agency chooses not to pursue a modification, any party may independently pursue their own request for a modification of a support order. The state may initiate a review of an order, without a specific request for review, if information is received by the IV-D agency that the non-custodial parent will be incarcerated for more than 180 calendar days, pursuant to the conditions specified in 45 CFR §303.8(b)(2), (7), and (c). Under 45 CFR §302.56 (c)(3), incarceration may not be treated as voluntary unemployment when a support order is being modified.
[8.50.108.13 NMAC - Rp, 8.50.108.13 NMAC, 1/1/2024]

8.50.108.14 PROVISION OF SERVICES TO IV-B AND IV-E PROGRAMS: Upon request for services from the state IV-B or IV-E program, the IV-D agency will review its caseload to determine if there is an active IV-D case. The IV-D agency will send a letter to both the custodial party and non-custodial parent(s) notifying them that the IV-B or IV-E agency has requested services due to the minor child(ren) being in state custody. If there is a current order of support in place, the IV-D agency will review the case for appropriate legal action. If there is not a current support order in place, the IV-D agency will work with the IV-B or IV-E agency to obtain a mutually agreed upon support order between the IV-B or IV-E agency and the IV-D agency.
[8.50.108.14 NMAC - Rp, 8.50.108.14 NMAC 1/1/2024]

8.50.108.15 FURNISHING CONSUMER REPORTS FOR CERTAIN PURPOSES RELATING TO CHILD SUPPORT: Section 604 of the Fair Credit Reporting Act (15 U.S.C. 1681b) authorizes the release of information contained in a non-custodial parent's credit report to the New Mexico IV-D agency. The information obtained from the consumer reporting agency is to be used solely for the purpose of establishing or modifying an order of support.
[8.50.108.11 NMAC - Rp, 8.50.108.11 NMAC, 1/1/2024]

History of 8.50.108 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, filed 6/23/1980.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, filed 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement, filed 12/30/94 - Repealed effective 5/31/2001.
8.50.108 NMAC, Establishment of Support Order, filed 5/14/2001 - Repealed effective 1/1/2010.
8.50.108 NMAC, Establishment of Support Order, filed 12/30/2009 - Repealed effective 1/1/2024.

Other History:
8.50.108 NMAC, Establishment of Support Order, filed 12/30/2009 - Replaced by 8.50.108 NMAC, Establishment of Support Order, effective 1/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 109 MEDICAL SUPPORT

8.50.109.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.50.109.1 NMAC - Rp, 8.50.109.1 NMAC 1/1/2024; A, 7/1/2024]

8.50.109.2 SCOPE: To the general public. For use by the Title IV-D agency and recipient of Title IV-D services.
[8.50.109.2 NMAC - Rp, 8.50.109.2 NMAC 1/1/2024]

8.50.109.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.109.3 NMAC - Rp, 8.50.109.3 NMAC 1/1/2024; A, 7/1/2024]

8.50.109.4 DURATION: Permanent.
[8.50.109.4 NMAC - Rp, 8.50.109.4 NMAC 1/1/2024]

8.50.109.5 EFFECTIVE DATE: January 1, 2024, unless a later date is cited at the end of a section.
[8.50.109.5 NMAC - Rp, 8.50.109.5 NMAC 1/1/2024]

8.50.109.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.109.6 NMAC - Rp, 8.50.109.6 NMAC 1/1/2024]

8.50.109.7 DEFINITIONS: The following definitions apply to this part. Additional definitions may be found under child support enforcement program general provisions at 8.50.100.7 NMAC.

A. "Cash medical support" means an amount ordered to be paid toward medical costs for minor child(ren) not covered by insurance.

B. "Health care coverage" means health insurance coverage, generally associated with a medical, dental or vision plan of benefits, whether it be an employment-related or other group health plan, a health maintenance organization, a non-profit health plan, coverage provided by a public entity (medicaid), or any other type of health care coverage under which medical, vison or dental services are provided, regardless of service delivery mechanism. Any health care plan coverage of a minor child shall, at a minimum, meet the standards of minimum health care protection as defined in the New Mexico Insurance Code, Section 59A-23B NMSA 1978.

C. "**Medical support"** means cash medical support, health care coverage, dental insurance, vision insurance, or a percentage split between the custodial party and the non-custodial parent for uncovered medical bills for the minor child(ren).

D. "National medical support notice" or "notice" means a qualified notice pursuant to a court order sent to an employer stating that an employee's children must be covered by the employment-related health care insurance plan if it is available and at a reasonable cost.
[8.50.109.7 NMAC - Rp, 8.50.109.7 NMAC 1/1/2024]

8.50.109.8 ESTABLISHMENT OF MEDICAL SUPPORT: All orders obtained by the IV-D agency must include a provision for medical support for the minor child(ren). For the purposes of the IV-D program reporting, medical support includes any one of the following: private health insurance, public health care coverage (health, dental, or vision), provided by a public entity (medicaid), coverage through Indian health services (IHS), the defense enrollment eligibility reporting services (DEERS), cash medical support, or a percentage split of uncovered medical expenses for the minor child(ren). Determination of a reasonable cash medical support obligation is pursuant to 45 CFR § 303.31(a)(3). If the child(ren) are covered by IHS, the IV-D agency will request that private care coverage or health care coverage provided by a public entity (medicaid) be provided by either or both parties, when available. If the non-custodial parent provides health care coverage and changes employment, and the new employer provides health care coverage, the IV-D agency must transfer notice of the provision to the new employer. The IV-D agency must request the inclusion of a medical support provision even when employment-related or other group health care

coverage is not available or when the child(ren) cannot be added at the time the order is entered. Health care coverage provided by a public entity meets the standards required under the Mandatory Medical Support Act and either party can be deemed a medical support obligor if they meet eligibility requirements for health care coverage through a public entity (medicaid). The cost of health care coverage is calculated by determining the amount charged to the medical support obligor for adding the minor child(ren) to the existing coverage, or the difference between individual and family coverage. The reasonableness of the cost of the health care coverage is if the cost to the party responsible for providing medical support does not exceed five percent of their gross income pursuant to 45 CFR §303.31(a)(b). The IV-D agency may request the provision of health care coverage by either or both the custodial party and the non-custodial parent and that the parties should be responsible for any uncovered medical expenses in proportion to their incomes on the current child support worksheet. If the court does not enter an order for medical support, the IV-D case record must specify that a provision for medical support was requested but was not issued, in accordance with 45 CFR §303.31(b)(1-4).
[8.50.109.8 NMAC - Rp, 8.50.109.8 NMAC 1/1/2024]

8.50.109.9 TIME FRAMES AND REQUIREMENTS: For all referral cases, within 90 calendar days of locating a non-custodial parent or of establishing parentage, a support order must be established or service of process must be completed to establish a support order. If service of process cannot be completed, then the case record must reflect unsuccessful attempts to serve process. If the court dismisses a petition for support order without prejudice, the office must, at the time of dismissal, examine the reasons for dismissal and determine when it could be appropriate to seek a support order in the future and seek a support order at that time.
[8.50.109.9 NMAC - Rp, 8.50.109.9 NMAC 1/1/2024]

8.50.109.10 AVAILABILITY OF MEDICAL CARE COVERAGE: Medical support will be addressed in actions to establish, enforce, or modify a support order for the minor child(ren). All support orders obtained or modified by the IV-D agency will include a provision requiring either or both custodial party and the non-custodial parent to promptly inform the IV-D agency of the name and address of their current employer(s), whether either the custodial party or the non-custodial parent has access to health care coverage and, if so, the health care coverage policy information.

A. The non-custodial parent may be required to provide immediate health, dental, or vision care coverage for the minor child(ren) if health care coverage is not available to the custodial party at a more reasonable cost than to the non-custodial parent for coverage of the minor child(ren); and it is available to the non-custodial parent through an employment-related or other group health insurance plan, regardless of service delivery mechanism, which may be a labor organization, union, non-profit organization or professional association.

B. If medical care coverage is not available to the non-custodial parent through an employment-related or other group health care coverage plan, and health care coverage is not being provided by the custodial party, the non-custodial parent may be required to provide immediate health insurance coverage for the minor child(ren) when it becomes available through an employment-related or other group health insurance plan.

C. Either the custodial party or the non-custodial parent may be deemed to be a medical support obligor based on the availability of health care coverage through a public entity when either party meets eligibility requirements.

D. Failure by a non-custodial parent to provide medical support for the minor child(ren), and to provide information concerning health care coverage, will subject the non-custodial parent to legal proceedings requiring the non-custodial parent to show cause as to why the non-custodial parent should not be held in contempt of court for failure to fulfill the requirements of the court order. This will be true even if medical support is the only area in which the non-custodial parent is not in compliance with the terms of the order.
[8.50.109.10 NMAC - Rp, 8.50.109.10 NMAC 1/1/2024]

8.50.109.11 PROVIDING CUSTODIAL PARTIES WITH HEALTH CARE COVERAGE INFORMATION: If the non-custodial parent is responsible for providing health care coverage, the IV-D agency will provide the custodial party with available health care coverage plan information when the non-custodial parent secures coverage for the minor child(ren). This includes any information available to the IV-D agency about the health care coverage plan that would permit a claim to be filed or services to be provided. In cases enforced by the national medical support notice, the health care coverage plan shall provide this information to the custodial party and the IV-D agency, as outlined on the notice.
[8.50.109.11 NMAC - Rp, 8.50.109.11 NMAC 1/1/2024]

8.50.109.12 MONITORING AND ENFORCING COVERAGE: In all cases in which there is a court order with no medical support ordered, the case will be reviewed pursuant to the IV-D agency's plan for automatic review of all IV-D cases every three years. Even if no other modification is expected, the IV-D agency must seek modification to include medical support, except in non-IV-A non-medicaid cases where the custodial party has not consented to the IV-D agency obtaining medical support. All remedies available for the collection and enforcement of child support apply to medical support. In cases where the non-custodial parent is required to provide health care coverage through an employment-related or other group health care coverage plan pursuant to a support order, the IV-D agency shall use, where appropriate, the national medical support notice to enforce the provisions of health care coverage for the minor child(ren).

A. The IV-D agency must use the notice, when appropriate, to notify employers of the provision for health care coverage of the minor child(ren). The IV-D agency must transfer the notice to the employer within two business days after the date of entry of an employee who is an obligor in an IV-D case in the state directory of new hires.

B. Employers must transfer the notice to the appropriate group health care coverage plan for which the minor child(ren) are eligible within 20 business days after the date of the notice.

C. Employers must withhold any obligation of the employee for employee contributions necessary for coverage of the minor child(ren) and send any amount withheld directly to the health care coverage plan. Employees may contest the withholding based on a mistake of fact. If the employee contests such withholding, the employer must proceed with withholding until such time as the employer receives notice from the IV-D agency that the contest is resolved.

D. Upon receipt of the national medical support notice, the employer shall enroll the medical support obligor's minor child(ren) in a qualified health care coverage plan as eligible dependents. Except as specifically outlined on the notice, the health care coverage plan shall not be required to provide benefits or eligibility for such benefits in addition to those provided under the terms of the plan immediately before receipt of the notice.

E. If the medical support obligor is enrolled in a qualified health care coverage plan, the minor child(ren) shall be enrolled in the same health care coverage plan in which the medical support obligor is enrolled. If the medical support obligor is not enrolled in a qualified health care coverage plan, the premiums charged for enrollment of the minor child(ren) only shall be the same as would be charged for enrollment of the medical support obligor only. If the medical support obligor is not enrolled in a qualified health care coverage plan and there is more than one health care coverage plan option available for enrollment of the minor child(ren), the employer shall notify the IV-D agency and the IV-D agency, in consultation with the custodial party, will select a qualified health care coverage plan option. If the custodial party does not notify the IV-D agency of the selected qualified health care coverage plan option within the timeframe required by the IV-D agency, the minor child(ren) shall be enrolled in the qualified health care coverage plan's default option, which is defined as the least costly health care coverage plan that conforms with the minimum health care protection as defined in the New Mexico Insurance Code, Section 59A-23B-1 et seq NMSA 1978.

F. The health care coverage plan must notify the IV-D agency of the status of health care coverage for the minor child(ren), as outlined on the notice, within 40 business days after the date of the notice. The plan shall also promptly notify the custodial party of the plan coverage and effective date, as outlined on the notice.

G. Employers must notify the IV-D agency promptly whenever the medical support obligor's employment is terminated, in the same manner as is required for income withholding cases.

H. The IV-D agency must promptly notify the employer when there is no longer a current order for medical support in effect for which the IV-D agency is responsible.

I. In instances in which a minor child is covered through a public entity, the medical support obligor is required to maintain the recertification of the health care coverage as long as the medical support obligor meets eligibility requirements.

[8.50.109.12 NMAC - Rp, 8.50.109.12 NMAC 1/1/2024]

8.50.109.13 MEDICAL SUPPORT PROVIDED BY THE CUSTODIAL PARTY: In cases where the custodial party has satisfactory medical care coverage for the minor child(ren), the amount expended by the custodial party for health care coverage will be taken into account pursuant to the New Mexico child support guidelines worksheet that will be attached to the order, if applicable. The IV-D agency will not enforce court ordered medical support against a custodial party.

[8.50.109.13 NMAC - Rp, 8.50.109.13 NMAC 1/1/2024]

8.50.109.14 COMMUNICATION WITH THE MEDICAL ASSISTANCE DIVISION: The IV-D agency is required to relay information regarding private health, dental, or vision care coverage to the medical assistance division. This information includes newly obtained coverage, changes in coverage, or coverage lapses. The IV-D agency must report to the medical assistance division any medical support payments made directly to the custodial party if there is an assignment of medical support pursuant to 42 CFR 433.146. The IV-D agency in cooperation with the medical assistance division will communicate to determine if there are any lapses in health care coverage for medicaid applicant/recipient.
[8.50.109.14 NMAC - Rp, 8.50.109.14 NMAC 1/1/2024]

8.50.109.15 ORDERING SPECIFIC DOLLAR AMOUNTS FOR MEDICAL SUPPORT: The support order should include a set amount and specify that the amount is designated for cash medical support as outlined in Section 40-4C-3 NMSA 1978. This amount should be in addition to and not in lieu of the non-custodial parent's obligation to pay a percentage of unreimbursed medical expenses. Either the custodial party or the non-custodial parent may request the court to order the provision of cash medical support. The IV-D agency will enforce a provision for cash medical support established or modified by any party so long as the support order designates a specific dollar amount to be paid in regular, equal installments (i.e., monthly, bi-weekly, weekly). If the order does not designate a specific dollar amount for medical support purposes, the IV-D agency is not required to collect the money.
[8.50.109.15 NMAC - Rp, 8.50.109.15 NMAC 1/1/2024]

8.50.109.16 DISTRIBUTION OF MEDICAL SUPPORT: The IV-D agency collects and distributes cash medical support and payments toward medical support judgments. Medical support shall be distributed directly to the custodial party when a court has ordered a cash medical support obligation in favor of the custodial party. The IV-D agency is not pursuing cash medical support on cases in which the minor child(ren) receive health care coverage through a public entity.
[8.50.109.16 NMAC - Rp, 8.50.109.16 NMAC 1/1/2024]

8.50.109.17 FEES: In IV-D cases being enforced for medical support pursuant to the requirements of the national medical support notice, an employer may not assess a fee for withholding or for sending to the health care coverage plan, the employee contributions necessary for health care coverage of the minor child(ren).
[8.50.109.17 NMAC - Rp, 8.50.109.17 NMAC 1/1/2024]

History of 8.50.109 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed 5/31/2001.
8.50.109 NMAC, Medical Support, filed 5/14/2001 - Repealed effective 1/1/2024.

Other History:
8.50.109 NMAC, Medical Support, filed 5/14/2001 - Replaced by 8.50.109 NMAC, Medical Support, effective 1/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 110 INCOME WITHHOLDING

8.50.110.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.110.1 NMAC - Rp, 8.50.110.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.110.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.
[8.50.110.2 NMAC - Rp, 8.50.110.2 NMAC, 12/30/2010; A, 1/1/2022]

8.50.110.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.110.3 NMAC - Rp, 8.50.110.3 NMAC, 12/30/2010; A, 1/1/2022; A 7/1/2024]

8.50.110.4 DURATION: Permanent.
[8.50.110.4 NMAC - Rp, 8.50.110.4 NMAC, 12/30/2010]

8.50.110.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.110.5 NMAC - Rp, 8.50.110.5 NMAC, 12/30/2010]

8.50.110.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.110.6 NMAC - Rp, 8.50.110.6 NMAC, 12/30/2010]

8.50.110.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.110.8 INCOME WITHHOLDING: State and federal laws require the Title IV-D agency to obtain an immediate income withholding in all Title IV-D cases.

A. The Title IV-D agency complies with 45 CFR § 303.100 by ensuring that payments for support, including lump sum payments, are made by immediate income wage withholding.

B. Although the Support Enforcement Act provides for a good cause exemption to immediate wage withholding and a procedure to avoid immediate income withholding, the Title IV-D agency will not stipulate or agree to such provisions. The party requesting to avoid wage withholding bears the burden of proof on this issue with the court.

(1) The Title IV-D agency will comply with any valid court or administrative order that prohibits wage withholding.

(2) If an obligor receives an exemption to wage withholding and later accrues a delinquency, the Title IV-D agency, in its discretion, may pursue wage withholding from the appropriate judicial or administrative authority.

(**3**) Wage withholding will commence immediately upon issuance of the notice of income withholding. The notice shall inform the obligor that he or she has 30 days from the date of the notice to contest or appeal the income withholding.

[8.50.110.8 NMAC – Rp, 12/30/2010; A, 7/1/2019; A, 1/1/2022]

8.50.110.9 TERMINATION OF INCOME WITHHOLDING: The Title IV-D agency will not terminate an income withholding once instituted, unless:

A. the support obligation terminates and all arrears are paid off; or

B. the court orders that income withholding cease; or

C. the Title IV-D agency closes its case pursuant to 8.50.129 NMAC.

[8.50.110.9 NMAC - Rp, 8.50.110.15 NMAC, 12/30/2010; A, 1/1/2022]

8.50.110.10 WITHHOLDING OF UNEMPLOYMENT COMPENSATION: A cooperative endeavor exists between the Title IV-D agency and the New Mexico department of workforce solutions for the withholding of unemployment benefits in those cases with an income withholding order pursuant to federal and state laws.
[8.50.110.10 NMAC - Rp, 8.50.110.16 NMAC, 12/30/2010; A, 1/1/2022]

8.50.110.11 WITHOLDING OF WORKMAN'S COMPENSATION: A cooperative endeavor exists between the Title IV-D agency and the New Mexico workers' compensation administration for the withholding of workman's compensation benefits in those cases with an income withholding order pursuant to federal and state laws.
[8.50.110.11 NMAC, 1/1/2022]

History of 8.50.110 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD CSEB 561.0000, Procedures for Enforcement, 6/23/1980.
ISD CSEB 564.0000, Collection by IRS, 6/23/1980.
ISD CSEB 564.0000, Collection by IRS, 3/7/1984.
ISD CSEB 565.0000, U.S. District Court Enforcement, 6/23/1980.
ISD CSEB 566.0000, Voluntary Wage Allotments of Federal Employees and Processing of Garnishment Orders for Child Support and/or Alimony, 11/3/1981.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.110 NMAC, Income Withholding, filed 5/14/2001 - Repealed effective 12/30/2010

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 111 GENERAL ENFORCEMENT OF SUPPORT OBLIGATIONS

8.50.111.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.111.1 NMAC - Rp, 8.50.111.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.111.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.
[8.50.111.2 NMAC - Rp, 8.50.111.2 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.111.3 NMAC - Rp, 8.50.111.3 NMAC, 12/30/2010; A, 1/1/2022; A, 7/1/2024]

8.50.111.4 DURATION: Permanent.
[8.50.111.4 NMAC - Rp, 8.50.111.4 NMAC, 12/30/2010]

8.50.111.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.111.5 NMAC - Rp, 8.50.111.5 NMAC, 12/30/2010]

8.50.111.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.111.6 NMAC - Rp, 8.50.111.6 NMAC, 12/30/2010]

8.50.111.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.111.8 GENERAL ENFORCEMENT OF SUPPORT OBLIGATIONS: The Title IV-D agency uses a variety of processes, both administrative and judicial, to enforce support obligations.
[8.50.111.8 NMAC - Rp, 8.50.111.8 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.9 PERSONS OWING OVERDUE SUPPORT: Pursuant to state and federal law, the Title IV-D agency may seek to obtain an order that requires the obligor to adhere to the support obligations or, if the person is not incapacitated, to participate in work activities. The Title IV-D agency does not charge a late fee for overdue support.
[8.50.111.9 NMAC - Rp, 8.50.111.9 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.10 INTEREST CALCULATIONS: The Title IV-D agency calculates interest in accordance with:

A. New Mexico law regarding the accrual of interest on support obligations is applied to New Mexico support orders; and

B. the interest rules of the issuing state (state that issued the order) apply when New Mexico registers a foreign support order; the initiating state (state requesting registration of a foreign support order) is responsible for providing an accurate audit to include interest, as appropriate.

[8.50.111.10 NMAC - Rp, 8.50.111.12 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.11 NON-DISCHARGEABILITY IN BANKRUPTCY: A debt of support is not released by a discharge in bankruptcy. (11 USC 523 (a)).
[8.50.111.11 NMAC - Rp, 8.50.111.15 NMAC, 12/30/2010]

8.50.111.12 CONTEMPT PROCEEDINGS: The Title IV-D agency will pursue contempt provisions when the non-custodial parent has a delinquency of at least three months, and there is sufficient evidence that the non-custodial parent has an ability to pay or otherwise comply with the order. If an obligor is found by a court to be in contempt of court, the Title IV-D agency may request the court issue a bench warrant for the arrest of the obligor.

Any bond requested by the Title IV-D agency in a bench warrant shall be a cash only bond to be paid to the Title IV-D agency and distributed in accordance with federal and state laws regarding distribution of support payments.

A. The Title IV-D agency will screen the case for information regarding the non-custodial parent's ability to pay or otherwise comply with the order.

B. The Title IV-D agency will provide the court with information regarding the non-custodial parent's ability to pay or otherwise comply with the order.

C. The Title IV-D agency will provide clear notice to the non-custodial parent that their ability to pay constitutes the critical question in the civil contempt action.

[8.50.111.12 NMAC - Rp, 8.50.111.16 NMAC, 12/30/2010: A, 1/1/2020; A, 1/1/2022]

8.50.111.13 GARNISHMENT: The Title IV-D agency may pursue garnishment of an obligor's wages to reduce his or her arrearage balance. A garnishment will not be pursued if there is currently a wage withholding in effect.

[8.50.111.13 NMAC - Rp, 8.50.111.17 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.14 LIENS: The Title IV-D agency has in effect and uses procedures for the imposition of liens against the real or personal property of an obligor who owes overdue support and who resides or owns property in New Mexico. Once a lien is secured, a release of lien will not be issued until there is a complete or partial satisfaction of the arrears, or upon agreement of the parties.

[8.50.111.14 NMAC - Rp, 8.50.111.18 NMAC, 12/30/2010]

8.50.111.15 POSTING OF BOND, GUARANTEE, OR OTHER SECURITY: The Title IV-D agency may request the court to order an obligor to secure the support payment by bond, guarantee, surety or other security deemed appropriate by the court.

[8.50.111.15 NMAC - Rp, 8.50.111.19 NMAC, 12/30/2010; A, 1/1/2022]

8.50.111.16 STATE OR FEDERAL CRIMINAL PROSECUTIONS: The Title IV-D agency will refer support obligors for state or federal criminal prosecution pursuant to state and federal law (See 18 USC 228 and Section 30-6-2 et seq., NMSA 1978). During the time a referral is being considered by or accepted by a state or federal agency for prosecution, the Title IV-D agency will suspend civil enforcement (court proceedings) unless otherwise instructed by the appropriate prosecutor's office. The Title IV-D agency will continue to administratively enforce the obligation.

[8.50.111.16 NMAC - Rp, 8.50.111.20 NMAC, 12/30/2010; A, 1/1/2022]

HISTORY OF 8.50.111 NMAC:

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

ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD CSEB 561.0000, Procedures for Enforcement, 6/23/1980.
ISD CSEB 564.0000, Collection by IRS, 6/23/1980.
ISD CSEB 564.0000, Collection by IRS, 3/7/1984.
ISD CSEB 565.0000, U.S. District Court Enforcement, 6/23/1980.
ISD CSEB 566.0000, Voluntary Wage Allotments of Federal Employees and Processing of Garnishment Orders for Child Support and/or Alimony, 11/3/1981.

NMAC History:

8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:

8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.111 NMAC, General Enforcement of Support Obligations, filed 5/14/2001 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 112 ADMINISTRATIVE ENFORCEMENT OF SUPPORT OBLIGATIONS

8.50.112.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.112.1 NMAC - Rp, 8.50.112.1 NMAC, 12/30/2010; A, 71/2024]

8.50.112.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.
[8.50.112.2 NMAC - Rp, 8.50.112.2 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et. seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.112.3 NMAC - Rp, 8.50.112.3 NMAC, 12/30/2010; A, 1/1/2022, A, 7/1/2024]

8.50.112.4 DURATION: Permanent.
[8.50.112.4 NMAC - Rp, 8.50.112.4 NMAC, 12/30/2010]

8.50.112.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.112.5 NMAC - Rp, 8.50.112.5 NMAC, 12/30/2010]

8.50.112.6 OBJECTIVE: To provide regulations in accordance with federal and state law and regulations.
[8.50.112.6 NMAC - Rp, 8.50.112.6 NMAC, 12/30/2010]

8.50.112.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.112.8 PARENTAL RESPONSIBILITY ACT (LICENSE SUSPENSION): The Title IV-D agency submits a certified list of support obligors who are 30 days or more delinquent on their monthly support obligation to the appropriate boards, commissions, courts, or agencies responsible for issuing drivers, professional, occupational, and recreational licenses as detailed in the Parental Responsibility Act, Sect. 40-5A-1 et seq., NMSA 1978.

A. Automated referral process: The Title IV-D agency provides a certified list of all obligors who meet the referral criteria to various state licensing boards. The licensing boards report back to the Title IV-D agency what action the board has taken in connection with the Parental Responsibility Act. The Title IV-D automated system will refer cases that meet the following criteria:

(1) the obligor is delinquent 30 days or more in payment of court ordered support;

(2) a notice has been sent to the obligor's last address of record with the Title IV-D agency notifying the obligor of the impending license suspension/revocation;

(3) there is no court order prohibiting the referral; and

(4) 30 calendar days have elapsed since the notice was sent to the obligor and no request for hearing was submitted by the obligor.

B. Administrative hearings are conducted by the licensing boards: If requested in writing by the licensing board, the Title IV-D agency will make available a witness to testify on the Title IV-D agency's behalf at an administrative hearing that may be held in connection with the Parental Responsibility Act.

C. Settlement:

(1) In all cases, the Title IV-D agency must make every effort to obtain lump sum payments to satisfy all arrearages, including prior judgments, current delinquency, and accrued interest.

(2) If an obligor has had their license suspended in multiple cases, the issuance of a certificate of compliance for one case will not release the license suspension(s) for obligor's other case(s). The obligor will have to make satisfactory arrangements for each case in order to be eligible for license reinstatement.

D. Arrears only cases: In an arrears only case, the monthly payment must be calculated using the current child support guidelines at Section 40-4-11.1 et seq., NMSA 1978, or a schedule that will fully pay the arrearages plus accumulated interest in 72 months or less.

E. Withdrawal of referral: If the obligor does not meet the minimum criteria for referral it will be withdrawn, and a certificate of compliance will be issued with a request to waive the reinstatement of fees.

F. Responsibilities of the obligor: The obligor must supply a valid mailing address for the processing of the certificate of compliance. The obligor may elect to have the certificate of compliance sent to their attorney of record, but must also provide the Title IV-D agency with a current, valid mailing address and physical address for the obligor.

[8.50.112.8 NMAC - Rp, 8.50.112.8 NMAC, 12/30/2010; A, 7/1/2019; A, 1/1/2022]

8.50.112.9 CONSUMER REPORTING AGENCIES (CREDIT BUREAUS):

A. The Title IV-D agency is required by federal and state law to report periodically to consumer reporting agencies the name of any obligor who is delinquent in the payment of support and the amount of the overdue support. The Title IV-D agency has procedures in place that ensure that overdue support is reported only:

(1) after the obligor has been afforded due process required under state law, including notice and a reasonable opportunity to contest the accuracy of such information;

(2) in cases where an appeal is made, after a determination by the administrative law judge that finds that the information is accurate and

(3) the information is reported only to an entity that has furnished satisfactory to the state that the entity is a legitimate consumer reporting agency.

B. At the request of a consumer reporting agency, and upon 30 day's advance notice to the obligor at the obligor's last known address of record with the Title IV-D agency, the HCA may release information regarding the delinquency of an obligor. The HCA may charge a reasonable fee to the consumer reporting agency, pursuant to Section 40-4A-15 et seq., NMSA 1978.

[8.50.112.9 NMAC - Rp, 8.50.112.9 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.10 FULL COLLECTION SERVICES BY THE SECRETARY OF THE TREASURY: Cases may be referred for full collection services after reasonable efforts have been made to collect the support through available mechanisms and these efforts have failed. When referring a case for full collection services by the Secretary of the Treasury, the Title IV-D agency shall comply with the provisions of 45 CFR § 303.71. The obligor has 30 days from the date of mailing of the notification of a referral for federal full collection to notify the Title IV-D agency that he or she contests the referral.

[8.50.112.10 NMAC - N, 1/1/2022]

8.50.112.11 COLLECTION OF PAST DUE SUPPORT BY FEDERAL TAX REFUND OFFSET: Federal tax refund offset is utilized to pay support arrearages, including child support, medical support, and spousal support. Cases meeting specific criteria are referred to the U.S. department of treasury's financial management service.

A. Criteria for federal income tax offset: A Title IV-D case may be referred for federal income tax offset, regardless of whether the child(ren) are emancipated, so long as there is a child support delinquency or arrearage. Title IV-D cases having spousal support delinquencies or arrearages will not be referred for federal income tax offset unless there is an ongoing child support obligation, delinquency, or arrearage. Title IV-D cases that are solely for processing payments will not be referred. Only Title IV-D cases that meet at least one of the criteria in 45 CFR § 303.72(a) are to be referred for federal income tax offset.

B. Periodic updates on referred obligors are sent by the Title IV-D agency to the treasury department. Those updates may result in modifications up or down on the balance due or deletions from the referral.

C. Joint return: The U. S. internal revenue service (IRS) will offset a refund from a joint income tax return to pay a past due support obligation if either tax filer is certified as being legally responsible for providing support. Complaints, questions, and forms (i.e., injured spouse claim and allocation) concerning joint refund cases can only be addressed by the IRS. If the obligor's spouse is not liable for the support debt, the IRS will issue a pro rata refund to the spouse (upon the filing of an IRS injured spouse claim and allocation form by the obligor's spouse) and the Title IV-D agency will be required to reimburse the IRS in the amount of the pro rata refund. The federal government will advise the Title IV-D agency of any adjustments to Title IV-D collections. The injured spouse may also agree to voluntarily release the claim of their portion of the joint refund to have it applied towards the child support obligation. This will result in an immediate distribution of the refund amount to the Title IV-D case. An

injured spouse may request the release form from the Title IV-D agency or may provide a notarized letter authorizing the release. The notarized letter shall set forth the injured spouse's name, the name of the obligor, and the obligor's CSSD case number(s).

D. Bankruptcy cases: The Title IV-D agency will review the non-custodial party's bankruptcy case to determine what action, if any, the Title IV-D agency should take.

E. Notification of federal income tax offset:

(1) Written advance notice is sent to inform an obligor that the amount of their past due support will be referred to the secretary of the U.S. treasury for collection by federal tax refund offset and that any amounts collected will be applied towards the obligor's child support obligation. The notice shall be sent to the obligor's last address of record with the Title IV-D agency and shall inform the obligor:

(a) of the right to contest the HSD's determination that past due support is owed;

(b) of the right to contest the amount of past due support;

(c) of the right to request an administrative review;

(d) of the procedures and time frame for requesting an administrative review;

(e) notice will be provided to any individual who filed a joint return with the obligor, advising of the process for requesting the obligor's share of the refund; and

(f) that the U.S. treasury will notify the obligor's spouse at the time of offset regarding steps to take to protect the share of the refund that may be payable to that spouse.

(2) At the time the offset occurs, the secretary of the U.S. treasury will notify the obligor that the offset has been made.

F. Contesting referral for federal offset: The obligor has 30 days from the date of mailing of the notification of a referral for federal tax intercept to notify the Title IV-D agency that he or she contests the referral. The notification issued by the Title IV-D agency provides the obligor with the address and telephone number to request a hearing to contest the referral.

(1) Upon receipt of an appeal request from the obligor, a notice is generated by the administrative law judge and sent to the obligor and the Title IV-D agency.

(2) The notice shall set forth the time and place of the administrative hearing. The hearing is conducted in accordance with 8.50.130 NMAC.

(3) If the appeal request concerns a joint tax refund that has not yet been intercepted, the obligor is informed that the secretary of the U.S. treasury will notify the obligor's spouse at the time of offset regarding steps to take to secure their proper share of the refund.

(4) If the appeal concerns a joint tax refund which has already been offset, the obligor will be referred to the secretary of the U.S. treasury to address the refund due to the obligor's spouse.

(5) If the hearing decision results in a deletion or decrease in the amount referred for offset, the federal office of child support enforcement will be notified.

(6) If an amount which has already been offset is found to have exceeded the amount of past due support owed, steps to refund the excess amount to the obligor will be promptly taken.

G. Interstate cases: The following applies to the New Mexico Title IV-D agency when it is the state that submits a case for federal income tax offset. The obligor shall request an administrative review be conducted by the New Mexico Title IV-D agency. If the underlying order upon which the referral for federal income tax offset is based has not been issued by a New Mexico district court, within 10 days of the receipt of the obligor's request for administrative review, the New Mexico Title IV-D agency must notify the Title IV-D agency in the state that referred the case to New Mexico of the obligor's request for administrative review. Within 45 days of receipt of the request for administrative review from the New Mexico Title IV-D agency, the Title IV-D agency in the state that referred the case to New Mexico should:

(1) Send notice to all appropriate parties setting forth the time and place of the administrative review; and

(2) Conduct the review and render a decision. If the administrative review conducted by the Title IV-D agency in the other state results in a reduction or elimination of the amount referred for offset, the Title IV-D agency that conducted the administrative review should inform the New Mexico Title IV-D agency and the OCSE of the decision. The New Mexico Title IV-D agency shall be bound by the determination of the Title IV-D agency in the state that conducted the review.

H. Distribution of collections from federal income tax offset: Single filer federal tax refund offsets will be placed on hold for 30 days and joint filer federal tax refund offsets will be split in half and the obligor's portion will be placed on hold for 30 days and the injured spouse's portion will be placed on hold for six months. Past-due support amounts collected as a result of the federal income tax refund offset shall be distributed pursuant to

8.50.125.12 NMAC after the appropriate holds have elapsed. The obligor shall receive full credit for the entire amount of tax intercept that is applied to their case(s), including fees. Distribution of tax intercept money for obligors with multiple Title IV-D cases shall be in accordance with federal and state laws. If an offset is made to satisfy non-TANF past due support from a refund based upon a joint return, the Title IV-D agency may delay distribution until notified that the injured spouse's proper share of the refund has been paid or for a period not to exceed six months from notification of offset, whichever is shorter.

I. Fees: A non-TANF custodial party who has applied for Title IV-D services is assessed fees for the federal income tax refund. The fees are deducted from the tax refund when it is intercepted but are credited to the obligor's support payment.

[8.50.112.10 NMAC - Rp, 8.50.112.10 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.12 COLLECTION OF PAST DUE SUPPORT BY NEW MEXICO TAXATION AND REVENUE DEPARTMENT BY STATE TAX REFUND OFFSET: New Mexico law allows for the interception (offset) of an obligor's tax refund to pay child support.

A. Criteria for state income tax offset: Cases submitted for tax refund offset to the New Mexico taxation and revenue department (TRD) must meet federal tax refund offset criteria. In interstate cases, if New Mexico is the responding state, obligors are referred to TRD only, not to IRS.

B. Pre-offset notices/final notices: Within 10 days after receiving notification of an offset from TRD, the Title IV-D agency will send a notice to the obligor at their last known address of record with the Title IV-D agency. The notice will include:

(1) a statement that an offset will be made and that the Title IV-D agency intends to apply the amount of the offset against a claimed debt;

(2) the amount of the debt asserted;

(3) the name, address, and telephone number of the Title IV-D agency to request a hearing;

(4) the amount of refund to be offset against the debt asserted;

(5) a statement that the obligor has 30 days from the date indicated on the notice to contest the offset and request a hearing; and

(6) a statement that failure of the obligor to request a hearing within 30 days will be deemed a waiver of the opportunity to contest the offset.

C. If the refund against which a debt is intended to be offset results from a joint return, within 10 days after receiving the notification from TRD, the Title IV-D agency will send a notice to the obligor's spouse (injured spouse) as identified on the return, to the obligor's last known address of record with the Title IV-D agency. The notice to the injured spouse will contain the following information:

(1) a statement that an offset may be made and the Title IV-D agency intends to apply the amount of the offset against a claimed debt;

(2) the total amount of the refund and the amount of each claimed debt;

(3) the name, address, and telephone number of the Title IV-D agency;

(4) a statement that no debt is claimed against the injured spouse and that the he or she may be entitled to receive all or part of the refund, regardless of the claimed debt against the obligor;

(5) a statement that to assert a claim to all or part of the refund, the injured spouse must notify the Title IV-D agency within 30 days from the date indicated on the notice of the injured spouse's intention to seek their portion of the refund; and

(6) a statement that failure of the injured spouse to notify the Title IV-D agency regarding their claim to all or part of the refund within 30 days may be deemed a waiver of any claim.

D. Upon the transfer of money from TRD to the Title IV-D account, the Title IV-D agency will notify the obligor of the final determination of the offset. The notice includes:

(1) the amount of the TRD refund to which the obligor was entitled prior to intercept;

(2) the offset amount and balance, if any, of the debt still due; and

(3) the amount of refund in excess of the debt due and owed to the obligor, if any.

E. Contesting referral for state tax offset: The appeal procedures are the same as for federal tax refund offset with some exceptions.

(1) When the injured spouse contacts the Title IV-D agency within the time required, no tax intercept hearing is held. Upon verification, the injured spouse's portion will be refunded as soon as the TRD money is posted to the case, and the obligor will not be given credit for the injured spouse's portion of the payment that is refunded.

(2) If the obligor's spouse files "married, but separated" the state taxation and revenue department does not honor this filing status for offset purposes and will offset the obligor's spouse's refund. In this instance, the injured spouse may contact the Title IV-D agency. Upon notification, the Title IV-D tax intercept unit will contact TRD to obtain verification and, upon obtaining verification, the Title IV-D agency will refund the spouse's portion of the offset to the injured spouse.

(3) If the injured spouse determines that he or she is entitled to more than one-half of the offset, he or she must notify the Title IV-D agency within 30 days of the date of mailing of the notice of offset that he or she wants an administrative hearing regarding the claim to a larger portion of the offset.

F. Distribution of collections from state income tax offset: State income tax offset collections will be placed on hold for 30 days. After the 30 day hold, the state income tax offset monies will be applied as a regular payment and distributed as outlined in 8.50.125.11 NMAC. The obligor shall receive full credit for the entire amount of tax intercept that is applied to their case(s) including fees. Distribution of tax intercept money for obligors with multiple Title IV-D cases shall be in accordance with federal and state laws. If an offset is made to satisfy non-TANF past due support from a refund based upon a joint return, the Title IV-D agency may delay distribution of the injured spouse's share until notified that the refund has been paid because of the injured spouse signed a release, or for a period not to exceed six months from notification of offset, whichever is shorter.
[8.50.112.11 NMAC - Rp, 8.50.112.11 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.13 DENIAL OF PASSPORTS FOR NONPAYMENT OF CHILD SUPPORT:

A. Referral for passport denial: The Title IV-D agency submits the names of obligors who owe support arrears in excess of $2,500 for inclusion in the OCSE database which is then sent to the U.S. department of state. The U. S. department of state denies passports to individuals whose name appears on the certified OCSE database of the OSCE as owing more than $2,500 in arrears. Once the department of state identifies a passport applicant as owing money for child support, the applicant will be notified by letter that the issuance or renewal of the passport has been denied, pending satisfactory payment of money owed to the Title IV-D agency. After the applicant makes satisfactory payment arrangements with the Title IV-D agency, the IV-D agency shall request that OCSE remove the applicant's name from its database. The Title IV-D agency makes every effort in its negotiations to obtain a lump sum payment sufficient to satisfy the entire delinquency and arrears balances, including accrued interest.

B. Contesting referral for passport denial: The obligor has 30 days from the date of the notification of a referral for passport denial to notify the Title IV-D agency that he or she contests the referral. The notification sent to the obligor provides the address and telephone number for the obligor to contact the Title IV-D agency to request a hearing to appeal the referral.

(1) Upon receipt of an appeal request from the obligor, a notice is generated by the administrative law judge and sent to the obligor and the Title IV-D agency.

(2) The notice shall set forth the time and place of the administrative hearing. The hearing is conducted in accordance with 8.50.130 NMAC.

(3) If the case is a non-IV-A case, the Title IV-D agency shall send a copy of the notice to the custodial party.
[8.50.112.13 NMAC - Rp, 8.50.112.13 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.14 LOTTERY: The Title IV-D agency and the lottery commission work cooperatively to intercept lottery winnings for debts collected by the Title IV-D agency.

A. State law authorizes the Title IV-D agency to place a lien on lottery winnings owed by delinquent child support obligors. Lists of delinquent obligors are provided by the Title IV-D agency to the lottery commission who then compares the list with lottery winners claiming prizes of more than $600. The lottery commission then notifies the Title IV-D agency of any matches. The Title IV-D agency must provide the lottery commission with verification of the support lien within five business days. The verification of the support lien will include a notice of administrative lien requesting the lottery commission retain the funds for 90 days or until such time the administrative process is completed, so long as the process is completed within 90 days. If no delinquency exists, the notification will be a release of lien.

B. If the lottery winner is verified by the Title IV-D agency as owing a debt collected by the agency, the Title IV-D agency has 90 days to initiate an administrative action against the winner. The Title IV-D agency will notify the winner by mailing a copy of the notice of administrative lien to the obligor at the last known address of record with the Title IV-D agency via registered mail. The notice of administrative lien will notify the obligor that he or she has 15 days from the date of the notice to contest or appeal the administrative lien. The notification

sent to the obligor provides the address and telephone number for the obligor to contact the Title IV-D agency to request a hearing to appeal the referral. If the obligor does not contest the notice of administrative lien within the required timeframe, a notice for release of funds to the Title IV-D agency is mailed to the lottery commission instructing it to forward the lottery winnings to the Title IV-D agency. If the obligor contests the notice of administrative lien and timely requests a hearing, an administrative hearing will be conducted in accordance with 8.50.130 NMAC.

C. If an administrative seizure proceeding is not initiated with the 90-day period, the Lottery Commission shall release the prize payment to the winner. Section 6-24-22 et seq., NMSA 1978.

[8.50.112.14 NMAC - Rp, 8.50.112.14 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.15 GAMING: The Title IV-D agency and the gaming board work cooperatively to intercept racetrack or gaming machine payouts for debts collected by the Title IV-D agency.

A. State law authorizes the Title IV-D agency to place a lien on delinquent obligor's gaming machine payout. Lists of delinquent obligors are provided by the Title IV-D agency to the gaming control board on a monthly basis. The racetrack licensees research the names of winners of $1,200 or more per payout against the list provided to the gaming control board by the Title IV-D agency. The racetrack licensee then notifies the Title IV-D agency of any matches. The Title IV-D agency must notify the racetrack licensee within seven business days (excluding weekends and state holidays) and provide verification of the support lien. If no delinquency exists, the Title IV-D agency will notify the racetrack licensee with a release of lien. If a delinquency exits, the verification of the support lien shall include a notice of administrative lien requesting the racetrack licensee to retain the gaming machine payout for 90 days or until such time as the administrative process is completed, so long as the process is completed within 90 days.

B. If the gaming machine winner is an obligor verified by the Title IV-D agency as owing a debt to or collected by the Title IV-D agency, the Title IV-D agency has 90 days to complete an administrative action against the winner, unless the winner agrees to an extension of the time or the administrative law judge extends the time. The Title IV-D agency shall notify the winner by mailing a copy of the notice of administrative lien to the obligor at the last known address of record with the Title IV-D agency via registered mail. The notice of administrative lien shall notify the obligor that the obligor has 15 days from the date of the receipt of the notice to contest or appeal the administrative lien. The notification sent to the obligor provides the address and telephone number to contact the Title IV-D agency to request an appeal. If the obligor does not contest the notice of administrative lien within the required timeframe, a notice for release of funds is mailed to the racetrack licensee within five business days after the expiration of the obligor's deadline to request a timely hearing, instructing the racetrack licensee to forward the gaming machine payout to the Title IV-D agency. If the obligor contests the notice of administrative lien and timely requests a hearing, an administrative hearing will be conducted in accordance with 8.50.130 NMAC. The Title IV-D agency shall notify the racetrack licensee within five business days of the ruling of any hearing held in accordance with this section.

[8.50.112.15 NMAC - Rp, 8.50.112.15 NMAC, 12/30/2010; A, 1/1/2022]

8.50.112.16 ADMINISTRATIVE OFFSET BY THE SECRETARY OF THE TREASURY:

A. Referral for administrative offset: federal administrative offset is utilized for payment of support arrearages, including child support, medical support, and, if appropriate, spousal support. Cases meeting specific criteria are referred to the U.S. department of treasury's financial management service. When referring a case for administrative offset by the secretary of the treasury, the Title IV-D agency shall comply with the provisions of 31 CFR § 285.1.

B. Notification of administrative offset: Prior to submitting a referral, written advance notice is sent to the obligor to inform the obligor that due to the amount of the obligor's past due support the obligor will be referred to the secretary of the U.S. treasury for collection by administrative offset. The notice shall be sent to the obligor's last address of record with the Title IV-D agency. The Title IV-D agency shall inform the obligor:

(1) of the right to contest the HCA's determination that past due support is owed;

(2) of the right to contest the amount of the past due support;

(3) of the right to request an administrative review 30 days from the date of the notification; and

(4) of the procedures for requesting an administrative review.

C. Contesting referral for administrative offset: The obligor has 30 days from the date of notification of a referral for administrative offset to notify the IV-D agency that he or she contests the referral. The notification

issued by the IV-D agency shall provide the address and telephone number for the obligor to request a hearing to contest the referral.

(1) Upon receipt of an appeal request from the obligor, a notice is generated by the administrative law judge and sent to the obligor and the Title IV-D agency.

(2) The notice shall set forth the time and place of the administrative hearing. The hearing is conducted in accordance with 8.50.130 NMAC.

[8.50.112.16 NMAC - N, 7/1/2019; A, 1/1/2022]

History of 8.50.112 NMAC:

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

ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD CSEB 561.0000, Procedures for Enforcement, 6/23/1980.
ISD CSEB 564.0000, Collection by IRS, 6/23/1980.
ISD CSEB 564.0000, Collection by IRS, 3/7/1984.
ISD CSEB 565.0000, U.S. District Court Enforcement, 6/23/1980.
ISD CSEB 566.0000, Voluntary Wage Allotments of Federal Employees and Processing of Garnishment Orders for Child Support and/or Alimony, 11/3/1981.

NMAC History:

8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:

8 NMAC 5.CSE, Child Support Enforcement - Repealed 5/31/2001.
8.50.112 NMAC, Administrative Enforcement of Support Obligations, filed 5/14/2001 - Repealed effective 11/13/2009.
8.50.112 NMAC, Administrative Enforcement of Support Obligations, filed 11/2/2009 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 113 ENFORCEMENT OF SUPPORT OBLIGATIONS FROM FEDERAL EMPLOYEES INCLUDING MEMBERS OF THE ARMED SERVICES

8.50.113.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.113.1 NMAC - Rp, 8.50.113.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.113.2 SCOPE: To the general public. For use by the IV-D agency and recipients of IV-D services.
[8.50.113.2 NMAC - Rp, 8.50.113.2 NMAC, 12/30/2010]

8.50.113.3 STATUTORY AUTHORITY: Public Assistance Act, NMSA 1978, Section 27-2-27. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.113. 3 NMAC - Rp, 8.50.113.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.113.4 DURATION: Permanent.
[8.50.113.4 NMAC - Rp, 8.50.113.4 NMAC, 12/30/2010]

8.50.113.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.113.5 NMAC - Rp, 8.50.113.5 NMAC, 12/30/2010]

8.50.113.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.113.6 NMAC - Rp, 8.50.113.6 NMAC, 12/30/2010]

8.50.113.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.113.8 AUTHORITY TO COLLECT SUPPORT FROM FEDERAL EMPLOYEES INCLUDING MEMBERS OF THE ARMED SERVICES: In accordance with federal regulations, the IV-D agency may secure and enforce support obligations from federal employees and members of the armed forces through income withholding, garnishment, and similar proceedings. Monetary amounts due from, or payable by, the United States or the District of Columbia for employment (including any agency, subdivision, or instrumentality thereof) to any individual, including members of the armed forces of the United States, will be subject, in like manner and to the same extent as if the United States or the District of Columbia were a private person, to withholding in accordance with state law, and to any other legal process brought by the IV-D agency to enforce the legal obligation of the individual to provide child support, medical support, or spousal support. (42 USC 659).

A. Requirements applicable to private person: With respect to notices to withhold income or any other order or process to enforce support obligations against an individual, (if the order or process contains or is accompanied by sufficient data to permit prompt identification of the individual and the amounts involved), each governmental entity specified above will be subject to the same requirements as would apply if the entity were a private person.

B. Notice of process: The IV-D agency shall send or serve notice to withhold income for an individual's child support, medical support, or spousal support payment obligation to the duly designated federal agent.

C. Priority of claims: If a governmental entity specified above receives notice or is served with process, as provided in this section, concerning amounts owed by an individual to more than one person, then federal law shall control the determination of the priority of competing claims.

D. No requirement to vary pay cycles: A governmental entity that is affected by legal process served for the enforcement of an individual's child support or spousal support payment obligations is not required to vary its normal pay and disbursement cycle in order to comply with the legal process.

E. Federal payments subject to process: Monetary amounts paid or payable to an individual that are considered to be based upon remuneration for employment consist of:

(1) compensation payable for personal services of the individual, whether the compensation is denominated as wages, salary, commission, bonus, pay, allowances, or otherwise (including severance pay, sick pay, and incentive pay);

(2) periodic benefits or other payments:

(a) under the insurance system established by Chapter 7, Subchapter II of the United States Code - (federal old-age, survivors, and disability insurance benefits);

(b) under any other system or fund established by the United States that provides for the payment of pensions, retirement or retired pay, annuities, dependents' or survivors' benefits, or similar amounts payable on account of personal services performed by the individual or any other individual;

(c) as compensation for death under any federal program;

(d) under any federal program established to provide "black lung" benefits; or

(e) by the secretary of veterans affairs as compensation for a service-connected disability paid by the secretary to a former member of the armed forces who is in receipt of retired or retainer pay if the former member has waived a portion of the retired or retainer pay in order to receive such compensation;

(3) worker's compensation benefits paid or payable under federal or state law; and

(4) benefits paid or payable under the railroad retirement system.

F. Federal payments not subject to process: Monetary amounts that are not considered to be based upon remuneration for employment consist of:

(1) payments by way of reimbursement or otherwise, to defray expenses incurred by the individual in carrying out duties associated with the employment of the individual; or

(2) payments made as allowances for members of the uniformed services as necessary for the efficient performance of duty.

[8.50.113.8 NMAC - Rp, 8.50.113.8 NMAC, 12/30/2010]

8.50.113.9 ENFORCEMENT OF CHILD SUPPORT OBLIGATIONS OF MEMBERS OF THE ARMED FORCES THROUGH INVOLUNTARY ALLOTMENTS:

A. In any case in which support payments are owed by a member of one of the uniformed services on active duty, such member may elect to satisfy the obligation by making allotments from their pay and allowances as payment of such support. In addition, in the event a member of the uniformed services who owes a duty of support accrues a delinquency equal to two months' obligation or more, a notice of said delinquency may be issued by the IV-D agency to the designated official in the appropriate uniformed service. A copy of the notice of delinquency shall also be provided to the service member. The issuance of said notice will compel the creation of an allotment to satisfy the service member's obligation. The amount of the allotment will be the amount necessary to comply with the order which, if the order so provides, may include arrearages as well as amounts for current support; however, the amount of the allotment, together with any other amounts withheld for support from the wages of the member, as a percentage of their pay from the uniformed service, will not exceed the limits prescribed in sections 1673(b) and (c) of Title 15, Chapter 41, Subchapter II of the United States Code. An allotment under this subsection will be adjusted or discontinued upon notice from the authorized person. Payments made by allotment will be sent to the IV-D agency for disbursement.

B. Regulations: The secretary of defense has issued regulations applicable to allotments to be made under this section, designating the officials to whom notice of failure to make support payments, or notice to discontinue or adjust an allotment, should be given, prescribing the form and content of the notice and specifying any other rules necessary for such secretary to implement this section.

C. Availability of locator information: The IV-D agency uses the United State's secretary of defense's centralized personnel locator service that includes the address of each member of the armed forces. Except as provided below, the address for a member of the armed forces shown in the locator service will be the residential address of that member. The address for a member of the armed forces shown in the locator service will be the duty address of that member in the case of a member:

(1) who is permanently assigned overseas, to a vessel, or to a routinely deployable unit; or

(2) with respect to whom the secretary concerned makes a determination that the member's residential address should not be disclosed due to national security or safety concerns.

[8.50.113.9 NMAC - Rp, 8 50.113.9 NMAC, 12/30/2010]

8.50.113.10 PAYMENT OF MILITARY RETIRED PAY IN COMPLIANCE WITH SUPPORT ORDERS:

A. Payments consistent with assignments of rights to states: In the case of a spouse or former spouse who assigns to the IV-D agency the rights of the spouse or former spouse to receive support, the secretary concerned may make the support payments to the IV-D agency in amounts consistent with that assignment of rights.

B. Arrearages owed by members of the uniformed services: In the case of a court order that is effectively served on the secretary of defense and that provides for payments from the disposable retired pay of a member to satisfy the amount of support set forth in the order, the authority to make payments from the disposable retired pay of a member to satisfy the amount of support set forth in a court order will apply to payment of any amount of support arrearages set forth in that order, as well as to amounts of support that currently become due.

[8.50.113.10 NMAC - Rp, 8.50.113.10 NMAC, 12/30/2010]

History of 8.50.113 NMAC:

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

ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.

NMAC History:

8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:

8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.

8.50.113 NMAC, Enforcement of Support Obligations From Federal Employees Including Members of the Armed Services, filed 5/14/2001 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 114 FINANCIAL INSTITUTION DATA MATCH (FIDM)

8.50.114.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.114.1 NMAC - Rp, 8.50.114.1 NMAC, 12/30/2010; A,7/1/2024]

8.50.114.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.
[8.50.114.2 NMAC - Rp, 8.50.114.2 NMAC, 12/30/2010; A, 1/1/2022]

8.50.114.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.114.3 NMAC - Rp, 8.50.114.3 NMAC, 12/30/2010; A, 1/1/2022; A,7/1/2024]

8.50.114.4 DURATION: Permanent.
[8.50.114.4 NMAC - Rp, 8.50.114.4 NMAC, 12/30/2010]

8.50.114.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.114.5 NMAC - Rp, 8.50.114.5 NMAC, 12/30/2010]

8.50.114.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.114.6 NMAC - Rp, 8.50.114.6 NMAC, 12/30/2010]

8.50.114.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.114.8 AGREEMENTS WITH FINANCIAL INSTITUTIONS: The HCA, through the Title IV-D agency, has developed procedures and forms by which it enters into agreements with financial institutions doing business in the state to develop and operate, in coordination with such financial institutions, a data match system for the purpose of identifying and seizing assets to satisfy past-due support. All references to the Title IV-D agency below are on behalf of the HCA.

A. Data match agreements: The Title IV-D agency has agreements with financial institutions for data match using a standard Title IV-D agency form. The institutions may elect to report through an agent.

B. Election of reporting methods: Financial institutions shall elect their method of reporting using forms provided by the Title IV-D agency and return reporting agreements to the Title IV-D agency within 30 days of notification of required reporting. Acceptable methods of reporting are contained in the federal office of child support enforcement's data match specification handbook (DMSH). The financial institution may elect to report through an agent authorized and identified to the Title IV-D agency by the financial institution.

C. Quarterly matches: Financial institutions shall conduct quarterly matches of their accounts against the names and social security numbers provided by the Title IV-D agency and report all accounts matched, or may elect to provide a quarterly list of all accounts in a format acceptable to the Title IV-D agency. Each calendar year, information matches shall be furnished no later than:

(1) March 31 (first quarter);
(2) June 30 (second quarter);
(3) September 30 (third quarter); and
(4) December 31 (fourth quarter).

D. Failure to report: Financial institutions failing to perform a quarterly match, return the reporting election forms, or furnish account information are subject to the penalties in 8.50.131 NMAC. If the financial institution is unable to perform a quarterly match due to circumstances outside of its control, it should immediately notify the Title IV-D agency to request an extension of time. If the Title IV-D agency grants an extension, a penalty shall not be assessed against the financial institution.

E. False statements: If false statements are used to obtain a release, penalties will be assessed as set forth in 8.50.131 NMAC.
[8.50.114.8 NMAC - Rp, 8.50.114.8 NMAC, 12/30/2010; A, 1/1/2022]

8.50.114.9 FREEZE ORDER:
A. An obligor who has been on wage withholding for at least six months or who has made all payments (voluntary) for the last 12 months is exempt from this process.
B. Issuance and effect: When a match occurs showing the existence of an obligor's assets in an amount of more than $2,000, the Title IV-D agency may issue an administrative freeze order to the financial institution. Account funds shall not be released by the financial institution during the pendency of proceedings involving a freeze order. The financial institution shall send a copy of the notice of lien to the obligor and to all persons listed on the account by certified mail within three business days after the notice of lien is received by the financial institution. The institution shall reply within 10 days on the form provided by the Title IV-D agency.
C. Right to appeal: The notice of lien shall notify the obligor that the obligor has 15 days from the date of the notice to contest or appeal the freeze.
[8.50.114.9 NMAC - Rp, 8.50.114.9 NMAC, 12/30/2010; A, 1/1/2022]

8.50.114.10 SEIZE ORDER:
A. Seizure: If no written appeal is received within the time frame for appeal, or if an appeal is not upheld, a seize order will be issued by the Title IV-D agency. The financial institution must transfer the assets to the Title IV-D agency within three working days of the receipt of the seize order.
B. Appeals: If an appeal is received, it will be processed in accordance with the appeals process set forth in 8.50.130 NMAC.
[8.50.114.10 NMAC - Rp, 8.50.114.10 NMAC, 12/30/2010; A, 1/1/2022]

8.50.114.11 INTERSTATE FIDM ORDERS: A freeze or seize order issued by another state's Title IV-D agency will be treated as if it were issued by New Mexico's Title IV-D agency. Any institution failing to honor the order will be subject to all fines and penalties as if the institution had failed to honor an order of New Mexico's Title IV-D agency.
[8.50.114.11 NMAC - Rp, 8.50.114.11 NMAC, 12/30/2010]

8.50.114.12 SEIZED ASSETS: Assets seized from accounts will be distributed according to the Title IV-D agency distribution rules.
[8.50.114.12 NMAC - Rp, 8.50.114.12 NMAC, 12/30/2010; A, 1/1/2022]

8.50.114.13 DISTRIBUTION OF FIDM COLLECTIONS IN MULTIPLE CASES: FIDM collections will always be prorated to all open Title IV-D cases for an obligor based on the arrearage owed in each case. By operation of law, arrearages include all adjudicated arrears and delinquency on current support, plus accrued interest.
[8.50.114.13 NMAC - Rp, 8.50.114.13 NMAC, 12/30/2010; A, 1/1/2022]

History of 8.50.114 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.114 NMAC, Financial Institution Data Match (FIDM), filed 5/14/2001 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 115 EXPEDITED PROCESSES AND ADMINISTRATIVE EXPEDITED PROCESS

8.50.115.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.115.1 NMAC - Rp, 8.50.115.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.115.2 SCOPE: To the general public. For use by the IV-D agency and recipients of IV-D services.
[8.50.115.2 NMAC - Rp, 8.50.115.2 NMAC, 12/30/2010]

8.50.115.3 STATUTORY AUTHORITY: Public Assistance Act, NMSA 1978, Section 27-2-27. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.115.3 NMAC - Rp, 8.50.115.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.115.4 DURATION: Permanent.
[8.50.115.4 NMAC - Rp, 8.50.115.4 NMAC, 12/30/2010]

8.50.115.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.115.5 NMAC - Rp, 8.50.115.5 NMAC, 12/30/2010]

8.50.115.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.115.6 NMAC - Rp, 8.50.115.6 NMAC, 12/30/2010]

8.50.115.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.115.8 EXPEDITED PROCESSES: Expedited processes are the administrative and judicial processes that increase program effectiveness and meet the processing time specified. The following timeframes apply to the IV-D agency.

A. In IV-D cases needing support order establishment, regardless of whether paternity has been established, action to establish support orders must be completed from the date of service of process to the time of disposition within the following time frames:

(1) seventy-five percent of cases within six months; and

(2) ninety percent of cases within 12 months.

B. In IV-D cases where a support order has been established, the IV-D agency must:

(1) monitor compliance with the support obligation;

(2) identify a delinquency on the date the obligor fails to make payments in an amount equal to the support payable for one month, or on an earlier date in accordance with state law; and

(3) enforce the obligation by:

(a) initiating income withholding;

(b) taking any appropriate enforcement action (except income withholding and federal and state tax intercepts):

(i) unless service of process is necessary, within no more than 30 calendar days of either identifying a delinquency or other support related non-compliance with the order, or the location of the delinquent parent, whichever occurs later; or

(ii) if service of process is necessary prior to taking an enforcement action, service must be completed (or unsuccessful attempts, despite diligent efforts to serve process, must be documented) and enforcement action taken if process is served, within 60 calendar days of identifying a delinquency or other support related non-compliance with the order, or the location of the delinquent parent, whichever occurs later; diligent efforts consist of a minimum of two separate attempts to complete service; the attempts must be made at different locations, or if at the same location, on different days;

(iii) submitting once a year all cases that meet the certification requirements for federal and state tax offset; and

(iv) in cases in which enforcement attempts have been unsuccessful, at the time an attempt to enforce fails, examining the reason the enforcement attempt failed and determining when it would be appropriate to take an enforcement action in the future, and taking an enforcement action in accordance with the requirements of this section at that time.

C. In cases where the IV-D agency uses long-arm jurisdiction and disposition occurs within 12 months of service of process on non-custodial parent, the case may be counted as a success within the six month tier of the time frame.

[8.50.115.8 NMAC - Rp, 8.50.115.8 NMAC, 12/30/2010]

8.50.115.9 HEARING OFFICERS AND EXPEDITED PROCESSES: Child support hearing officers contribute to expedited processes by handling child support cases that would otherwise be heard by a state district court judge. Cases assigned to a child support hearing officer are expedited for hearings, as necessary. The child support hearing officer program is operated by the courts in accordance with Section 40-4B-1 et seq. NMSA 1978.

[8.50.115.9 NMAC - Rp, 8.50.115.9 NMAC, 12/30/2010]

8.50.115.10 SERVICE OF PROCESS: Service of process may be required, depending upon the type of action the IV-D agency is pursuing. Any action initiated by the IV-D agency involving a court proceeding will include service of process on all appropriate parties in accordance with New Mexico law regarding service of process. Any administrative action taken by IV-D agency that requires notice or service of process will be in accordance with New Mexico law including the New Mexico administrative code, as appropriate.

[8.50.115.10 NMAC - Rp, 8.50.115.10 NMAC, 12/30/2010]

8.50.115.11 ADMINISTRATIVE EXPEDITED PROCESS: The IV-D agency is authorized to take administrative action without the need to seek a judicial order. Those actions include:

A. issuing administrative subpoenas that carry a possible penalty under 8.50.131 NMAC in addition to any court imposed sanctions;

B. accessing information regarding employment compensation from any entity in the state; and

C. obtaining records from:

(1) automated databases of certain governmental agencies;

(2) private entities to include last known address; and

(3) financial institutions.

[8.50.115.11 NMAC - Rp, 8.50.115.11 NMAC, 12/30/2010]

8.50.115.12 ADMINISTRATIVE ORDERS: In accordance with state and federal laws, the IV-D agency may issue administrative orders for the following:

A. genetic testing for the purposes of establishing paternity;

B. changing the payee to the IV-D agency, when there has been an assignment from a IV-A or Title XIX program, or payment is to be made to the state disbursement unit;

C. requiring income withholding for any IV-D case in which there is not an automatic wage withholding already in effect and there is no judicial or administrative order to the contrary;

D. securing assets to satisfy an obligor's arrearage; and

E. increasing payments toward arrearages, as appropriate.

[8.50.115.12 NMAC - Rp 8.50.115.12 NMAC, 12/30/2010]

8.50.115.13 FAILURE TO COMPLY WITH ADMINISTRATIVE SUBPOENA OR ORDER:

A. Upon failure to comply with an order or subpoena issued hereunder, the IV-D agency may pursue one or more of the following:

(1) administer the penalties pursuant to 8.50.131 NMAC;

(2) commence appropriate enforcement action with the court;

(3) seek sanctions against a person who is required to cooperate pursuant to an assignment of rights pursuant to NMSA 1978, Section 27-2-28; or

(4) close the case for non-cooperation.

B. Stay: Upon receipt of an appeal, written notice, or a request from a person or entity that the IV-D agency's administrative order be stayed, the IV-D agency may, for good cause, stay the order, revoke the order, or seek appropriate enforcement. The IV-D agency will notify the parties regarding any stay of an administrative order

via written notification sent by first class US mail to the last address of record with the IV-D agency. Appeals shall be scheduled for hearing in accordance with 8.50.130 NMAC.
[8.50.115.13 NMAC - Rp, 8.50.115.19 NMAC, 12/30/2010]

8.50.115.14 PROVIDE UPDATED INFORMATION: Any party to a paternity or child support proceeding shall provide, and update as needed, the following information: social security number; residential and mailing addresses; telephone number; driver's license number; name, address, and telephone number of all employers. All court orders obtained or modified by the IV-D agency will contain language requiring that both the obligor and the obligee provide the IV-D agency, in writing, with any and all changes to this information.
[8.50.115.14 NMAC - Rp, 8.50.115.21 NMAC, 12/30/2010]

8.50.115.15 DUE PROCESS SAFEGUARDS: The IV-D agency has due process safeguards related to the issuance and enforcement of administrative orders and subpoenas. In all instances where the IV-D agency issues an administrative order or administrative subpoena, the administrative order or administrative subpoena will not be considered properly served unless the service requirements for each type of administrative order or administrative subpoena are met pursuant to New Mexico law, to include New Mexico administrative law. The IV-D agency will maintain a copy of the proof of service for each service of process in the IV-D agency's records, and will produce the proof of service at the request of the judicial or administrative tribunal. Each administrative order or administrative subpoena, as described in these regulations, will provide instructions on the procedure to be followed to contest the action of the IV-D agency. These instructions will specify that the proper tribunal for appeal of the IV-D agency's administrative orders and administrative subpoenas is the state district court of New Mexico.
[8.50.115.15 NMAC - Rp, 8.50.115.23 NMAC, 12/30/2010]

History of 8.50.115 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
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NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.115 NMAC, Expedited Processes and Administrative Expedited Process, filed 5/14/2001 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 117 INTERNATIONAL CHILD SUPPORT ENFORCEMENT

8.50.117.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.117.1 NMAC - Rp, 8.50.117.1 NMAC, 12/30/2010; A, 7/1/2/024]

8.50.117.2 SCOPE: To the general public. For use by the IV-D agency and recipients of IV-D services.
[8.50.117.2 NMAC - Rp, 8.50.117.2 NMAC, 12/30/2010]

8.50.117.3 STATUTORY AUTHORITY: Public Assistance Act, NMSA 1978, Section 27-2-27. The health care authority - child support division is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.117.3 NMAC - Rp, 8.50.117.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.117.4 DURATION: Permanent.
[8.50.117.4 NMAC - Rp, 8.50.117.4 NMAC, 12/30/2010]

8.50.117.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.117.5 NMAC - Rp, 8.50.117.5 NMAC, 12/30/2010]

8.50.117.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.117.6 NMAC - Rp, 8.50.117.6 NMAC, 12/30/2010]

8.50.117.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.117.8 INTERNATIONAL SUPPORT ENFORCEMENT: Special enabling legislation allows the state of New Mexico, and all other states, to directly enter into agreements for child support enforcement services with foreign nations (42 USC 659 (A)). With Mexico and Canada, these agreements are arranged on a state-by-state or province-by-province basis.
[8.50.117.8 NMAC -Rp, 8.50.117.8 NMAC, 12/30/2010]

8.50.117.9 FOREIGN CURRENCY CONVERSION: Some interstate cases handled by the IV-D agency are received from foreign nations or are initiated to foreign nations.

A. Responding international cases:

(1) Establishment of an obligation for support: If the IV-D agency is asked to establish an order for support by the child support agency of a foreign nation, the IV-D agency shall:

(a) file the action in the appropriate state district court;

(b) convert the custodial party's income into United States dollars, provided that it is appropriate to utilize the custodial party's income in a calculation of support under the laws of New Mexico;

(c) utilize the non-custodial parent's actual or imputed income, in United States dollars;

(d) obtain a support order to be paid in United States dollars; and

(e) all payments collected by the IV-D agency's SDU shall be remitted to the child support agency in the foreign nation in United States dollars.

(2) Enforcement of a foreign nation's order for support: If the IV-D agency is asked to enforce an existing order for support from a foreign nation, the IV-D agency shall:

(a) register the order for support in the appropriate state district court;

(b) at the time of registration of the foreign support order, the amount of the obligation registered for enforcement shall be in United States dollars; if the initiating jurisdiction has not already converted the monetary amount into United States dollars, the IV-D agency shall convert the obligation from the currency of the foreign nation into United States dollars; the currency exchange rate used for the conversion of the foreign currency into United States dollars shall be obtained by the IV-D agency from the internet websites of

respected financial journals or news organizations; the IV-D agency shall, at the time of the conversion, print out and retain in its file a copy of the dated exchange rate information relied upon by the IV-D agency in calculating the correct amount of the obligation to be enforced in United States dollars.

B. Initiating international cases: In all cases initiated by the IV-D agency to the child support agency of a foreign nation, regardless of whether for the establishment or the enforcement of an obligation of support, the IV-D agency shall ensure all financial records or information sent by the IV-D agency reflect United States dollars.
[8.50.117.9 NMAC - N, 12/30/2010]

History of 8.50.117 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/15/2001.
8.50.117 NMAC, International Child Support Enforcement, filed 5/14/2001 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 124 INTERSTATE CASES

8.50.124.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.124.1 NMAC - Rp, 8.50.124.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.124.2 SCOPE: To the general public. For use by the IV-D agency and recipients of IV-D services.
[8.50.124.2 NMAC - Rp, 8.50.124.2 NMAC, 12/30/2010]

8.50.124.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.124.3 NMAC - Rp, 8.50.124.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.124.4 DURATION: Permanent.
[8.50.124.4 NMAC - Rp, 8.50.124.4 NMAC, 12/30/2010]

8.50.124.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.124.5 NMAC - Rp, 8.50.124.5 NMAC, 12/30/2010]

8.50.124.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.124.6 NMAC - Rp, 8.50.124.6 NMAC, 12/30/2010]

8.50.124.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.124.8 INTERSTATE CASES: The IV-D agency extends the full range of services available under its program to other states or territories. In addition, services are extended to nations that have entered into reciprocal agreements for the establishment and enforcement of orders for support with the United States. These cases shall be handled by the IV-D agency in accordance with the requirements of 45 CFR 303.7 and Section 40-6A-101, et seq., NMSA 1978, Uniform Interstate Family Support Act (UIFSA).
[8.50.124.8 NMAC - Rp, 8.50.124.8 NMAC, 12/30/2010]

8.50.124.9 HIGH VOLUME, AUTOMATED ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES: The Title IV-D agency may, by electronic or other means, transmit to another state a request for assistance in enforcing support orders through high-volume, automated administrative enforcement. The request must include such information as will enable the responding state to compare the case information sent by the IV-D agency to the information in the data bases of the responding state.
[8.50.124.9 NMAC - Rp, 8.50.124.13 NMAC, 12/30/2010]

8.50.124.10 INTERSTATE WITHHOLDING: The Uniform Interstate Family Support Act authorizes direct interstate wage withholding without a requirement of registration. A Title IV-D worker in New Mexico can send a wage withholding directly to an employer in any other state, and any other state can send a wage withholding directly to a New Mexico employer.
[8.50.124.10 NMAC - Rp, 8.50.124.14 NMAC, 12/30/2010]

8.50.124.11 FEES FOR GENETIC TESTING: In accordance with 45 CFR 303.7(d)(2) and (3), the Title IV-D agency in the initiating state must pay for the cost of genetic testing in actions to establish paternity. If paternity is established in New Mexico by the Title IV-D agency, the Title IV-D agency must attempt to obtain a judgment for the costs of genetic testing from the party who denied paternity and must reimburse the initiating state with any sums so collected.
[8.50.124.11 NMAC - Rp, 8.50.124.16 NMAC, 12/30/2010]

8.50.124.12 COOPERATION DEFINED IN INTERSTATE CASES: In interstate cases, the Title IV-D agency works closely with the child support agency in another jurisdiction. It is important that the Title IV-D agency be made aware of all communication in interstate cases in order to stay fully aware of the status of the cases. Accordingly, a party to an interstate action must not communicate directly with a child support agency in another jurisdiction. If an individual communicates directly with a child support agency in another jurisdiction without utilizing the Title IV-D agency, this conduct may be deemed to be "non-cooperation" by the Title IV-D agency and may subject the party to sanction and case closure, as appropriate. Parties in interstate cases must also follow the cooperation guidelines set forth in 8.50.105.12 NMAC or be deemed to be "non-cooperative" and be subjected to sanction and case closure, as appropriate.
[8.50.124.12 NMAC - N, 12/30/2010]

8.50.124.13 DOMESTIC VIOLENCE SAFEGUARDS:

A. Responding interstate cases: In all responding interstate cases (cases sent to the Title IV-D agency by another jurisdiction for the establishment or enforcement of a support obligation), the Title IV-D agency should review the documents received from the child support agency in the other jurisdiction to determine if the case has been noted as a non-disclosure case. If the case is a non-disclosure case, then the Title IV-D agency, in accordance with Section 40-6A-312 NMSA 1978, shall:

(1) prepare appropriate documents requesting the temporary sealing of the court file;

(2) upon issuance by the state district court of the temporary order sealing court file and notice of hearing, as appropriate, serve the non-custodial parent with redacted copies of all pleadings and attachments; the Title IV-D agency shall redact all addresses, telephone numbers, and social security numbers for the custodial party and the child(ren) in the initiating jurisdiction;

(3) at the hearing on sealing of the court file, inform the custodial party that they shall testify as to why the court's file should be permanently sealed to prevent the disclosure of contact information for the custodial party and the child(ren);

(4) if the court enters an order permanently sealing the court file, only forward to the non-custodial party documents that have all contact information for the custodial party and the child(ren) redacted.

B. Initiating interstate cases: In all initiating interstate cases (cases sent by the Title IV-D agency to the child support agency of another jurisdiction), if the initiating individual (custodial party or non-custodial parent) requests non-disclosure status, then the IV-D agency shall require the party to complete documents relating to the non-disclosure request and forward the request to the other state or territory.
[8.50.124.13 NMAC - N, 12/30/2010]

8.50.124.14 FOREIGN CURRENCY CONVERSION: If there is a need to convert the support or judgment amounts into foreign currency, refer to 8.50.117.9 NMAC for the Title IV-D agency's process.
[8.50.124.14 NMAC - N, 12/30/2010]

History of 8.50.124 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD CSEB 570.0000, Interjurisdictional Cases, 6/23/1980.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.124 NMAC, Interstate Cases, filed 5/14/2001 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 125 FEES, PAYMENTS, AND DISTRIBUTIONS

8.50.125.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.125.1 NMAC - Rp, 8.50.125.1 NMAC, 9/1/2022; A,7/1/2024]

8.50.125.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of IV-D services.
[8.50.125.2 NMAC - Rp, 8.50.125.2 NMAC, 9/1/2022]

8.50.125.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.125.3 NMAC - Rp, 8.50.125.3 NMAC, 9/1/2022; A,7/1/2024]

8.50.125.4 DURATION: Permanent.
[8.50.125.4 NMAC - Rp, 8.50.125.4 NMAC, 9/1/2022]

8.50.125.5 EFFECTIVE DATE: September 1, 2022, unless a later date is cited at the end of a section.
[8.50.125.5 NMAC - Rp, 8.50.125.5 NMAC, 9/1/2022]

8.50.125.6 OBJECTIVE: To provide regulations in accordance with federal and state law and regulations.
[8.50.125.6 NMAC - Rp, 8.50.125.6 NMAC, 9/1/2022]

8.50.125.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.125.8 CHILD SUPPORT PAYMENTS:

A. The IV-D agency has in effect procedures for the payment of support through the IV-D agency upon the request of either the non-custodial party or the custodial party, regardless of whether arrearages exist or withholding procedures have been instituted. The IV-D agency is designated to administer the state's withholding system. The IV-D agency monitors all amounts paid and the dates of payments and records them on an individual payment record. As a condition of receiving IV-D services and cooperating with the IV-D agency, recipients must submit to the IV-D agency child support received directly from the non-custodial party. If the recipient of title XIX (medicaid) services elects to receive medical support services only, the recipient of title XIX (medicaid) services may keep child support payments received directly from the payor.

B. All support payments disbursed by the IV-D agency shall be through electronic funds transfer (EFT). The custodial party must elect to receive the payments via direct deposit or a pre-paid debit card authorized by the IV-D agency. If a custodial party receiving support payments fails to choose either option at the time of application or when requested by the IV-D agency, they will automatically be enrolled in the IV-D authorized pre-paid debit card program and will be sent a fee schedule. Exceptions to disbursements via EFT may be granted for exceptional circumstances. Those wishing to request an exemption should request an "EFT exemption form" from the IV-D agency. The form must be fully completed to include an explanation of the exceptional circumstances requiring an exemption from EFT. The IV-D agency will respond in writing either granting or denying the request for an exemption.
[8.50.125.8 NMAC - Rp, 8.50.125.8 NMAC, 9/1/2022]

8.50.125.9 STATE DISBURSEMENT UNIT: The state IV-D agency has established and operates a state disbursement unit (SDU) for the collection and disbursement of payments in all IV-D cases pursuant to 42 USC 654(a).
[8.50.125.9 NMAC - Rp, 8.50.125.9 NMAC, 9/1/2022]

8.50.125.10 COLLECTION OF FEES/RECOUPMENTS: New Mexico is a cost recovery state, and other states' IV-D agencies have been notified of this fact. All fees charged to the custodial party are deducted from payments the IV-D agency distributes to the custodial party. The amount the IV-D agency deducts from each payment will not exceed ten percent of the total amount of the distribution. Once the percentage for the fee is deducted, the balance of the distribution is sent to the custodial party. Title IV-A, Title IV-E and medicaid-only (Title XIX) recipients are not charged any fees. Federal regulations will not allow cost recovery on these cases. A listing of any applicable fees will be given to all customers.

A. Potential fee types:

(1) non-IV-D wage withholding payment processing only: actual cost;
(2) non-IV-A full service IRS collection: actual cost;
(3) paternity genetic testing: actual cost;
(4) non-IV-A/IV-E case processing: actual cost;
(5) filing fee: actual cost;
(6) witness fee: actual cost;
(7) service of process: actual cost;
(8) expert witness fee: actual cost;
(9) court costs: actual cost;
(10) establishment of support order and paternity (if necessary): actual cost;
(11) order modification: actual cost
(12) enforcement actions: actual cost;
(13) IRS tax intercept service: actual cost per intercept;
(14) TRD tax intercept service: actual cost per intercept;
(15) administrative offset: applicable federal fee;
(16) parental kidnapping locator fee: actual cost;
(17) bad check: actual cost;
(18) recoupment: actual cost;

B. Refund of fees: Fees are to be refunded only under the following conditions:

(1) fees have been charged in error or overcharged;
(2) the court orders a refund.

C. Fees are assessed to the custodial or non-custodial party requesting an action or service (i.e. establishment of paternity, modification or enforcement of support obligation) in a IV-D case in accordance with the fee schedule above.

D. Genetic testing fees: See 8.50.107.12 NMAC in addition to the fee schedule listed above.

E. Recoupment: The IV-D agency will recoup from the custodial party for any over-distribution of funds and for any funds collected from the non-custodial party that are returned for insufficient funds. If the recoupment is pursuant to an over-distribution of funds, the recoupment amount shall not exceed twenty five percent of any future distribution to the custodial party until paid in full. If the recoupment is pursuant to insufficient funds received from the non-custodial party's payment, the recoupment amount shall be one hundred percent of any future distribution to the custodial party until paid in full.

[8.50.125.10 NMAC - Rp, 8.50.125.10 NMAC, 9/1/2022; A, 1/1/2024]

8.50.125.11 DISTRIBUTION OF COLLECTIONS (EXCEPT FOR FEDERAL INCOME TAX REFUND OFFSETS): Specific terms used in this section are derived from 42 USC 657 and 45 CFR 300 through 303.

A. In accordance with federal regulations, for purposes of distribution in a IV-D case, amounts collected, except for amounts collected through federal income tax refund offset, must be distributed as follows:

(1) monthly payment ordered for current ongoing support;
(2) monthly payment ordered for judgment on arrears;
(3) current support delinquency;
(4) past due support delinquency;
(5) in each of the categories above, the payment is prioritized in the following order: child support, medical support, spousal support; any payment that is insufficient to meet the entire obligation will be applied in the order stated above.

B. The requirement to apply collections first to satisfy the current support obligation is critical in all IV-D cases to ensure that payment records are consistent in interstate cases, regardless of whether the amount

applied to current support is paid to the family (as in a former assistance case) or retained by the state to recover unreimbursed assistance in a current assistance case.

C. Current assistance cases: The state will (not exceeding the cumulative amount of unreimbursed assistance paid to the family):

(1) pay to the federal government the federal share of the amount collected that is applied to assigned support;

(2) retain the state share of the amount collected that is applied to assigned support; and

(3) reduce the cumulative amount of unreimbursed assistance by the total amount collected that is applied to assigned support and disbursed under Paragraphs (1) and (2) of Subsection, C of 8.50.125.11 NMAC and distribute collections exceeding the cumulative amount of unreimbursed assistance to the family in excess of Paragraphs (1) and (2) of Subsection, C of 8.50.125.11 NMAC to satisfy never assigned support, unassigned support and conditionally assigned support.

D. The order in which collections are applied to satisfy assigned and unassigned arrearages in current assistance cases differ by state.

(1) For collections made prior to January 23, 2023, the state of New Mexico has selected the following option:

(a) collections will be first applied to current support;

(b) additional collections will be applied to temporarily assigned arrearages or conditionally assigned arrearages;

(c) additional collections will be applied to permanently assigned arrearages and

(d) additional collections will be applied to never assigned arrearages, unassigned pre-assistance arrearages and unassigned during assistance arrearages.

(2) For collections made effective on or after January 23, 2023, the state of New Mexico has selected the following option:

(a) collections will be first applied to current support;

(b) additional collections will be first applied to permanently assigned arrearages;

(c) additional collections will be applied to temporarily assigned arrearages or conditionally assigned arrearages; and

(d) additional collections will be applied to never assigned arrearages, unassigned Pre-assistance arrearages and unassigned during assistance arrearages.

E. Former assistance cases:

(1) For collections made prior to October 1, 1998, the state shall:

(a) first, distribute the amount collected to satisfy the current monthly support obligation and pay that amount to the family;

(b) second, distribute any amount above the current monthly support obligation to arrearages owed to the family or assigned to the state; the federal statute does not specify the order in which collections are applied to satisfy arrearages; the state must have procedures that specify the order in which assigned arrearages will be satisfied; if the state distributes any amount to assigned arrearages, the state must pay to the federal government the federal share of the amount so collected; the state must retain the state share of the amount so collected, with one exception; the state may retain or pay to the family the state share of collections applied to arrearages that accrued while the family was receiving assistance after October 1, 1996.

(2) For collections made on or after October 1, 1998, or earlier at state option, the state shall:

(a) distribute the amount collected to satisfy the current monthly support obligation and pay that amount to the family;

(b) distribute any amount above the current monthly support obligation to satisfy never-assigned arrearages and pay that amount to the family;

(c) distribute any amount above amounts distributed in Subparagraphs (a) and (b) of this section to satisfy unassigned pre-assistance arrearages and conditionally-assigned arrearages in any order and pay that amount to the family;

(d) distribute any amount above amounts distributed in Subparagraphs (a), (b) and (c) of this section to satisfy permanently-assigned arrearages; the state must pay the federal government the federal share of the amount collected that is applied to assigned support; the state must retain the state share of the amount so collected with one exception; the state may retain or pay to the family the state and federal share of collections applied to arrearages that accrued while the family was receiving assistance after October 1, 1996;

(e) reduce the cumulative amount of unreimbursed assistance by the total amount distributed under subparagraph (d), distribute collections exceeding the cumulative amount of unreimbursed assistance to satisfy unassigned during-assistance arrearages and pay those amounts to the family.

(3) For collections made effective on or after January 23, 2023 (other than through federal Income tax refund offset), the state shall:

(a) distribute the amount collected to satisfy the current monthly support obligation and pay that amount to the family;

(b) distribute any amount above the current monthly support obligation to satisfy never-assigned arrearages and pay that amount to the family;

(c) distribute any amount above amounts distributed in Subparagraphs (a) and (b) of Paragraph (3) of Subsection E of 8.50.125.11 NMAC to satisfy unassigned pre-assistance arrearages and pay that amount to the family;

(d) distribute any amount above amounts distributed in Subparagraphs (a), (b) and (c) of Paragraph (3) of Subsection E of 8.50.125.11 NMAC to satisfy unassigned during assistance arrearages and pay those amounts to the family;

(e) distribute any amount above amounts distributed in Subparagraphs (a), (b), (c) and (d) of Paragraph (3) of Subsection E of 8.50.125.11 NMAC to satisfy conditionally-assigned arrearages and pay that amount to the family; the state must pay the federal government the federal share of the amount collected that is applied to assigned support; the state must retain the state share of the amount so collected with one exception; the state may retain or pay to the family the state and federal share of collections applied to conditionally assigned arrearages; and

(f) distribute any amount above amounts distributed in Subparagraphs (a), (b), (c), (d) and (e) of Paragraph (3) of Subsection E of 8.50.125.11 NMAC to satisfy permanently-assigned arrearages and reduce the cumulative amount of unreimbursed assistance by the total amount distributed under Subparagraph (e) and (f) of this Paragraph; the state must pay the federal government the federal share of the amount collected that is applied to assigned support;; the state must retain the state share of the amount so collected with one exception; the state may retain or pay to the family the state and federal share of collections applied to permanently assigned arrearages;

F. Never-assistance cases: All support collections in never-assistance cases must be paid (less any applicable fees) to the family.

G. Collected funds will be distributed to the resident parent, legal guardian, caretaker relative having custody of or responsibility for the child or children, judicially-appointed conservator with a legal and fiduciary duty to the custodial parent and the child, or alternate caretaker designated in a record by the custodial parent. An alternate caretaker is a nonrelative caretaker who is designated in a record by the custodial parent to take care of the children for a temporary time period.

H. When the non-custodial parent has multiple cases with the IV-D agency, payments received from the non-custodial parent through wage withholding shall be distributed among all active cases on a pro-rata basis determined by the total amount of all monthly support obligations. Payments received through administrative enforcement mechanisms shall be distributed among multiple cases on a pro-rata split based on the total amount of arrearages owed at the time of the referral for administrative enforcement, except for reinstatement of license(s). Payments received for the reinstatement of licenses will be applied to the specific case(s) rather than split among multiple cases. Any other direct payments made by the non-custodial parent will be divided among all active cases involving the non-custodial parent.

[8.50.125.11 NMAC - Rp, 8.50.125.11 NMAC, 9/1/2022]

8.50.125.12 DISTRIBUTION OF COLLECTIONS THROUGH FEDERAL INCOME TAX REFUND OFFSET: Any amount of support collected through federal income tax refund offset may be retained by the state to the extent support arrearages have been assigned to the state up to the amount necessary to reimburse the state for cumulative amounts paid to the family as assistance by the state. The state will pay to the federal government the federal share of the amounts so retained. To the extent the amount collected exceeds the amount required to be retained, the state will pay the excess to the family.

A. Current assistance cases: Support collections through federal income tax refund offsets in current assistance cases are retained by the state up to the cumulative amount of unreimbursed assistance paid to the family. Collections over and above the cumulative amount of unreimbursed assistance are paid to the family. The order in which collections are applied to satisfy assigned and unassigned arrearages in current assistance cases differ by state.

(1) For collections made prior to January 23, 2023, the state of New Mexico has selected the following option:

(a) collections will first be applied to temporarily assigned arrearages or conditionally assigned arrearages;

(b) additional collections will be applied to permanently assigned arrearages; and

(c) additional collections will be applied to never assigned arrearages, unassigned pre-assistance arrearages and unassigned during assistance arrearages.

(2) For collections made on or after January 23, 2023, the state of New Mexico has selected the following option:

(a) collections will be first applied to current support (pass through described in Section 8.50.125.13 NMAC may apply here);

(b) additional collections will be first applied to permanently assigned arrearages;

(c) additional collections will be applied to temporarily assigned arrearages or conditionally assigned arrearages; and

(d) additional collections will be applied to never assigned arrearages, unassigned pre-assistance arrearages and unassigned during assistance arrearages.

B. Former assistance cases:

(1) For support collections made through federal income tax refund offsets made prior to January 23, 2023, the state has selected the following options:

(a) collections will first be applied to temporarily assigned arrearages or conditionally assigned arrearages;

(b) additional collections will be applied to permanently assigned arrearages; and,

(c) additional collections will be applied to never assigned arrearages,
Unassigned, pre-assistance arrearages and unassigned during assistance arrearages.

(2) For support collections made through federal income tax refund offsets made on or after January 23, 2023, the state has selected the following options:

(a) distribute the amount collected to satisfy the current monthly support obligation and pay that amount to the family;

(b) distribute any amount above the current monthly support obligation to satisfy never-assigned arrearages and pay that amount to the family;

(c) distribute any amount above amounts distributed in Subparagraphs (a) and (b) of this subsection to satisfy unassigned pre-assistance arrearages and pay that amount to the family;

(d) distribute any amount above amounts distributed in Subparagraphs (a), (b) and (c) of this subsection to satisfy unassigned during assistance arrearages and pay those amounts to the family;

(e) distribute any amount above amounts distributed in Subparagraphs (a), (b), (c) and (d) of this subsection to satisfy conditionally-assigned arrearages and pay that amount to the family; the state must pay the federal government the federal share of the amount collected that is applied to assigned support; the state must retain the state share of the amount so collected with one exception; the state may retain or pay to the family the state and federal share of collections applied to conditionally assigned arrearages; and

(f) distribute any amount above amounts distributed in Subparagraphs (a), (b), (c), (d) and (e) of this subsection to satisfy permanently-assigned arrearages and reduce the cumulative amount of unreimbursed assistance by the total amount distributed under Subparagraphs (e) and (f) of Paragraph 2 of Subsection B of 8.50.125.12 NMAC; the state must pay the federal government the federal share of the amount collected that is applied to assigned support; the state must retain the state share of the amount so collected with one exception; the state may retain or pay to the family the state and federal share of collections applied to permanently assigned arrearages and conditionally assigned arrearages.

C. Never-assistance cases: Support collections through federal income tax refund offsets in non-assistance cases are paid to the family.

[8.50.125.12 NMAC - Rp, 8.50.125.12 NMAC, 9/1/2022; A, 1/1/2024]

8.50.125.13 CURRENT ASSISTANCE PASS THROUGH PAYMENTS: At the discretion of the New Mexico legislature, the IV-D agency may disburse an amount based on budget availability (refer to Section 27-2B-7 NMSA 1978 and disregard for child support payments in 8.102.520.9 NMAC for allowable amount), to the IV-A service recipient from collections on current support. Under no circumstances is a current or former IV-A recipient entitled to receive said amount as part of the arrearages owed to them. The disbursement to the custodial party, up to the maximum amount, shall only be made if the recipient is currently receiving TANF and the IV-D agency collects

a payment from the non-custodial party. If the non-custodial party pays less than the maximum amount allowed to pass through, the custodial party shall only receive the amount of the payment collected. Neither the IV-D agency nor the IV-A agency will pay the difference to the custodial party between the maximum pass through amount and the amount paid by the non-custodial party. If the custodial party has more than one IV-D case, they will only receive the lower of the amount of the maximum disregard or the current monthly collection received on all cases. A pass through payment is in addition to, not in lieu of, the monthly TANF payment.
[8.50.125.13 NMAC - N, 9/1/2022]

8.50.125.14 DISTRIBUTION OF COLLECTIONS IN TITLE IV-E FOSTER CARE CASES: Amounts collected as support in Title IV-E foster care cases will be distributed in accordance with 45 CFR 302.52.
[8.50.125.14 NMAC - Rp, 8.50.125.13 NMAC, 9/1/2022]

8.50.125.15 ASSIGNED MEDICAL SUPPORT COLLECTIONS: The IV-D agency is not pursuing cash medical support on cases in which the child(ren) receives health care coverage through a public entity.
[8.50.125.15 NMAC - Rp, 8.50.125.14 NMAC, 9/1/2022; A, 1/1/2024]

8.50.125.16 CHILD LEVEL ACCOUNTING: An application for public assistance by any person constitutes an assignment by operation of law of any support rights the person is entitled to from any other person, whether the support rights are owed to the applicant or to any family member for whom the applicant is applying for or receiving assistance. Therefore, in current or former assistance cases, the IV-D agency may not use child-level accounting by splitting or pro-rating the family grant amount on a per-child basis when the child is (or was) included in the family unit and must continue to apply collections to the cumulative amount of unreimbursed assistance balances based on the total monthly family grant amount.
[8.50.125.16 NMAC - Rp, 8.50.125.15 NMAC, 9/1/2022]

8.50.125.17 CHILD SUPPORT RECEIVED DIRECTLY FROM PAYORS: As a condition of receiving IV-D services, all recipients must submit to the IV-D agency all court ordered, voluntary agreement and voluntary contribution child support directly received from the non-custodial party. Failure to cooperate with this requirement may constitute cause for closing the IV-D case for non-cooperation. If the recipient of IV-D services elects to receive medical support services only, the recipient of IV-D services may keep child support payments received directly from the payor.
[8.50.125.17 NMAC - Rp, 8.50.125.16 NMAC, 9/1/2022]

8.50.125.18 CHILD SUPPORT COLLECTED FOR MEDICAID REFERRALS: A medicaid only recipient, for whom an assignment of support rights is in effect, must receive medical support services but may choose to receive full services. If the recipient elects to receive full services, the recipient is required to turn over all child support received, to be distributed in accordance with federal and state regulations. If the recipient elects to receive only medical support services, the recipient may keep child support payments received directly from the payor.
[8.50.125.18 NMAC - Rp, 8.50.125.17 NMAC, 9/1/2022]

8.50.125.19 CHILD SUPPORT CASE SERVICES: The IV-D agency provides two types of case services: full service and payment processing only.

A. Full services cases: Recipients of IV-A services are automatically enrolled for full services and recipients of title XIX may elect to receive full services for all support or solely for medical support. Full services cases include all services listed below as specific services may not be selected. Applicants not receiving any type of public assistance may also request full services that include:

(1) establishment of paternity;

(2) establishment of a child support order, medical support order, or both;

(3) enforcement of child support orders, spousal support orders (so long as there is a current order for child support), and medical support orders;

(4) administrative enforcement of orders, including but not limited to referrals for tax intercepts, passport denial, license revocation, and financial institution data match;

(5) issuance of wage withholding against a non-custodial party's earnings/wages for support obligations; and

(6) modification of child support orders, if appropriate.

B. Payment processing only cases: A custodial party currently receiving full services from the IV-D agency or opening a new case with the IV-D agency may elect to receive payment processing only services so long as they are not currently receiving public assistance (Title IV-A or Title XIX) and does not have an outstanding balance of arrears owed to the state for prior public assistance. Payment processing only services are charged an annual fee as stated in section 10, above. In order to receive payment processing only services, the applicant for services must produce a valid court order (either issued by or registered by a court in New Mexico) for a support obligation that contains an income withholding provision or a copy of an income withholding order indicating that payments are to be sent to the IV-D agency.

(1) The IV-D agency is not responsible for:

(a) establishing, modifying, or enforcing the support obligation;

(b) establishing, modifying, enforcing, sending, or terminating the income withholding order;

(c) calculating or determining the appropriate amount of support, payment toward arrears, delinquencies, and arrearages;

(d) appearing in court for any issues involving the establishment, modification, enforcement or termination of the support obligations.

(2) The IV-D agency will provide either the custodial party or the non-custodial party a printout of the payments received by the IV-D agency after receiving a written request.

(3) The IV-D agency may terminate the payment processing only services if no payments are received for a period of two months.

[8.50.125.19 NMAC - Rp, 8.50.125.18 NMAC, 9/1/2022; A, 1/1/2024]

8.50.125.20 ISSUANCE OF REPLACEMENT WARRANTS: If a custodial party or non-custodial parent claims that a warrant issued to them has not been received, a replacement warrant shall be issued only if the original warrant has not been redeemed or at the discretion of the IV-D agency. If the IV-D agency determines that a replacement warrant will be issued, any warrants that were fraudulently redeemed shall be reported by the intended recipient to the proper authorities as a pre-condition for the issuance of a replacement warrant. An unredeemed warrant is subject to the undistributed collections process, see 8.50.132 NMAC. The IV-D agency will replace a warrant that it can confirm was not redeemed and has not escheated to the IV-D agency through the undistributed collections process. If the IV-D agency is unable to confirm that a warrant has been redeemed due to the length of time that has passed since the warrant was issued, the IV-D agency will deny the request for a replacement warrant.

[8.50.125.20 NMAC - Rp, 8.50.125.19 NMAC, 9/1/2022; A, 1/1/2024]

History of 8.50.125 NMAC:

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

ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD CSEB 521.0000, Non-AFDC Fees and Costs, 6/23/1980.
ISD CSEB 521.0000, Non-AFDC Fees and Costs, 1/20/1981.
ISD CSEB 592.0000, Collection, 6/23/1980.
ISD CSEB 593.0000, Distribution, 6/23/1980.

NMAC History:

8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:

8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.125 NMAC, Fees, Payments, and Distributions, filed 5/14/2001 - Repealed effective 12/30/2010.
8.50.125 NMAC, Fees, Payments, and Distributions, filed 12/13/2010 - Repealed effective 9/1/2022.

Other: 8.50.125 NMAC, Fees, Payments, and Distributions, filed 5/14/2001 Replaced by 8.50.125 NMAC, Fees, Payments, and Distributions effective 12/30/2010.
8.50.125 NMAC, Fees, Payments, and Distributions, filed 12/13/2010 Replaced by 8.50.125 NMAC, Fees, Payments, and Distributions effective 9/1/2022.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 129 CASE MANAGEMENT

8.50.129.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.129.1 NMAC - Rp, 8.50.129.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.129.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of IV-D services.
[8.50.129.2 NMAC - Rp, 8.50.129.2 NMAC, 12/30/2010]

8.50.129.3 STATUTORY AUTHORITY: Public Assistance Act, NMSA 1978, Section 27-2-27. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.129.3 NMAC - Rp, 8.50.129.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.129.4 DURATION: Permanent.
[8.50.129.4 NMAC - Rp, 8.50.129.4 NMAC, 12/30/2010]

8.50.129.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.129.5 NMAC - Rp, 8.50.129.5 NMAC, 12/30/2010]

8.50.129.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.129.6 NMAC - Rp, 8.50.129.6 NMAC, 12/30/2010]

8.50.129.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.129.8 CASE RECORDS: The IV-D agency maintains electronic and physical records necessary for the proper and efficient operation of the program.
[8.50.129.8 NMAC - Rp, 8.50.129.8 NMAC, 12/30/2010]

8.50.129.9 RETENTION OF RECORDS: Records will be retained in accordance with the state's retention schedule for the health care authority at 1.18.630 NMAC.
[8.50.129.9 NMAC - Rp, 8.50.129.9 NMAC, 12/30/2010]

8.50.129.10 SUSPENSION OF CASES: New Mexico IV-D cases may be suspended when it is not possible to proceed with the case and the case does not meet federal closure criteria.
[8.50.129.10 NMAC - Rp, 8.50.129.11 NMAC, 12/30/2010]

8.50.129.11 CLOSURE OF CASES: IV-D cases may be closed if they meet the federal case closure criteria in 45 CFR 303.11 or they were opened in error.
[8.50.129.11 NMAC - Rp, 8.50.129.12 NMAC, 12/30/2010]

History of 8.50.129 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.

8.50.129 NMAC, Case Management, filed 5/14/2001 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 130 ADMINISTRATIVE HEARINGS

8.50.130.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.130.1 NMAC - Rp, 8.50.130.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.130.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.
[8.50.130.2 NMAC - Rp, 8.50.130.2 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.130.3 NMAC - Rp, 8.50.130.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.130.4 DURATION: Permanent.
[8.50.130.4 NMAC - Rp, 8.50.130.4 NMAC, 12/30/2010]

8.50.130.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.130.5 NMAC - Rp, 8.50.130.5 NMAC, 12/30/2010]

8.50.130.6 OBJECTIVE: To provide regulations in accordance with federal and state law and regulations.
[8.50.130.6 NMAC - Rp, 8.50.130.6 NMAC, 12/30/2010]

8.50.130.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.130.8 ADMINISTRATIVE HEARINGS: Administrative hearings will be provided by the Title IV-D agency in the following situations:

A. an obligor requests a review pertaining to income withholding, consumer reporting, an adverse administrative order, referral for federal tax intercept, referral for state tax intercept, referral for passport denial, referral for administrative offset, lien on lottery winnings, lien on gaming winnings, or a FIDM referral;

B. any IV-A recipient or former IV-A recipient who believes the recipient is entitled to part or all of a support payment that was made to the Title IV-D agency but not disbursed to the recipient;

C. an obligor's spouse who requests the refund of more than one-half of a state tax intercept; and

D. an owner as defined in 8.50.132.7 NMAC who is claiming an interest in undistributed collections.

[8.50.130.8 NMAC - Rp, 8.50.130.8 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.9 IN GENERAL:

A. The hearing process provides the appellant notice and an opportunity to the appellant's claim.

B. Hearing appellant: A hearing "appellant" for the purpose of these regulations is any obligor, obligor's spouse (only in cases involving a state tax intercept), or obligee requesting and entitled to a review.

C. Appellant's rights: the right to a hearing includes the right:

(1) to be advised of the nature and availability of a hearing;

(2) to safeguards of the appellant's opportunity to present a case;

(3) to have prompt notice and implementation of the decision based upon the hearing results; and

(4) to be advised that if the appellant is not in agreement with the administrative hearing result, a judicial review may be invoked to the extent such review is available under state law.

[8.50.130.9 NMAC - Rp, 8.50.130.8 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.10 NOTICE OF ADMINISTRATIVE ENFORCEMENT ACTION:

A. Notices to obligor of referral to tax-offset program: The IV-D agency or federal office of child support enforcement sends written notice to inform an obligor that due to the amount of the obligor's past-due support the obligor will be referred for a tax refund offset. One or more of the following notices is sent:

(1) FMS pre-offset notice (obligor);
(2) taxation and revenue department pre-offset notice (obligor);
(3) taxation and revenue department pre-offset notice (injured spouse);
(4) IRS notice of offset; and
(5) taxation and revenue department final distribution notice.

B. Notice to obligor of FIDM freeze order: The Title IV-D agency will mail a notice of lien to the obligor at the last known address on file with the IV-D agency.

C. Notice to obligor of administrative lien on lottery and gaming winnings: The Title IV-D agency will mail a copy of the notice of administrative lien to the obligor at the last known address on file with the Title IV-D agency.

D. Notice to obligor for passport referral: Notice regarding the referral for passport denial is included in the FMS offset notice and is sent to the obligor at the last known address on file with the Title IV-D agency.

E. Notice to owner of an undistributed collection: The Title IV-D agency will mail a copy of the notice of undistributed collection to the owner at the last known address on file with the Title IV-D agency.

F. Notice to obligor for administrative offset referral: The Title IV-D agency will mail notice regarding the referral for administrative offset is included in the FMS offset notice and is sent to the obligor at the last known address on file with the Title IV-D agency.

G. All notices will include the process and timeframes for requesting an appeal.

[8.50.130.10 NMAC - Rp, 8.50.130.8 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.11 TIME FRAMES FOR REQUESTING AN ADMINISTRATIVE HEARING: In all cases where a time frame is not specifically provided, the appellant has 15 calendar days following the date of mailing of notice by the Title IV-D agency to submit a written request for an administrative hearing. The appellant has 30 days from the date on the pre-offset notice to request a hearing. In order to be considered timely, the request for a hearing on a pre-offset notice must be received by the Title IV-D agency no later than the close of business on the 30th day, or the next business day if the 30th day is a weekend or federally recognized holiday.

[8.50.130.11 NMAC - Rp, 8.50.130.8 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.12 CONTESTING TAX REFUND INTERCEPT IN INTERSTATE CASES:

A. If an appellant requests an administrative hearing the administrative law judge will send a notice of acknowledgment to the appellant and to the respective Title IV-D agency worker. The notice and acknowledgement shall include a statement regarding the timeliness of the request for hearing. In non-Title IV-A cases, the Title IV-D agency shall notify the custodial party of the time and place of the administrative hearing. The Title IV-D agency worker shall be available to testify at the administrative hearing.

B. If the appeal concerns an IRS joint tax refund that has not yet been intercepted, the appellant is informed that the IRS will notify the injured spouse at the time of intercept regarding the steps to take to secure their proper share of the refund. If the appeal concerns a joint tax refund that has already been intercepted, the injured spouse is referred to the IRS to seek resolution.

[8.50.130.12 NMAC - Rp, 8.50.130.9 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.13 CONTESTING TAX REFUND INTERCEPT IN RESPONDING INTERSTATE CASES: Administrative hearing requests are referred to the central registry in the responding state if the obligor requests a hearing in that state.

A. When the obligor, after receiving the FMS offset notice from the other state, contacts the Title IV-D agency worker, the worker may refer the obligor to the state that issued the notice. However, if the obligor contacts the Title IV-D agency as the last resort because they cannot get assistance from the other state, the worker may contact the other state, or refer the obligor to central registry and central registry staff will contact the other state.

B. If a request from the obligor for an administrative hearing in New Mexico is received and the case was submitted based on another state's order, a review of the arrearage computation submitted for tax intercept and the underlying documentation, and any new evidence provided by the appellant is completed, and an attempt is made to resolve the complaint. If the complaint cannot be resolved by the Title IV-D agency worker and the obligor requests an administrative hearing in the initiating state, the other state is notified by the New Mexico Title IV-D

agency of the request and all necessary information is provided within 10 days of the obligor's request for an administrative hearing.

C. The initiating state is responsible for all procedures required for conducting a hearing within that state.

[8.50.130.13 NMAC - Rp, 8.50.130.10 NMAC, 12/30/2010; A, 1/1/2020]

8.50.130.14 CONTESTING THE DENIAL OF PAYMENT OF AN UNDISTRIBUTED COLLECTION: An owner who is claiming an interest in an undistributed collection has 30 calendar days following the date that the Title IV-D agency denied payment of the undistributed collection to submit a written request for an administrative hearing.

[8.50.130.14 NMAC - N, 12/30/2010; A, 1/1/2022]

8.50.130.15 INITIATION OF HEARING PROCESS:

A. A request for hearing must be made in writing.

B. The administrative law judge shall acknowledge, in writing, the receipt of a written hearing request, and shall provide the appellant with written acknowledgment of the receipt.

C. Upon the request of the appellant, the Title IV-D staff shall assist in the preparation of a notice of hearing. The notice of hearing will be signed by the appellant.

[8.50.130.15 NMAC - N, 12/30/2010; A, 1/1/2022]

8.50.130.16 DENIAL/DISMISSAL OF REQUEST FOR HEARING:

A. The administrative law judge may deny or dismiss a request for hearing when:

(1) the request is not received within the specified time period;

(2) the situation has been resolved;

(3) the request is not made in writing; or

(4) a written withdrawal of request for hearing is received from the appellant, or a written agreement settling all issues is approved by all parties and is submitted to the administrative law judge.

B. A request for a hearing is considered abandoned and therefore dismissed if neither the appellant nor their representative appears at the time and place of the hearing, and if, within 10 days after a notice of abandonment is mailed by the administrative law judge, the appellant has not presented good cause for failing to appear. Good cause includes verification of a death in the family, doctor's note verifying a disabling personal illness, or other significant emergencies. At the discretion of the administrative law judge, a showing of exceptional circumstances is considered good cause.

[8.50.130.16 NMAC - Rp, 8.50.130.13 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.17 NOTICE OF HEARING: As early as possible and not less than 15 days prior to the hearing, written notice is sent by the administrative law judge to all parties involved in the hearing. The notice shall set forth the time, date and place of the hearing. Arrangements will be made to ensure that the hearing process is accessible to and accommodates the appellant, as long as the appellant provides at least 10 days advance notice to the administrative law judge of the need for reasonable accommodations. The notice of hearing includes an explanation of the hearing process and limitation of the scope of the hearing, the procedures to be followed during the hearing, and notification that the appellant should be ready to produce any required witnesses at the hearing or secure legal counsel prior to the hearing. The appellant is told that neither the HCA nor the Title IV-D agency will pay for any representation or legal counsel for appellant or for any hearing costs. The issuance of a notice of hearing by the administrative law judge shall act to stay the administrative action, pending the issuance of a ruling.

[8.50.130.17 NMAC - Rp, 8.50.130.12 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.18 APPELLANT'S RIGHTS: The appellant is given adequate opportunity to review and present evidence that is within the scope of the hearing.

A. The appellant may examine all documents to be used at the hearing prior to the date of the hearing, as well as during the hearing. If requested, the Title IV-D staff will provide copies of the portions of the case file that are relevant to the hearing. Confidential information that is protected from release and other documents or records that the appellant will not otherwise have an opportunity to challenge will not be introduced at the hearing or affect the administrative law judge's decision.

B. The appellant may present their case or have it presented by a representative.

C. The appellant may bring witnesses to present information that the appellant believes is relevant to the case.

D. The appellant may advance relevant arguments without undue interference.

E. The appellant may confront and cross-examine adverse witnesses.

F. The appellant may submit relevant evidence to support pertinent facts and defenses in the case.

[8.50.130.18 NMAC - Rp, 8.50.130.14 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.19 TITLE IV-D AGENCY RESPONSIBILITY: To ensure an appellant's rights during the hearing process, the Title IV-D agency shall:

A. make available, in a timely manner, without charge, the case documents (excluding any privileged, safeguarded or confidential information) necessary for an appellant or representative to determine whether a hearing should be requested or to prepare for a hearing;

B. provide an interpreter if the appellant requests one;

C. provide reasonable accommodations, if requested in advance; and

D. prepare a summary of evidence to include all documents to be presented by the Title IV-D agency at the hearing and all documents should be provided to the appellant, or their representative, by the Title IV-D agency at least 10 days prior to the hearing.

[8.50.130.19 NMAC - Rp. 8.50.130.15 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.20 PRE-HEARING ACTIVITY:

A. Preliminary conference: A preliminary conference may be scheduled prior to the hearing to discuss the issues concerning the hearing. The preliminary conference is held between the Title IV-D agency worker, the appellant, the Title IV-D attorney if an attorney is representing the appellant and the appellant's representative, as applicable. The administrative law judge is not involved and will not participate in the preliminary conference. This conference may provide an opportunity to resolve the dispute. A preliminary conference may lead to an informal resolution of the dispute. However, a hearing shall still be held unless the appellant makes a written withdrawal of their request for a hearing. If a written withdrawal is received by the Title IV-D agency worker, it must be forwarded to the administrative law judge. Appellants are advised that the preliminary conference is optional and that it will not delay or replace the hearing process.

B. The purposes of the pre-hearing conference include, but are not limited to:

(1) clarification, formulation and simplification of issues;

(2) resolution of some or all issues;

(3) exchange of documents and information;

(4) review of any audit findings; and

(5) discussion of other matters that might help dispose of any of the pending issues.

C. Matters left unresolved: If all matters in controversy are not resolved at the preliminary conference, a hearing is held.

[8.50.130.20 NMAC - Rp, 8.50.130.16 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.21 CONDUCT OF HEARING:

A. Conduct of a hearing is as follows:

(1) all hearings are conducted telephonically;

(2) the hearing is not open to the public;

(3) the administrative law judge identifies for the record all persons present at the hearing; and

(4) the administrative law judge takes administrative notice of those matters the same as state courts take judicial notice of, including the Title IV-D agency's policies and procedures.

B. Record: A hearing is electronically recorded. The recording is placed on file at the hearings unit and is available for examination by the appellant or representative for 30 days following the hearing. If a decision is appealed, an index log of the tape is prepared by the Title IV-D agency and a copy of the index log is supplied to the appellant free of charge.

C. Admission of evidence: Formal rules of evidence and civil procedure do not apply. The administrative law judge may allow hearsay testimony if it is deemed relevant to the decision. The rules of privilege will be effective to the extent that they are recognized in civil actions in the New Mexico district courts.

D. Case records: An appellant or representative is allowed to examine the entire hearing case record before, during and after the proceedings. The appellant or representative must request the hearing record and the Title IV-D agency will provide the record within a reasonable period of time.
[8.50.130.21 NMAC - Rp, 8.50.130.17 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.22 DECISION MAKING:

A. Authority: The hearing decision is based only on the evidence introduced and admitted by the administrative law judge during the hearing. This includes the record of the testimony, all reports, documents, forms, etc., made available at the hearing, provided that the appellant was given an opportunity to examine them as part of the hearing process.

B. Written decision: The administrative law judge will issue a written decision within 20 business days after the hearing.
[8.50.130.22 NMAC - Rp, 8.50.130.18 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.23 IMPLEMENTATION OF DECISIONS: The administrative law judge's decision is final and binding on all issues within the scope of a hearing and that have been the subject of a hearing, unless stayed by an appeal or a district court order.

A. Decision favorable to appellant regarding offsets:

(1) If the administrative hearing results in a deletion of, or decrease in, the amount referred for tax intercept, the tax intercept unit notifies the OCSE within 10 business days of the administrative hearing.

(2) If, as a result of the administrative hearing, an amount which has already been offset is found to have exceeded the amount of past-due support owed, the Title IV-D agency refunds the excess amount to the obligor promptly, and reports the refund to the OCSE. In joint return cases, the refund check is made payable to both parties.

B. Decisions regarding liens on lottery, gaming, or FIDM: The Title IV-D agency will take appropriate action in accordance with the decision of the administrative law judge. If the administrative law judge rules in favor of the appellant, the Title IV-D agency will take action to fully or partially release a freeze order or administrative lien, as appropriate. If the administrative law judge rules in the agency's favor, the Title IV-D agency will proceed to have the funds routed for distribution to the obligor's case(s) or held by the Title IV-D agency until all appeals relevant to the action have been exhausted.
[8.50.130.23 NMAC - Rp, 8.50.130.19 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.24 RIGHT OF APPEAL: Either party has the right to judicial review of the administrative law judge's decision or a denial of a hearing issued pursuant to 8.50.130.15 NMAC, unless a written withdrawal of request for hearing was signed by the appellant. If a hearing decision is in favor of the Title IV-D agency, appellant is notified of the right to pursue judicial review at the time of the decision.

A. Timeframes for appealing decision: Within 30 days after the date on the administrative law judge's decision, an appellant or the Title IV-D agency may appeal by filing an appropriate action for judicial review with the clerk of the appropriate district court, and filing a copy with the Title IV-D administrative law judge.

B. Record sent to district court: All appeals to the district court are on the record made at the hearing. The administrative law judge files one copy of the hearing record with the clerk of the appropriate district court and furnishes one copy to the appellant within 20 days after receipt of the notice of appeal.

C. Stay pending appeal: An appeal to the state district court shall act as a stay of the underlying administrative action, pending the court's ruling.
[8.50.130.24 NMAC - Rp, 8.50.130.20 NMAC, 12/30/2010; A, 1/1/2022]

8.50.130.25 STATE DIRECTORY OF NEW HIRES PENALTY ASSESSMENT HEARINGS: The health care authority, Title IV-D agency, has established a hearing process that provides for impartial review of New Mexico state directory of new hires claims against non-complying employers. (45 USC 653(d)). For purposes of these regulations, an employer requesting a hearing is referred to as an appellant.

A. Appellant eligibility: The Title IV-D agency established a hearing process for any individual who meets the following criteria:

(1) any employer who believes they have been erroneously assessed penalties; and

(2) who has been unable to resolve this issue with the New Mexico state directory of new hires representative at a preliminary conference.

B. Hearing appellant: A hearing appellant for the purposes of these regulations is any employer requesting review.

C. Appellant's rights: The right to a hearing includes the right:

(1) to be advised of the nature and availability of a hearing and the process to request a hearing;

(2) to be represented at the hearing by counsel or other person of the appellant's choice;

(3) to have a hearing that safeguards the appellant's opportunity to present a case;

(4) to have prompt notice and implementation of the administrative law judge's decision and

(5) to be advised that the appellant may request judicial review to the extent such review is available under state law, and that the Title IV-D agency does not pay for the cost of such proceedings

D. Penalty assessment notice: The New Mexico state directory of new hires sends written notice to inform an employer that penalties have been assessed. Each penalty assessment notice will:

(1) cite the statutory authority (Section 50-13-4 et seq., NMSA 1978) for the assessment of the penalty;

(2) include the name and last four digits of the social security number for each party not reported;

(3) list the total amount of penalties assessed;

(4) inform the employer that failure to report is the basis for penalty and does not require a knowing or deliberate act on the part of the employer;

(5) inform the employer that conspiracy can be established by circumstantial evidence;

(6) list requirements for employers to request a hearing if they disagree with the assessment;

(7) provide the name and business telephone number of a Title IV-D agency contact to provide additional information or answer questions relating to the assessment of penalties and to request a hearing.

E. Time frames for requesting hearing: The appellant has 30 days from the date on the penalties assessment notice to submit a written request for a hearing. In order to be considered timely, the request must be received by the administrative law judge no later than the close of business on the 30th day. When a timely request for hearing is received by the administrative law judge, the administrative law judge notifies the new hires directory, state project manager immediately so that a preliminary conference can be scheduled.

F. Notice of hearing: Upon receipt of a timely request for hearing, written notice is sent by the administrative law judge to all parties involved in the hearing regarding the time, date and place of the hearing. Arrangements will be made to ensure that the hearing process is accessible to and accommodates the appellant. In the hearing notice, appellants are also given an explanation of the hearing process, the procedures to be followed for the hearing, and enough time to secure witnesses or legal counsel. The appellant shall be informed that neither the HCA nor the Title IV-D agency pays for representation or legal counsel for appellant or for any hearings costs, and are provided the name and business telephone number of a contact who can provide additional information relating to the assessment of penalties. A hearing may be continued or rescheduled with the consent of all parties.

G. State directory of new hires responsibility: To ensure an appellant's rights during the hearing process, the state directory of new hires staff will:

(1) upon request, make available in a timely manner the documents necessary for an appellant or representative to determine whether to request a hearing or to prepare for a hearing;

(2) upon request, help appellant submit a written hearing request.

H. Effect of issuance of notice of hearing: All provisions contained in sections 8.50.130.15, 8.50.130.17, 8.50.130.19, 8.50.130.20 and 8.50.130.22 NMAC apply when a notice of hearing is issued pursuant to subsection F above.

[8.50.130.25 NMAC - Rp, 8.50.130.21 NMAC, 12/30/2010; A, 1/1/2022]

History of 8.50.130 NMAC:

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

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NMAC History:

8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:

8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.

8.50.130 NMAC, Administrative Hearings, filed 5/14/2001 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 131 PENALTIES

8.50.131.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.131.1 NMAC - Rp, 8.50.131.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.131.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of IV-D services.
[8.50.131.2 NMAC - Rp, 8.50.131.2 NMAC, 12/30/2010]

8.50.131.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.131.3 NMAC - Rp, 8.50.131.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.131.4 DURATION: Permanent.
[8.50.131.4 NMAC - Rp, 8.50.131.4 NMAC, 12/30/2010]

8.50.131.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.131.5 NMAC - Rp, 8.50.131.5 NMAC, 12/30/2010]

8.50.131.6 OBJECTIVE: To provide regulations in accordance with federal and state law and regulations.
[8.50.131.6 NMAC - Rp, 8.50.131.6 NMAC, 12/30/2010]

8.50.131.7 DEFINITIONS: [RESERVED]
[See 8.50.100.7 NMAC]

8.50.131.8 PENALTIES: In cases of non-compliance with an administrative subpoena or order, the IV-D agency may levy penalties as provided by these rules. If no response is made to a mailed subpoena or administrative order, it may be personally served and the charges for the service may be awarded against the person or entity failing to respond. Monetary penalty amounts shall include the following.

A. For financial institutions' failure to execute and return a FIDM reporting election form: $100 per day commencing on the date the response was due until the required information is furnished to the IV-D agency.

B. For failure to file quarterly match or for failure to file in proper form: $1,000 per day commencing on the day the response was due, except in circumstances outside the control of the financial institution and approved by the IV-D agency.

C. For failure to comply with a freeze order: The amount of any assets released up to the amount of the subpoena or freeze order, plus ten percent.

D. For failure to comply with a seize order: The amount of any assets released up to the amount of the subpoena or seize order, plus ten percent.

E. For failure to comply with an administrative subpoena: The value of any assets released up to the amount to satisfy judgment, plus ten percent.

F. For failure to comply with an increase in the amount of withholding: $100 per day, plus the amount(s) which was or were not withheld.

G. For failure to comply with an order for withholding: $100 day, plus the amount(s) that were not withheld.

H. For failure to comply with an order for genetic testing: $100 per day.

I. For failure to comply with an order to provide information: $100 per day.

J. For failure to comply with any other administrative order issued by the IV-D agency: $100 per day.

K. For obtaining release of assets through false statements: $1,000 per occurrence, plus the value of any assets released. Persons submitting fraudulent material may also be referred for criminal prosecution.

L. For deliberate falsification of a financial institution data match form: $1,000 per account plus the value of any assets released. Persons submitting fraudulent material may also be referred for criminal prosecution.

M. A reasonable cost may also be levied for the expense of an enforcement action under these regulations.

N. The IV-D agency will impose a civil penalty of $20 on employers for each instance of failure to comply with the provisions of 8.50.106.18 NMAC, unless the failure is the result of a conspiracy between the employer and the employee to not supply the required report or to supply a false or incomplete report, in which case the penalty will be $500 on the employer for each instance. An employer may appeal a penalty as provided in 8.50.130 NMAC.

[8.50.131.8 NMAC - Rp, 8.50.131.8 NMAC, 12/30/2010]

History of 8.50.131 NMAC:

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

ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.

NMAC History:

8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:

8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.

8.50.131 NMAC, Penalties, filed 5/14/2001 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 132 UNCLAIMED CHILD, SPOUSAL OR MEDICAL SUPPORT

8.50.132.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Services Division.
[8.50.132.1 NMAC - Rp, 8.50.132.1 NMAC, 12/30/2010; A, 7/1/2024]

8.50.132.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of IV-D services.
[8.50.132.2 NMAC - Rp, 8.50.132.2 NMAC, 12/30/2010]

8.50.132.3 STATUTORY AUTHORITY: Public Assistance Act, Paragraph (5) of Subsection A of Section 27-2-27 NMSA 1978. The health care authority (HCA) is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.132.3 NMAC - Rp, 8.50.132.3 NMAC, 12/30/2010; A, 7/1/2024]

8.50.132.4 DURATION: Permanent.
[8.50.132.4 NMAC - Rp, 8.50.132.4 NMAC, 12/30/2010]

8.50.132.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.132.5 NMAC - Rp, 8.50.132.5 NMAC, 12/30/2010]

8.50.132.6 OBJECTIVE: To provide regulations in accordance with federal and state law and regulations.
[8.50.132.6 NMAC - Rp, 8.50.132.6 NMAC, 12/30/2010]

8.50.132.7 DEFINITIONS: For purposes relating to unclaimed child, spousal or medical support payments the following definitions will apply.

A. "Department" is the New Mexico health care authority (HCA), child support services division (also known as the Title IV-D agency or IV-D agency).

B. "Owner" means a person who has a legal interest in property. In cases where support is due and owing, the owner is the custodial party. In cases where support is fully satisfied and the IV-D agency has excess funds on hold, the owner is the obligor. If support is received from an employer, and there is no information regarding the custodial or non-custodial party, the owner is the employer until such time that a custodial or non-custodial party can be identified.

C. "Support" means money (including a check, draft, deposit, interest, overpayment, refund or credit), real or personal property, or other assets held, received, or seized pursuant to an order to pay child support, spousal support (alimony) or medical support.

D. "Unclaimed" means that no person to whom to deliver the support received or seized by the department can be located or identified. "Unclaimed" also includes situations when the custodial party, non-custodial party, or child(ren) are deceased and no claimant comes forward after notice is sent to the last known address or last known employer of the custodial party and non-custodial party. Money distributed to a custodial party via electronic funds transfer is not subject to being unclaimed property in possession of the IV-D agency once it is distributed to an account.
[8.50.132.7 NMAC - Rp, 8.50.132.7 NMAC, 12/30/2010]

8.50.132.8 EFFORTS TO LOCATE: Before support may be declared unclaimed by the HCA, the HCA shall make reasonable attempts to locate the owner. These attempts shall include the following:

A. If there is no case or payee identified in the support transmittal, the HCA shall attempt to ascertain the case to which property should be applied through any documents accompanying the payment.

B. If unable to ascertain the case to which the support should be applied, the HCA shall attempt to contact the person, if any, named in the return address on the mailing envelope by mailing a notice of intent to declare property unclaimed to the return address.

[8.50.132.8 NMAC - Rp, 8.50.132.8 NMAC, 12/30/2010]

8.50.132.9 NOTICE OF ABANDONMENT OF UNCLAIMED SUPPORT:

A. If, after 36 months from the date the support is paid to the HCA, the HCA is unable to disburse a payment to the owner because of failure to locate, the HCA shall send a notice indicating that the unclaimed support shall revert to the HCA unless the owner files a claim within 30 days from the date of the notice.

B. Support not claimed within the timeframe described in subsection A above will be deemed as "unclaimed" support and will be distributed to the HCA. In cases where the custodial party is owed the support and fails to claim the support, the non-custodial party will receive credit for the amount of support paid.

[8.50.132.9 NMAC - Rp, 8.50.132.9 NMAC, 12/30/2010]

8.50.132.10 RECOVERY BY PERSON TO WHOM SUPPORT IS OWED: The HCA may make payment or return support to a person reasonably appearing to be entitled to payment, if the support has not already been disbursed to the department as unclaimed property. The owner should immediately contact the HCA as indicated below in 8.50.132.11 NMAC to establish a claim for the undistributed support. When the owner's identity is verified, the HCA will distribute the support to the owner so long as the owner made their claim within the appropriate timeframes.

[8.50.132.10 NMAC - Rp, 8.50.132.10 NMAC, 12/30/2010]

8.50.132.11 FILING CLAIM WITH HCA; HANDLING OF CLAIMS BY DEPARTMENT: A person, claiming they are owed money or property from the HCA under this rule, may file a claim on a form prescribed by the HCA and verified under oath or affirmation by the claimant.

A. Within 30 days after a claim is filed, the HCA shall allow or deny the claim and give written notice of the decision to the claimant.

B. A person whose claim has not been acted upon within 30 days after its filing may immediately file an administrative appeal to establish the claim.

C. A person adversely affected by a decision of the HCA may, within 30 days after notice of the decision, file an administrative appeal in accordance with 8.50.130 NMAC.

[8.50.132.11 NMAC - Rp, 8.50.132.12 NMAC, 12/30/2010]

History of 8.50.132 NMAC:

History of Repealed Material:

8.50.132 NMAC, Unclaimed Child, Spousal, or Medical Support, filed 5/3/2004 - Repealed effective 12/30/2010.

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 140 GENERAL OPERATING POLICIES CASE FILES

8.100.140.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.140.1 NMAC - Rp, 8.100.140.1 NMAC, 11/27/2013; A, 7/1/2024]

8.100.140.2 SCOPE: The rule applies to the general public.
[8.100.140.2 NMAC - Rp, 8.100.140.2 NMAC, 11/27/2013]

8.100.140.3 STATUTORY AUTHORITY:
A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations...." It also provides for administration of public assistance programs.
B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.
C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.100.140.3 NMAC - Rp, 8.100.140.3 NMAC, 11/27/2013 A, 7/1/2024]

8.100.140.4 DURATION: Permanent.
[8.100.140.4 NMAC - Rp, 8.100.140.4 NMAC, 11/27/2013]

8.100.140.5 EFFECTIVE DATE: November 27, 2013, unless a later date is cited at the end of a section.
[8.100.140.5 NMAC - Rp, 8.100.140.5 NMAC, 11/27/2013]

8.100.140.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for the ISD administered programs.
[8.100.140.6 NMAC - Rp, 8.100.140.6 NMAC, 11/27/2013]

8.100.140.7 DEFINITIONS: [Reserved]

8.100.140.8 PURPOSE OF CASE FILES
A. ISD case records consisting of forms, records, narrative material, correspondence, and documents are scanned into electronic format and maintained in the department's secure electronic data management system. Documents submitted in person will be electronically scanned and returned to the individual. Original documents mailed to or left with the office will be photocopied and the originals mailed back to the client at their last known address known to the department. The copied documents will be electronically scanned and destroyed once successful completion of a scan into electronic format is confirmed. The case record documents the current and historical eligibility of a recipient group and thereby to establish the validity of decisions to approve or deny assistance.
B. Case records are the property of the HCA and are established and maintained solely for use in the public assistance programs administered by the HCA. Information contained in the case records is confidential and is released only under the limited circumstances and conditions as provided in federal and state laws and regulations, including 8.100.100 NMAC, Sections 13 through 15. Case records and their contents must remain in the possession of the HCA, its contractors, or approved federal employees. Copies of case records may be released in accordance with federal and state laws and regulations or pursuant to a court order.
C. Electronic eligibility system information: Client information stored on the HCA's electronic eligibility system is subject to the same guidelines for release of information as the HCA's case record.
[8.100.140.8 NMAC - Rp, 8.100.140.8 NMAC, 11/27/2013]

8.100.140.9 CONTENT OF CASE NARRATIVE: The following narrative outline is used on all applications for assistance, and to record data and verification concerning all variable conditions of eligibility. After the initial determination of eligibility for assistance, no additional data are required in redeterminations except for those eligibility conditions which are subject to change.

A. The case narrative is used for the comprehensive recording of relevant factual information in the case record. Narrative entries must be made promptly, with dates of relevant contacts.

B. Recorded information should be limited to items which are applicable to the case, such as changes in eligibility factors since the last review. Information which does not change, such as social security numbers, is not repeated.

C. The items below are intended as a minimum requirement for case narratives. Each county office manager has the privilege of expanding it at their discretion.

[8.100.140.9 NMAC - Rp, 8.100.140.9 NMAC, 11/27/2013]

8.100.140.10 ESSENTIAL INFORMATION AT INITIAL DETERMINATION

A. Heading: Case name and number.

B. Application and intake:

(1) date of application, program applied for and reason for application stated in terms of the client's circumstances;

(2) documentation of worker's explanation of client's rights and responsibilities;

(3) names of individuals for whom application is being made.

C. Basic eligibility factors: Explanation of how each basic eligibility factor has been established, including: residence; non-transfer of property; school attendance; nonconcurrent receipt of assistance; living in the home of the specified relative; citizenship; parentage; and age.

D. Child support services division (CSSD) cooperation: Status of cooperation with the CSSD.

E. Enumeration: Status of enumeration (social security number) of each person.

F. Retroactive medicaid status: Status of eligibility for retroactive medicaid requested by applicant.

G. Work program status:

(1) current work program participation status, work participation agreement, assessment certification or copy of assessment and individual responsibility plan for each benefit group member subject to work program requirements;

(2) disability determination request for applying for limited work participation status;

(3) determination of limited work participation status request;

(4) any other work program related documentation.

H. Medical resources - third party liability: Verification of third party liability that includes the name(s) of the private health insurance, type of available coverage, name of each insured individual(s), the policy and group number for each insured individual, and other information, as needed, in accordance with federal and state laws and regulations.

I. Need:

(1) documentation and discussion of all pertinent factors relating to the condition of eligibility;

(2) list of amounts, verifications and dates of income and resources by individual;

(3) explanation of earned income computations.

J. Shelter (for applicable programs)**:** Documentation of shelter information, including whether housing is subsidized by the government.

K. SNAP: Status of the certification. Explanation of circumstances affecting SNAP certification.

L. Disposition of application: Effective date of approval/denial. Reference to appropriate manual section for denials.

M. Follow-up: Necessary follow-ups.

[8.100.140.10 NMAC - Rp, 8.100.140.10 NMAC, 11/27/2013]

8.100.140.11 REDETERMINATION/RECERTIFICATION

A. date of interview and how household composition or living arrangements are established;

B. documentation of school attendance of children in benefit group;

C. documentation of current resources and income; accounting for all formerly reported income and resources;

D. updated information on non-custodial parents and status of cooperation with the CSSD;

E. review of work and work program participation and planning;

F. disposition of SNAP certification; and

G. list of necessary follow-ups.

[8.100.140.11 NMAC - Rp, 8.100.140.11 NMAC, 11/27/2013]

History of 8.100.140 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center: ISD Rule 131, Administrative Policy, filed 2/10/1988.

History of Repealed Material:
8 NMAC 3.ISD.140, General Operating Policies, Case Files, filed 6/16/1997 - Repealed effective 7/1/1997.
8.100.140 NMAC, General Operating Policies Case Files, filed 3/26/2001 - Repealed effective 11/27/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 640 RESTORATION AND CLAIMS

8.100.640.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.640.1 NMAC - N, 09/30/2013; A, 7/1/2024]

8.100.640.2 SCOPE: The rule applies to the general public.
[8.100.640.2 NMAC - N, 09/30/2013]

8.100.640.3 STATUTORY AUTHORITY:

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

B. The income support division (ISD) of the HCA was created by the HCA secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.

[8.100.640.3 NMAC - N, 09/30/2013 ; A, 7/1/2024]

8.100.640.4 DURATION: Permanent.
[8.100.640.4 NMAC - N, 09/30/2013]

8.100.640.5 EFFECTIVE DATE: September 30, 2013, unless a later date is cited at the end of a section.
[8.100.640.5 NMAC - N, 09/30/2013]

8.100.640.6 OBJECTIVE: The objective of these regulations is to provide regulations in accordance with federal and state laws and regulations for the ISD administered programs.
[8.100.640.6 NMAC - N, 09/30/2013]

8.100.640.7 DEFINITIONS: Unless otherwise apparent from the context, the following definitions shall apply throughout these regulations.

A. Claim: means correcting the over-issuance of benefits an eligibility determination group received, but was not entitled to receive, subject to the recovery of such overpayments.

B. Administrative or agency error (AE) claim: means any claim for an overpayment caused by an action or failure to take action by the HCA.

C. Eligibility determination group: means the basic assistance unit for a category of assistance, or a group of people, either mandatory or optional, to be included in determining the monthly benefit amount.

D. Inadvertent household error (IHE) claim: means any claim for an overpayment resulting from a misunderstanding or unintended error on the part of the eligibility determination group.

E. Intentional program violation (IPV) claim: means any claim for an overpayment or trafficking resulting from an individual committing an IPV, as defined in regulation in Subsection D of 8.139.647.8 NMAC.

F. Restoration: means the issuance of benefits to an eligibility determination group that it was entitled to receive, but did not receive due to:

(1) an agency error or HCA discovered error;

(2) judicial action; a favorable fair hearing decision or an erroneous administrative disqualification for an IPV that is later reversed; or

(3) a regulation specifically requiring issuance of lost benefits.

G. Sponsored non-citizens: means a non-citizen lawfully admitted for permanent residence in the United States as an immigrant, as defined in Subsection 101(a)(15) and Subsection 101(a)(2) of the Immigration and Nationality Act.

H. Supplement: means the amount of benefits issued in addition to the monthly benefit amount the eligibility determination group has already received that equals the amount of benefits the group was entitled to receive for that month.

[8.100.640.7 NMAC - N, 09/30/2013]

8.100.640.8 ERRONEOUS PAYMENT PROVISIONS: An erroneous payment exists when an error is made by the client or the HCA that resulted in an underpayment or overpayment of program benefits. The difference between the amount issued and the corrected amount is the amount of the payment error. The HCA shall take action to correct errors in the supplemental nutrition assistance program (SNAP), state SNAP supplement, New Mexico combined application project (NMCAP), New Mexico works (NMW) cash assistance, general assistance for disabled adults and unrelated children (GA), adult residential shelter care home (ARSCH), education works (EWP), refugee cash assistance, medical assistance, and LIHEAP benefits issued to an eligibility determination group regardless of the cause of the error. NMW cash assistance, GA, ARSCH, EWP, refugee cash assistance will be referenced as cash assistance programs throughout the regulations unless otherwise specified.

A. The HCA will correct the error by restoring benefits for an underpayment or establishing claims for an overpayment.

B. SNAP: The amount of the restoration or claim is determined by using the maximum SNAP benefit amount and applying the allowable deductions in place for a particular month, including any federal law placing a restriction on the use of deductions.

C. Cash assistance programs: The amount of the restoration or claim is determined using the standard of need the case was eligible for on the first day of a month. If the standard of need increases during the month, the higher amount shall be allowed for the entire month.

[8.100.640.8 NMAC - N, 09/30/2013]

8.100.640.9 ESTABLISHING PERIOD OF ERROR:

A. An erroneous payment occurs when an error is made by the client or the HCA that resulted in an underpayment or overpayment of program benefits or assistance.

B. Restoration of benefits: If benefits must be restored to an eligibility determination group, the HCA shall determine each month for which the eligibility determination group was underpaid benefits. The month(s) may or may not be consecutive. In some cases, federal regulations mandate the restoration of SNAP benefits to eligibility determination groups for a specific time period.

C. Overpayment of benefits:

(1) Establishing period of overpayment: If benefits have been overpaid to an eligibility determination group, the HCA shall determine each month in which the eligibility determination group received benefits to which it was not entitled. The months may or may not be consecutive.

(a) The first month in which a benefit is considered erroneous is the month in which the eligibility determination group received a benefit amount differing from the amount that the eligibility determination group was entitled to receive.

(b) The last month of an erroneous payment ends on the last day of the last month in which payment is discovered. In the case of an overpayment, if the period of overpayment has been extended while a proposed reduction or termination is the subject of an administrative hearing decision, it is included in the overpayment claim period.

(2) Establishing a claim: A claim will be established against any eligibility determination group for any month in which the eligibility determination group received an overpayment of benefits if it exceeds the claims establishment threshold as defined in Subsection G of 8.100.640.11 NMAC.

(a) At a minimum, the HCA shall take action on claims for which 12 months or less have elapsed between the month an overpayment occurred and the month the overpayment was discovered.

(b) The HCA may choose to take action on claims for which more than 12 months have elapsed.

(c) No action will be taken on claims for which more than six years have elapsed between the month an overpayment occurred and the month an overpayment was discovered.

[8.100.640.9 NMAC - N, 09/30/2013]

8.100.640.10 RESTORATION OF BENEFITS:

A. Entitlement:

(1) Program benefits will be restored to an eligibility determination group when the loss was caused by:

(a) agency error;

(b) SNAP administrative disqualification for IPV that is later reversed; or

(c) a regulation specifically requiring restoration of lost benefits.

(2) Unless there is a specific regulation authorizing benefit restoration for a longer period,

SNAP benefits will be restored for not more than the 12 months prior to whichever of the following occurred first:

(a) date the HCA receives a request for restoration from an eligibility determination group; or

(b) date the HCA is notified or otherwise discovers that a loss to an eligibility determination group has occurred; or

(c) if the resolution of a request extends beyond the 12 month limit, an eligibility determination group will be entitled to more than 12 months of restored benefits.

B. Errors in benefits:

(1) ISD discovered errors:

(a) If the HCA determines that a loss of benefits has occurred, and that an eligibility determination group is entitled to a restoration of benefits, action will be taken automatically to restore lost benefits. No action by the eligibility determination group is necessary.

(b) Benefits will not be restored if benefits were lost more than 12 months before the month the loss was discovered in the normal course of business, or loss occurred more than 12 months before the month the HCA was notified, in writing or orally, of a possible loss to a specific eligibility determination group.

(c) The HCA shall notify the eligibility determination group of entitlement to lost benefits; amount of benefits to be restored; any offsetting that will be done; method of restoration, and right to appeal through the fair hearing process if the eligibility determination group disagrees with any aspect of the proposed restoration.

(2) Judicial action:

(a) The HCA shall restore benefits found by any judicial action to have been wrongfully withheld.

(b) If the judicial action is the first action the recipient has taken to obtain restoration of lost benefits, then benefits will be restored for a period of not more than 12 months from the date the court action was initiated.

(c) If the judicial action is a review of the HCA's action, benefits will be restored for a period of not more than 12 months from the first of the following dates:

(i) date the HCA receives a request for restoration;

(ii) if a request for restoration is not received, date the fair hearing action was initiated; but never more than one year from the date the HCA is notified of, or discovers, the loss.

(3) Disqualification for SNAP IPV:

(a) For each month an eligibility determination group member is erroneously disqualified, not to exceed 12 months, the amount to be restored is determined by comparing the SNAP benefit amount the eligibility determination group received with the amount the eligibility determination group would have received if the disqualified member had been allowed to participate.

(b) Participation in an administrative disqualification hearing in which the eligibility determination group is contesting the HCA's assertion of IPV is considered notification that the eligibility determination group is requesting restored SNAP benefits.

(4) Agency errors:

(a) If an eligible eligibility determination group's application has been erroneously denied, the month the loss initially occurred will be the month of application; or for an eligible eligibility determination group filing a timely reapplication, the month following the expiration of its certification period.

(b) If an eligible eligibility determination group's application was delayed, the months for which benefits were lost will be calculated in accordance with application processing guidelines for delayed eligibility determinations in Subsection D of 8.139.110.13 NMAC, Subsection D of 8.102.110.12 NMAC and Subsection C of 8.106.110.12 NMAC.

(c) If an eligibility determination group's benefits were erroneously terminated, the month the loss initially occurred will be the first month that benefits were not received as a result of the erroneous action.

C. Processing the restoration:

(1) SNAP: Regardless of whether an eligibility determination group is currently eligible or ineligible, the HCA shall restore lost benefits to an eligibility determination group by issuing an amount equal to the amount of benefits that were lost. The amount restored is issued in addition to the benefit amount a currently eligible eligibility determination group is entitled to receive.

(a) For each month affected by the loss, the HCA shall determine if the eligibility determination group was actually eligible.

(b) In cases where there is no information in the eligibility determination group's case record to document that the eligibility determination group was actually eligible, the HCA shall notify the eligibility determination group in writing of what information is necessary to determine eligibility for these months. For each month the eligibility determination group cannot provide the necessary information to demonstrate its eligibility, the eligibility determination group will be determined ineligible.

(2) Cash assistance programs: The HCA shall restore lost cash assistance benefits for eligibility determination groups who are currently eligible under the cash assistance program that the error occurred or would be eligible except for the error causing the underpayment.

(a) A restoration to a denied applicant or to a former participant who is not eligible at the time the error is discovered shall be corrected if the applicant is, or participant becomes, eligible at a later date.

(b) Before issuing a benefit correcting an underpayment, the HCA subtracts from the amount owed to the participant any outstanding claim against the participant in the cash assistance program that the error is being corrected.

(3) Medical assistance programs: The HCA shall restore months of eligibility for individuals who are currently eligible under the medical assistance program that the error occurred or would be eligible except for the error causing the ineligibility.

[8.100.640.10 NMAC - N, 09/30/2013]

8.100.640.11 OVERPAYMENTS (CLAIMS AGAINST ELIGIBILITY DETERMINATION GROUPS): The HCA shall take action to establish a claim against any eligibility determination group that received more benefits than it was entitled to receive, including LIHEAP benefits paid to a vendor on behalf of the eligibility determination group, whether or not the overpayment occurred because of an IHE, an AE, or an IPV.

A. Claim recovery:

(1) All adult eligibility determination group members will be jointly liable for any overpayment of benefits to the eligibility determination group.

(2) A claim will be established against any or all of the adult members of an eligibility determination group at the time an overpayment occurred.

(3) A claim will be established against any eligibility determination group that contains an adult member who was an adult member of another eligibility determination group that received more benefits than it was entitled to receive.

(4) The earned income deduction of twenty percent is not allowed when determining an overpayment due to the failure of an eligibility determination group to report earned income in a timely manner.

B. Types of claims for all programs:

(1) IHE claims:

(a) A claim will be handled as an IHE claim if the overpayment was caused by:

(i) the misunderstanding or unintended error on the part of the eligibility determination group; or

(ii) the misunderstanding or unintended error on the part of a categorically eligible eligibility determination group, provided that a claim can be calculated based on a change in the eligibility determination group's net income, eligibility determination group size, or both; or

(iii) a social security administration action, or failure to take action, resulting in an eligibility determination group becoming or continuing categorical eligibility, provided that a claim can be calculated based on a change in net income, eligibility determination group size, or both.

(b) Instances of IHE's that may result in a claim include, but are not limited to, the following:

(i) eligibility determination group unintentionally failed to provide the HCA with correct or complete information; or

(ii) eligibility determination group unintentionally failed to report changes in its circumstances; or

(iii) eligibility determination group unintentionally received benefits or received more benefits than it was entitled to receive pending a fair hearing decision because the eligibility determination group requested a continuation of benefits based on the mistaken belief it was entitled to them; or

(iv) eligibility determination group received benefits solely because of categorical eligibility, but was later determined ineligible for cash assistance; or

(v) social security administration took action or failed to take appropriate

action, resulting in the eligibility determination group improperly receiving supplemental security income (SSI).

(2) Administrative or agency errors:

(a) A claim will be handled as an AE claim if the overpayment was caused by the HCA's action or failure to take action.

(b) In the case of a SNAP categorical eligibility, a claim will be handled as an AE if action by an agency of the state or local government resulted in the eligibility determination group's improper eligibility for cash assistance.

C. IPV claims established for SNAP:

(1) A claim will be handled as an IPV claim only if:

(a) an administrative disqualification hearing official or a court of appropriate jurisdiction has determined that an eligibility determination group member committed an IPV; or

(b) an individual is disqualified as a result of signing a waiver of disqualification hearing in a case referred for prosecution; or

(c) an individual has signed a disqualification consent agreement in a case of deferred adjudication; or

(d) an individual has signed a waiver of an administrative disqualification hearing in a case referred for disqualification.

(2) Before the determination of an IPV or the signing of either the waiver of right to a disqualification hearing or a disqualification consent agreement, the claim against an eligibility determination group is handled as an IHE claim.

D. Claims for medical assistance benefits: Upon a determination that the individual is not eligible for the category of assistance in which they were enrolled, the HCA shall determine if the individual is eligible for any category of assistance. If the individual is ineligible for any category, the HCA shall determine which months the individual was not eligible and forward the documentation to the medical assistance division for the determination of repayment of fee for service payments or the capitation payments made to the health maintenance organization on behalf of the individual for months the individual was not eligible for the category of assistance. The HCA will pursue the repayment of capitation amounts paid to the health maintenance organization for the months the individual was ineligible for any medical assistance programs and received medical services.

E. Development of information: When quality control review findings, or information reported or received indicate, that benefits may have been issued incorrectly; the HCA shall attempt to obtain and verify whether benefits were provided in error.

F. When claims are not established: Overpayment claims shall not be established for administrative or IHE's, if an over-issuance occurred because the HCA did not ensure that the following procedural requirements were fulfilled:

(1) an application form was signed; or

(2) appropriate work registration code was entered.

G. Claim establishment threshold: Claims for SNAP, cash assistance and LIHEAP will not be established when the cumulative amount of the claim is less than the establishment thresholds.

(1) Claims for all programs resulting from an administrative error will not be established if the cumulative claim is less than $500.

(2) Claims resulting from an IHE will not be established if the cumulative error is less than $250.

(3) Claims resulting from fraud or an IPV will always be established for the full amount of the overpayment.

[8.100.640.11 NMAC - N, 09/30/2013]

8.100.640.12 CALCULATING THE AMOUNT OF THE ERROR (CALCULATING CLAIMS)

A. SNAP:

(1) Calculating the claim for an IHE and AE: For each month that benefits have been over-issued to an eligibility determination group because of an IHE or AE, the HCA shall determine the correct benefit amount the eligibility determination group was entitled to receive.

(a) The total amount of the claim is calculated, based at a minimum, on the monthly overpayment amount which occurred during the 12 months preceding the date the overpayment was discovered.

(b) The HCA shall calculate the amount of the claim back to the month the error occurred regardless of the length of time that elapsed until the error was discovered.

(c) The HCA shall not include in the calculation any overpayment amount that occurred in a month more than six years before the date the overpayment was discovered.

(2) Calculating the claim for an IPV:

(a) For each month that benefits have been over-issued to an eligibility determination group because of an IPV, the HCA shall determine the correct amount of benefits the eligibility determination group was entitled to receive.

(b) The amount of the IPV claim will be calculated back to the month the IPV occurred, regardless of the length of time that elapsed until the determination of an IPV was made.

(c) The HCA may not include in the calculation any amount of the overpayment that occurred in a month more than six years prior to the date the overpayment was discovered.

(d) If an eligibility determination group member is determined to have committed an IPV by intentionally failing to report a change in eligibility determination group circumstances, the first month affected by the failure to report will be the first month in which the change would have been effective if it had been timely reported.

(e) In no event shall the HCA determine as the first month that the change would have been effective any month later than two months after the month that the change in eligibility determination group circumstances occurred.

(f) If an eligibility determination group received a larger benefit amount than it was entitled to receive, a claim will be established against the eligibility determination group equal to the difference between the benefit amount the eligibility determination group received and the amount the eligibility determination group should have received.

(g) Earned income deduction penalty: When determining the amount of benefits the eligibility determination group should have received, the twenty percent earned income deduction is not applied to that portion of earned income that the eligibility determination group intentionally failed to report. A claim must be recomputed if it was initially handled as an IHE claim.

(3) Offsetting the claim: Once the amount of the claim for IPV, IHE, and AE is established, the HCA may offset the amount of the claim against any benefit amount not yet restored to the eligibility determination group. Action must be taken to initiate collection of the remaining balance, if any.

B. Cash assistance programs:

(1) Claims for administrative and client caused errors: Claims are established when the HCA issues more than the eligibility determination group was eligible to receive due to an AE or if the eligibility determination group fails, either intentionally or unintentionally, to report correct information at application or while receiving benefits.

(a) For each month of eligibility, the grant determinations are made using the standard of need, case information and policy in effect for that month.

(b) The HCA shall recover all cash assistance overpayments, including overpayments resulting from an AE, and any assistance paid while pending a fair hearing decision.

(c) An historical change that results in a lower payment than was originally issued, results in an overpayment and the establishment of a claim if it exceeds the claims establishment thresholds listed in Subsection G of 8.100.640.11 NMAC.

(d) If a change occurs that makes the eligibility determination group eligible for a lower benefit payment for a month, the adult member(s) of the eligibility benefit group is responsible for paying the difference back to the HCA.

(e) If a change occurs that lowers the standard of need for which the eligibility determination group is eligible, the eligibility determination group shall be allowed the amount that they were eligible on the first day of the month.

(2) Overpayments to sponsored non-citizens:

(a) Non-citizens and sponsors are jointly liable for overpayments caused by failure of the sponsor to provide correct information, unless the sponsor is without fault or has good cause. "Without fault" or "good cause" exists when:

(i) the agency failed to request information from the sponsor; or

(ii) the sponsor can show that the sponsor provided all information available to the sponsor at the time the information was provided;

(iii) the non-citizen provided incorrect information without the knowledge of the sponsor; or

(iv) the sponsor can show that the giving of incorrect information was not intentional on the part of the sponsor.

(b) If good cause is found to exist, the non-citizen has sole responsibility for repayment.

(3) Developing substantiating information:

(a) Upon receiving indication that a possible error exists, the HCA shall investigate whether an erroneous payment has occurred. Pertinent information shall be requested from the participant. Because this information may be used to prosecute the participant for fraud, the participant shall not be required to provide such information; however, if the participant declines to provide information crucial to the determination of overpayment, the participant shall be ineligible for the period in question because of failure or refusal to provide information.

(b) The same standards shall be used in determining erroneous payments as are used to determine initial and ongoing eligibility and payment.

(c) The participant must be periodically reminded of the reporting responsibilities and must indicate, no less frequently than at every certification, that the participant understands these requirements. This requirement is met by the use of a HCA form that reminds participants at each certification of their reporting responsibilities. This form also serves as the participant's statement that the participant understands the reporting responsibilities. If it is determined that a participant may have difficulty understanding the reporting responsibilities because of language, literacy, or mental or emotional problems, the HCA shall supplement the written notice with an oral explanation. All such oral explanations must be documented in the case record.

(d) The participant shall become ineligible on a continuing basis if there is a continuing failure to provide information affecting the participant's current eligibility.

(4) Offsetting the claim: Once the amount of the claim for IPV, IHE and AE is established, any restoration the eligibility determination group is eligible to receive is reduced or offset by the amount of the claim. Action must be taken to initiate collection of the remaining balance, if any.

C. LIHEAP:

(1) A claim shall be established for LIHEAP benefits that have been overpaid regardless of the reason of the overpayment.

(2) The HCA may establish a claim that exceeds the claim establishment threshold, as identified in Subsection G of 8.100.640.11 NMAC, for LIHEAP benefits overpaid up to six years prior to the date the overpayment occurred.

(3) Offsetting the claim: A benefit amount may be offset during the issuance process in order to recover a LIHEAP overpayment. The amount that is offset shall be conveyed to the restitutions bureau to be applied to the eligibility determination group's overpayment.

D. Claims involving reported changes: In cases involving reported changes, the HCA shall determine the first month the overpayment occurred.

(1) Inadvertent household error: If caused by an inadvertent error on the part of the eligibility determination group (failure to report a change in circumstances within the required time frames), the first month affected by the eligibility determination group's failure to report is the first month in which the change would have been effective if it had been reported timely. In no event will the HCA determine as the first month in which the change would have been effective any month later than two months from the month in which the change in eligibility determination group's circumstances occurred.

(2) Agency error: If an eligibility determination group reported a change timely but the HCA did not act on the change within the required time frame, the change should have taken effect the first month following the reported change, if it had been acted upon within the time frame. In no event shall the HCA determine as the first month in which the change would have been effective any month later than two months from the month in which the change in eligibility determination group circumstances occurred. If an adverse action notice was required but was not provided, the HCA shall assume for the purpose of calculating the claim that the maximum advance notice period would have expired without the eligibility determination group requesting a fair hearing.
[8.100.640.12 NMAC - N, 09/30/2013]

8.100.640.13 RECOVERY (COLLECTION ACTION): The HCA shall initiate collection action by sending the eligibility determination group an overpayment notice.

A. Adverse action notice: If the amount of the claim was not established by a fair hearing decision, the eligibility determination group will be provided with an adverse action notice. The adverse action notice is sent on all claims established after March 26, 1990, and on any preexisting claims if at any time after March 26, 1990, a

follow-up demand letter is sent on the claim. A one-time adverse action notice that informs the eligibility determination group that it has 90 days to appeal the amount of the claim will satisfy notice requirements.

B. Demand letter: Collection action is initiated by sending the eligibility determination group a demand letter. The demand letter informs the eligibility determination group of the claim amount, the reason for the claim, time period for which there is a claim, any offset that reduces the claim and how the eligibility determination group may pay the claim. The first demand letter to a participating eligibility determination group shall inform the eligibility determination group:

(1) that unless the eligibility determination group selects an acceptable method of payment and informs the HCA within the specified time limit, or timely requests a fair hearing and continued benefits, their SNAP benefit amount will be reduced;

(2) that benefit reduction will affect the eligibility determination group's monthly benefits, only if the HCA has not otherwise informed the eligibility determination group;

(3) that if the eligibility determination group timely selects an acceptable benefit reduction amount, the reduction will begin with the first benefit month that is issued after the selection;

(4) that if the eligibility determination group fails to make a timely selection or fails to request a fair hearing and continued benefits, the benefit reduction will be effective with the first benefit issued after timely notice of such selection or request for hearing is due to the HCA; and

(5) advise the eligibility determination group of any individual or organization that provides free legal representation.

C. Collection action:

(1) Initiating action: The HCA shall initiate collection action on all claims unless the claim is collected through an offset or one of the following conditions applies:

(a) the total amount of the claim is less than the established claims threshold outlined in Subsection G of 8.100.640.11 NMAC, and the claim cannot be recovered by reducing the eligibility determination group's SNAP benefit amount; or

(b) the HCA has documentation that establishes the eligibility determination group cannot be located.

(2) Postponing action: Collection action will be postponed on claims where an eligibility determination group is being referred for possible prosecution or for administrative disqualification, and the determination is made that collection action will prejudice the case.

(3) Collection action: Restitution bureau shall pursue collection as specified in 8.100.640.13 NMAC.

D. SNAP Intentional program violation (IPV):

(1) Initiating collection: If an eligibility determination group member is found to have committed an IPV or has signed either a waiver or a disqualification consent agreement, the HCA shall initiate collection action against the individual's eligibility determination group. Personal contact with the eligibility determination group is made, if possible. The HCA is required to initiate such collection unless:

(a) the eligibility determination group has repaid the overpayment already; or

(b) the HCA has documentation establishing that the eligibility determination group cannot be located; or

(c) the HCA determines that collection action will prejudice the case against an eligibility determination group member referred for prosecution.

(2) Partially paid claim: The HCA shall initiate collection action for an unpaid or partially paid claim, even if collection action was previously initiated while the claim was being handled as an IHE claim.

(3) In cases where an eligibility determination group member has been found guilty of misrepresentation or fraud by a court or has signed a disqualification consent agreement in a case referred for prosecution, the HCA shall request that the matter of restitution be brought before the court or be addressed in the agreement reached between the prosecutor and the accused individual.

(4) Changes in eligibility determination group composition:

(a) Collection action will be initiated by the restitution bureau against the eligibility determination group containing the member found to have committed an IPV.

(b) If a change in eligibility determination group composition occurs, collection action is pursued against any or all of the adult members of an eligibility determination group at the time an overpayment occurred.

(c) Collection action is pursued against any eligibility determination group which has a member who was an adult member of the eligibility determination group that received the overpayment.

E. Fraud exception: Notice of overpayment and administrative hearings rights shall not be given if the HCA has decided to pursue criminal prosecution for fraud. In such cases, the participant's notice of rights are limited to those afforded by state criminal statutes. No attempt shall be made by HCA staff to recover overpayments in such cases, nor shall any offers to refund the overpayment be accepted by the county office.

F. Recovery action:

(1) Overpayments of less than $1,000: Overpayments of less than $1,000 to currently eligible cases shall be immediately processed by the HCA for recoupment.

(2) Overpayments over $1,000: Overpayments of more than $1,000 to currently eligible cases shall be referred to the office of inspector general (OIG) for a fraud action decision.

(3) Response to referral:

(a) The HCA shall be notified by the OIG within 30 days whether fraud action has or will be taken on an open case. If no fraud action is contemplated, the case shall be immediately processed for either recoupment or cash recovery.

(b) If a response is not received from the OIG within 30 days of referral, the county will initiate recoupment from currently eligible cases.

G. Fraud referral:

(1) Fraud elements:

(a) By state statute, Section 30-16-6, NMSA 1978, fraud is the intentional misappropriation or taking of anything of value that belongs to another by means of fraudulent conduct, practices or representations.

(b) Fraud exists when:

(i) a person, by words or conduct, misrepresents facts to the HCA with the intention to deceive the HCA; and

(ii) because of the misrepresentation and the HCA's reliance upon it, the eligibility benefit group has obtained benefits from the HCA to which they were not entitled.

(2) Referral for investigation: If the HCA decides that fraud may exist, the case is referred to the OIG for further investigation or possible prosecution.

[8.100.640.13 NMAC - N, 09/30/2013]

8.100.640.14 METHODS FOR COLLECTING OVERPAYMENTS:

A. Recoupment: The HCA shall retain the value of benefits collected to repay a claim against a participating eligibility determination group, whether or not the claim occurred because of an IHE, an AE, or an IPV. The eligibility determination group's monthly SNAP or cash assistance benefit amount will be reduced to recover any amount of a claim that was not repaid through a lump sum cash or SNAP benefit payment, unless a payment schedule has been negotiated with the eligibility determination group. Collection of a claim by the HCA may also be obtained through recoupment of unemployment compensation benefits, federal pay, income tax intercepts, or any other method established by the HCA.

(1) Recoupment from monthly benefit allotments: A claim may be recovered from an eligibility determination group currently participating in SNAP or cash assistance programs by reducing the eligibility determination group’s monthly benefit allotment.

(2) Recoupment amount: The amount of benefits that will be recovered each month through benefit reduction will be determined by one the following methods.

(a) SNAP IHE and AE: The amount of reduction will be ten percent of the eligibility determination group’s monthly SNAP benefit amount, or $10 per month, or the agreed amount, whichever is greater.

(b) SNAP IPV: The SNAP benefit amount to be recovered will be twenty percent of the eligibility determination group’s monthly SNAP benefit amount, or $20 per month, or the agreed amount, whichever is greater.

(c) Cash assistance errors: The cash assistance benefit amount to be recouped is equal to fifteen percent of the eligibility determination group's payment standard.

(d) Recoupment is the last step in the calculation prior to determining the monthly benefit amount.

B. Cash payment methods:

(1) Lump sum cash:

(a) If the eligibility determination group asks to make a lump sum cash payment or is financially able to repay the claim at one time, the restitution bureau shall collect a lump sum cash payment.

(b) An eligibility determination group will not be required to liquidate all of its resources to make a lump sum payment.

(c) If an eligibility determination group is financially unable to pay the entire amount of the claim at one time and prefers to make a lump sum cash payment as partial payment of the claim, the HCA shall accept this method of payment.

(d) If an eligibility determination group chooses to make a lump sum payment of benefits from their EBT account as full or partial payment of the claim, the HCA shall accept this method of repayment, to include:

(i) SNAP benefits to repay a SNAP claim; or

(ii) cash benefits to repay a cash assistance claim or medical assistance claim; or

(iii) cash benefits to repay a SNAP claim.

(2) Installment payment schedules:

(a) The HCA shall negotiate a payment schedule with the eligibility determination group for repayment of any amounts of the claim not repaid through a lump sum payment.

(b) Payments will be accepted in regular installments.

(c) An eligibility determination group may use its SNAP or cash assistance benefits as full or partial payment of any installment repayment to include:

(i) SNAP benefits to repay a SNAP claim; or

(ii) cash benefits to repay a cash assistance claim or medical assistance claim; or

(iii) cash benefits to repay a SNAP claim.

(3) Repayment of SNAP overpayments:

(a) If an eligibility determination group is currently receiving benefits, and a payment schedule is negotiated for repayment of a claim, the negotiated amount to be repaid each month in installment payments may not be less than the amount that could be recovered through benefit reduction.

(b) The amount to be repaid each month through installment payments will remain unchanged regardless of subsequent changes in the eligibility determination group's monthly SNAP benefit amount.

(4) Repayment of cash assistance overpayments:

(a) Repayments are used to recover cash assistance overpayments from cases no longer receiving cash assistance or where recovery of an overpayment from an active cash assistance case cannot be liquidated within 20 months by recoupment.

(b) The amount the HCA tries to recover monthly through repayment is based on the following schedule, or, if a court order for repayment exists, in accordance with the court order. If the level of payment sought would cause an extreme hardship on the participant, the restitution bureau may agree to accept a lesser amount. Arrangements for repayments are made by the restitution bureau in all cases, except those where the participant is willing to repay the entire overpayment in a single payment.

(c) Repayment schedule:

Overpayment Amount	Monthly Repayment Payment
$ 35 -$100	$ 5
$101 - $200	$10
$201 - $300	$15
$301 - $400	$20
$401 - $500	$25
$501 - $600	$30
$601 - $700	$35
$701 - $800	$40
$801 - $900	$45
$901 or more	$50

(5) Repayment of LIHEAP benefits:

(a) The eligibility determination group will have 45 days from the date of notification of the claim amount to repay the claim in full or make arrangements to make regular installments to repay the claim.

(b) The HCA will initiate collection action to recover the claim amount on day 45 if

the eligibility determination group does not repay or make arrangements to repay the amount owed.

(6) Renegotiating payments: The restitution bureau, the eligibility determination group, or both, have the option to initiate renegotiation of the payment schedule if either or both believes that the eligibility determination group's economic circumstances have changed enough to warrant such action.

(7) Failure to pay: If an eligibility determination group fails to make a payment in accordance with the established repayment schedule, (either a lesser amount is paid, or no payment is made), the restitution bureau shall send the eligibility determination group a notice explaining that no payment or insufficient payment was received.

(a) The notice informs an eligibility determination group that renegotiation of the payment schedule may be discussed with the restitution bureau.

(b) The notice also informs an eligibility determination group that unless the overdue payments are made or the restitution bureau is contacted to discuss renegotiation of the payment schedule, the SNAP benefit amount of a currently participating eligibility determination group against which a claim has been established will be reduced without an adverse action notice.

(c) If the eligibility determination group responds to the notice, one of the following actions will be taken by the restitution bureau.

(i) If the eligibility determination group makes the overdue payments and wishes to continue making payments based on the previous schedule, the eligibility determination group is permitted to do so.

(ii) If the eligibility determination group requests renegotiation, and if the restitution bureau concurs, a new payment schedule will be negotiated.

(iii) If the eligibility determination group requests renegotiation of the amount of its repayment schedule, but the restitution bureau believes that the eligibility determination group's economic circumstances have not changed enough to justify the requested settlement, renegotiation will continue until a settlement can be reached.

(d) The restitution bureau has the option to invoke SNAP benefit reduction against a currently participating eligibility determination group for repayment of a claim if a settlement cannot be reached.

(e) If a currently participating eligibility determination group against which a claim has been established fails to respond to the notice, a benefit reduction will be initiated. If benefit reduction is initiated, no notice of adverse action will be required.

C. Other payment methods:

(1) Federal tax intercept: The HCA may offset an eligibility determination group's federal income tax return following notification to the eligibility determination group, and apply the offset to the oldest established SNAP claim.

(2) Unemployment compensation benefit reduction: The HCA may offset the unemployment compensation benefits of an adult eligibility determination group member, following notification to the eligibility determination group, and apply the offset to the oldest established active SNAP claim.

(3) Federal pay: The HCA may offset an eligibility determination group member's federal pay, following notification to the eligibility determination group, and apply the offset to the oldest established active SNAP claim.

(4) Any other means: The HCA may invoke collections by any other means available, including but not limited to, the use of private collection agencies, following notification to the eligibility determination group.

(5) State tax intercept: The HCA may offset a household's state income tax return following notification to the household, and apply the offset to the oldest established active cash claim.

[8.100.640.14 NMAC - N, 09/30/2013]

8.100.640.15 TERMINATING OVERPAYMENT CLAIMS: A terminated claim is a claim in which all collection action has ceased. The HCA may terminate a claim for any of the reasons described in Subsections A through E of this section. SNAP, LIHEAP, TANF, AFDC, GA and refugee cash assistance and support services for participation in the SNAP and TANF work programs can be terminated.

A. Invalid claims: The overpayment is determined to be invalid based on an administrative hearing decision, a court decision or a HCA determination that the claim was established in error.

B. Death: All adult members responsible for repayment of the claim are deceased.

C. Cost effectiveness: The HCA has determined that the cost of further collection action is likely to exceed the amount that can be recovered because:

(1) the cumulative amount of all existing claims against the eligibility determination group equals $25 or less; and

(2) a payment on the claim has not been received by the HCA in at least 90 days.

D. Failure to locate: There is documentation establishing that the eligibility determination group cannot be located and the existing claim has been delinquent for at least six years.

E. Inability to pay: There is written documentation establishing the eligibility determination group has filed for bankruptcy and the HCA is named as a creditor.

F. Reinstating a terminated claim: A terminated claim may be reinstated when a new collection method or a specific event substantially increases the likelihood of further collections.

G. Uncollectible claims:

(1) A claim may be determined uncollectible after being held in suspense for three years.

(2) A suspended or terminated claim may be offset against any SNAP benefit amount to be restored.

H. Overpaid claims:

(1) If a household has overpaid a claim, the HCA shall reimburse any overpaid amounts as soon as possible after the overpayment becomes known.

(2) The household may be reimbursed by whatever method the HCA deems appropriate after considering the household's circumstances.

I. Compromising the claim:

(1) If the full or remaining amount of a claim cannot be liquidated in three years, the restitution bureau may compromise the claim by reducing it to an amount that will allow the household to make restitution within three years.

(2) A compromised claim will be offset by any benefit that has not yet been restored to the household.

(3) Claims caused by a SNAP IPV will not be compromised.

[8.100.640.15 NMAC - N, 09/30/2013]

8.100.640.16 WRITING OFF A CLAIM: Writing off a claim means that the claim is no longer considered a receivable subject to any federal or state collection requirements such as the Treasury Offset Program at 31 CFR 285 or the Supplemental Nutrition Assistance Program at 7 CFR 273.18. A claim may be written off if the claim is at least six years old and at least one of the provisions of Subsections A through E of 8.100.640.15 NMAC apply. Only SNAP, LIHEAP and NMW cash assistance claims may be written off.

[8.100.640.16 NMAC - N, 09/30/2013]

8.100.640.17 EBT Adjustments:

A. EBT adjustment pertains to any EBT transaction resulting in a change to a client's cash or snap benefits. If a system error causes a customer to receive funds to which they were not entitled or causes their account to not be charged for an EBT transaction, an adjustment may be completed to reclaim the funds or settle the transaction.

(1) **Client-initiated adjustments:** The HCA must act on all requests for adjustments made by client households within 90 calendar days of the error transaction.

(a) For SNAP the HCA has 10 business days from the date the household notifies it of the error to investigate and reach a decision on an adjustment and move funds into the client account.

(b) For cash the HCA has 20 business days from the date the household notifies it of the error to investigate and reach a decision on an adjustment and move funds into the client account.

(c) These timeframes also apply if the HCA or entity other than the household discovers a system error that requires a credit adjustment to the household. Business days are defined as calendar days other than Saturdays, Sundays, and federal holidays.

B. Retailer-initiated adjustments: The HCA must act upon all adjustments to debit a household's account no later than 10 business days from the date the error occurred, by placing a hold on the adjustment balance in the household's account. If there are insufficient benefits to cover the entire adjustment, a hold shall be placed on any remaining balance that exists, with the difference being subject to availability only in the next future month. The household shall be given adequate notice. The notice must be sent at the time the initial hold is attempted on the household's current month's remaining balance, clearly state the full adjustment amount, and advise the household that any amount still owed is subject to collection from the household's next future month's benefits.

(1) The household shall have 90 days from the date of the notice to request a fair hearing.

(2) Should the household dispute the adjustment and request a hearing within 10 days of the notice, a provisional credit must be made to the household's account by releasing the hold on the adjustment balance within 48 hours of the request by the household, pending resolution of the fair hearing. If no request for a hearing is made within 10 days of the notice, the hold is released on the adjustment balance, and this amount is credited to the retailer's account. If there are insufficient funds available in the current month to cover the full adjustment amount, the hold may be maintained and settled at one time after the next month's benefits become available.
[8.100.640.17 NMAC - N, 3/1/2020]

8.100.640.18 DORMANT BENEFIT ACCOUNTS: Stale benefit accounts are those SNAP and cash assistance accounts that have not been accessed for 90 days from the most recent date of withdrawal.

A. Offline accounts: If EBT accounts are not accessed for 90 days, the HCA may store such benefits in an offline account.

(1) Notification: The HCA shall notify the eligibility determination group of this action before storing benefits in an offline account and how to reactivate the account.

(2) Reinstatement: An adult eligibility determination group member or authorized representative may contact the HCA or the EBT customer service help desk and request reinstatement of their EBT account.

(a) SNAP: SNAP benefits may be restored within 274 days of the initial date of benefit activity. Initial date of benefit activity is the first deposit made to the account upon initial approval of the eligibility determination group's benefits.

(b) Cash assistance: Cash assistance benefits may be restored within 364 days of the initial date of benefit activity. Initial date of benefit activity is the first deposit made to the account upon initial approval of the eligibility determination group's benefits.

B. Expungements: SNAP and cash assistance benefits that have not been accessed in excess of the threshold for each program will be expunged. All benefits will no longer be available to the eligibility determination group. The eligibility determination group loses all rights to expunged benefits.

(1) Stale benefit threshold:

(a) SNAP: SNAP benefits will be expunged after no activity within 274 days of the initial date of benefit activity.

(b) Cash assistance: Cash assistance benefits which have had no activity within 180 days of the initial date of benefit activity will be expunged.

(2) Notification: The contractor shall notify the HCA no less than five days prior to expungement of the SNAP benefits. The HCA shall identify any SNAP claims against the eligibility determination group and shall apply upon expungement.

(a) SNAP: The HCA shall notify the eligibility determination group no less than 30 days prior to the expungement of the SNAP benefits. Request from the participant to reinstate any benefit must be received prior to date of expungement.

(b) Cash assistance: The HCA shall attempt to notify the eligibility determination group no less than 45 days prior to the expungement of the cash assistance benefits. A request from the participant to reinstate any benefit must be received prior to the date of expungement.

(3) Payments of claims against the eligibility determination group. The contractor shall notify the HCA no less than five days prior to expungement of the SNAP or cash assistance benefits and any claims against the eligibility determination group shall be removed from the account and applied to the claims upon expungement.
[8.100.640.17 NMAC - N, 09/30/2013; A and Rn, 3/1/2020; A, 10/1/2021]

History of 8.100.640 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 100 RECIPIENT POLICIES - DEFINITIONS AND ACRONYMS

8.102.100.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.100.1 NMAC - Rp, 8.102.100.1 NMAC 11/01/2023; A, 7/1/2024]

8.102.100.2 SCOPE: The rule applies to the general public.
[8.102.100.2 NMAC - Rp, 8.102.100.2 NMAC 11/01/2023]

8.102.100.3 STATUTORY AUTHORITY:

A. Chapter 27, Articles 1 and 2 NMSA 1978, authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works (NMW) program was created to replace the AFDC program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority (HCA) is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the HCA is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the HCA administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.100.3 NMAC - Rp, 8.102.100.3 NMAC 11/01/2023; A,7/1/2024]

8.102.100.4 DURATION: Permanent.
[8.102.100.4 NMAC - N, 07/01/2001; Rp, 11/01/2023]

8.102.100.5 EFFECTIVE DATE: November 1, 2023, unless a later date is cited at the end of a section.
[8.102.100.5 NMAC - Rp, 8.102.100.5 NMAC 11/01/2023]

8.102.100.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.100.6 NMAC - Rp, 8.102.100.6 NMAC 11/01/2023]

8.102.100.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) Applicant: means person applying for cash assistance on behalf of a benefit group.

(2) Application: means a written or electronic request, on the appropriate ISD form, with the signature of the applicant or on the applicant's behalf by an authorized representative, for assistance.

(3) Attendant: means an individual needed in the home for medical, housekeeping, or childcare reasons.

(4) Authorized representative: means an adult, who is designated in writing by the

applicant, who is sufficiently knowledgeable about the applicant/benefit group's circumstances to complete the application form correctly and can represent the benefit group.

B. Definitions beginning with "B":

(1) Basic needs: include food, clothing, shelter, utilities, personal requirements and the individual's share of household supplies.

(2) Beginning month: means the first month for which a benefit group is certified after a lapse in certification of at least one calendar month; beginning month and initial month are used interchangeably. A benefit group is budgeted prospectively in a beginning month.

(3) Benefit group: means a group of people, either mandatory or optional, to be included in determining the monthly benefit amount.

(4) Benefit month: means the month for which cash assistance benefits have been issued. This term is synonymous with issuance month defined below.

(5) Budget month: means the calendar month for which income and other circumstances of the benefit group shall be determined in order to calculate the cash assistance amount.

C. Definitions beginning with "C":

(1) Capital gains: means proceeds from the sale of capital goods or equipment.

(2) Cash assistance: means cash payments funded by the temporary assistance for needy families (TANF) block grant pursuant to the federal act and by state funds; or state funded cash assistance in the general assistance program.

(3) Caretaker relative: means an individual who assumes parental control over a child living in the home.

(4) Categorical eligibility (CE): means a SNAP household that meets one of the following conditions is considered to be CE and have limited eligibility requirements.

(a) Financial CE: Any SNAP household in which all members receive Title IV-A assistance (TANF), general assistance (GA), or supplemental security income (SSI) benefits is considered to be categorically eligible for SNAP benefits.

(b) Broad-based CE: Any SNAP household, in good standing, in which at least one member is receiving a non-cash TANF/MOE funded benefit or service and household income is below one hundred sixty five percent FPG.

(5) Certification: means the authorization of eligibility of a benefit group for the issuance of cash assistance benefits.

(6) Certification period: means the time period assigned to a benefit group that is approved to receive cash assistance benefits. The certification period shall conform to calendar months and include an interim report to be completed mid certification.

(7) Collateral contact: means an individual or agency designated by the benefit group to provide information concerning eligibility.

(8) Conciliation process: means a 30-day process prior to imposing a sanction during which the HCA and the individual have the opportunity to address barriers to compliance or to correct whatever failure has generated the noncompliance determination.

(9) Conversion factor: means anticipated monthly income received on a weekly or bi-weekly basis shall be converted to a monthly amount.

D. Definitions beginning with "D":

(1) Date of application: means the date the application is received by the income support division offices during regular business hours, this includes applications that are dropped off, submitted in person and electronically. The date the application and forms received by ISD will be documented on the form. Applications that are dropped off or submitted electronically after regularly scheduled business hours, holidays and weekends will be considered received as of the next business day.

(2) Date of admission: means the date established by the immigration and naturalization service (INS) as the date a non-citizen (or sponsored non-citizen) was admitted for permanent residence.

(3) Date of entry: means the date established by the immigration and naturalization service (INS) as the date an non-citizen (or sponsored non-citizen) was admitted for permanent residence.

(4) Department: means the health care authority (HCA).

(5) Dependent child: means a natural child, adopted child, stepchild or ward that is:

(a) 17 years of age or younger; or

(b) 18 years of age and is enrolled in high school; or

(c) between 18 and 22 years of age and is receiving special education services

regulated by the public education department.

(6) Director: means the director of the income support division.

(7) Diversion payment: means a lump sum payment, which will enable the applicant to keep a job or to accept a bona fide offer of employment.

(8) Documentation: means a written statement entered in the paper or electronic case record regarding the type of verification used and a summary of the information obtained to determine eligibility.

E. Definitions beginning with "E":

(1) Earned income: means cash or payment in-kind that is received as wages from employment or payment in lieu of wages; and earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services.

(2) Education works program (EWP): provides state-funded cash assistance to a benefit group where at least one individual is enrolled in a post-secondary institution. The applicant or recipient benefit group must be otherwise eligible for NMW cash assistance but chooses to participate in the education works cash assistance program.

(3) Emancipated: means an individual under the age of 18 years who is legally recognized as no longer under parental control due to marriage or by a decision of a court.

(4) Encumbrance: means debt owed on property.

(5) Equity value: means the fair market value of property, less any encumbrances owed on the property.

(6) Expedited services: means the process by which benefit groups reporting little or no income or resources will be provided an opportunity to participate in the SNAP program.

(7) Expungement: means the permanent deletion of cash benefits from an EBT account that is stale.

F. Definitions beginning with "F":

(1) Fair hearing: means an administrative proceeding which a claimant or claimant's representative may request if:

(a) an application is not acted on within a reasonable time after the filing of the application;

(b) an application is denied in whole or in part; or

(c) the cash assistance or services are modified, terminated, or not provided.

(2) Fair market value (FMV): means the amount an item can be expected to sell for on the open market at the prevailing rate of return. For vehicles, the term FMV means the amount a dealer would buy a vehicle for wholesale or offer as a trade-in. It is not the amount the dealer would sell the vehicle for at retail.

(3) Federal act: means the federal Social Security Act and rules promulgated pursuant to the Social Security Act.

(4) Federal fiscal year: October 1 through September 30 of the calendar year.

(5) Federal means-tested public benefit: means benefits from the SNAP program; the food assistance block grant programs in Puerto Rico, American Samoa and the commonwealth of the Northern Mariana islands, supplemental security income (SSI), and the TANF block grant program under Title IV of the Social Security Act; medicaid and SCHIP.

(6) Federal poverty guidelines: means the level of income defining poverty by family size published annually in the federal register by the United States department of health and human services.

(7) Five-year bar: means the federally imposed prohibition on receiving federal means-tested public benefits for certain qualified non-citizens who entered the United States (U.S.) on or after August 22, 1996, until they continuously lived in the U.S. for five years. The count for the five-year bar begins on the date the non-citizen attains qualified non-citizen status.

(8) Food Stamp Act: the Food Stamp Act of 1977 (P.L. 95-113), the Food and Nutrition Act of 2008 (P.L. 110-246), and subsequent amendments.

G. Definitions beginning with "G":

(1) General assistance (GA) benefit group: means a benefit group in which all members receive cash assistance financed by state or local funds.

(2) Government entity: includes any federal, state, tribal or local unit of government as well as any non-government entity which receives public funds for the purpose of meeting the housing needs of its clientele.

(3) Gross income: means the total amount of income that a benefit group is entitled to receive before any voluntary or involuntary deductions are made, such as, but not limited to, federal and state taxes,

FICA, garnishments, insurance premiums (including medicare), and monies due and owing the benefit group, but diverted by the provider. Gross income does not include specific income exclusions, such as but not limited to, the cost of producing self-employment income, and income excluded by federal law.

(4) Gross income test (eighty-five percent test): for the benefit group to be eligible, the gross earned income of the benefit group must be less than eighty-five percent of the federal poverty guidelines as determined in 8.102.500.8 NMAC.

(5) Guaranteed basic income: Guaranteed basic income provides an individual or household a one time or recuring cash payment or transfer funded from a public or private source intended to support the basic needs of individuals or households by reducing poverty, promoting economic mobility, or increasing the financial stability.

H. Definitions beginning with "H":

(1) Hardship extension: means an extension of the TANF/NMW 60-month lifetime limit due to specific conditions enumerated at 8.102.410.17 NMAC.

(2) Head of household: means the payee who is the responsible case head for the benefit group. The payee may be the parent, guardian, sole adult member, specified relative, pregnant woman, a GA recipient, or caretaker relative.

I. Definitions beginning with "I":

(1) Immigrant: means a non-citizen within the meaning found in Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(2) Immigration and naturalization service (INS): a division of the U.S. department of justice dealing with U.S. citizenship and immigration services.

(3) Impairment: means a condition resulting from anatomical, physiological, or psychological abnormalities evidenced by medically acceptable clinical and laboratory diagnostic techniques. Impairment has to do only with the medical, psychiatric, or both processes. To evaluate both physical and mental impairment, medical evidence consisting of signs, symptoms and objective findings must be obtained.

(4) Incapacity review unit: means a special unit in the HCA that determines the status of participants for the family violence option and limited work participation status. This is also known as the IRU.

(5) Individual development account program: means an account created for eligible individuals which is established and maintained by an authorized financial institution to be used for individual development.

(6) Individual development program: means a program that establishes and administers individual development accounts and reserve accounts in order to provide financial training required by the division for account owners.

(7) Ineligible non-citizen: means an individual who does not meet the eligible non-citizen requirements.

(8) Initial month: means the first month for which a benefit group is certified for participation in the cash assistance program. An initial month is also a month in which a benefit group is certified following a break in participation of one calendar month or longer.

(9) Inquiry: means a request for information about eligibility requirements for a financial, medical, or food assistance program that is not an application.

(10) Institution of higher education: means certain college-level institutions, such as vocational schools, trade schools, and career colleges that award academic degrees or professional certifications.

(11) Institution of post-secondary education: means an institution of post-secondary education, any public or private educational institution that normally requires a high school diploma or equivalency certificate for enrollment, or that admits persons who are beyond the age of compulsory school attendance in the state in which the institution is located, regardless of the high school prerequisite, provided that the institution is legally authorized or recognized by the state to provide an educational program beyond secondary education in the state or a program of training to prepare students for gainful employment.

(12) Irrevocable trust funds: means an arrangement to have monies held by one person for the benefit of another that cannot be revoked.

(13) Issuance month: means the calendar month for which cash assistance is issued. In prospective budgeting, the budget and issuance months are the same.

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

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

L. Definitions beginning with "L":

(1) Legal guardian: means a legally created relationship between a child and appointed

adult wherein the appointed adult acquires legal decision-making authority for a child.

(2) Limited work participation hours: means the reduced work requirement hours approved by the IRU or the NMW service provider, as appropriate, after a participant has been approved for a limited work participation status.

(3) Limited work participation status: means a NMW participant has a verified condition or barrier as outlined at Subsection A of 8.102.420.11 NMAC that precludes the ability to meet the standard work requirement hours and has been approved for such status by the IRU or NMW service provider, as appropriate.

M. Definitions beginning with "M":

(1) Maintenance of effort (MOE): means the amount of general funds the state agency must expend annually on the four purposes of temporary assistance for needy families (TANF) to meet a minimum expenditure requirement based on a state's historical assistance to families with dependent children (AFDC) expenditures.

(2) Medicaid: medical assistance under title XIX of the Social Security Act, as amended.

(3) Minor unmarried parent: means an unmarried parent under the age of 18 years or is age 18 and enrolled in high school.

(4) Month of approval: means the month the action to approve a benefit group for cash assistance is taken.

N. Definitions beginning with "N":

(1) Net income tests: means for the benefit group to be eligible, the benefit group's net earned income must be less than the standard of need applicable to the benefit group after allowable deductions have been made to the earned and unearned income.

(2) Net monthly income: means gross non-exempt income minus the allowable deductions. It is the income figure used to determine eligibility and cash assistance benefit amount.

(3) Non-benefit group members: means persons residing with a benefit group who are specifically excluded by regulation from being included in the benefit group certification.

(4) Non-cash TANF/MOE benefit or service: means non-cash TANF/MOE benefit or services include programs or services that do not provide cash to recipients, but are funded by the TANF program, either by the federal TANF block grant or the state MOE share. These services may include transportation, childcare, counseling programs, parenting programs, pamphlets or referrals to other TANF/MOE-funded services.

(5) Non-citizen U.S. national: means a person who is not an U.S. citizen but was born in an outlying possession of the U.S. on or after the date the U.S. acquired the possession, or a person whose parents are non-citizen U.S. nationals. A person who resides on one of the following U.S. island territories is a non-citizen U.S. national: American Samoa, Swains island or the Northern Mariana islands.

(6) Notice: means written correspondence that is generated by any method including handwritten, typed or electronic, delivered to the client or their authorized representative by hand, U.S. mail, professional delivery or by any electronic means. The term "written notice" and "notice" are used interchangeably.

(7) Notice of adverse action (NOAA): means a written or electronic notice that includes a statement of the action the HCA has taken or intends to take, the reason for the action, the benefit group's right to a fair hearing, who to contact for additional information, the availability of continued benefits, and liability of the benefit group for any over-issuance received if the hearing decision is adverse to the benefit group. This notice may be received prior to an action to reduce benefits, or at the time reduced benefits will be received, or if benefits are terminated, at the time benefits would have been received if they had not been terminated. Recipients have 13 days from the mailing date or the date of electronic transmittal of the notice to request a fair hearing and to have benefits restored to their previous level.

(8) NMW compliance requirements: means the various work program activities a TANF/NMW participant is expected to attend and complete in order to avoid conciliation or sanction.

O. Definitions beginning with "O": Over-issuance means the amount by which cash assistance benefits issued to a benefit group exceed the amount the benefit group was eligible to receive.

P. Definitions beginning with "P":

(1) Parent: means natural parent, adoptive parent, or stepparent.

(2) Participant: means a recipient of cash assistance or services or a member of a benefit group who has reached the age of majority.

(3) Payment standard: means the amount of the cash assistance payment, after the countable net earned and unearned income of the benefit group has been subtracted from the benefit group's standard of need, and prior to reduction by sanction, recoupment or both.

(4) Permanent total disability: means an individual must have a physical or mental

impairment, expected to last at least 12 months, that prevents gainful employment in any employment position within the individual's current employment capacity.

(5) Person: means an individual.

(6) Prospective budgeting: means the computation of a benefit group's eligibility and benefit amount based on a reasonable estimate of income and circumstances that will exist in the current month and future months.

Q. Definitions beginning with "Q": Qualified non-citizen status means a person lawfully admitted into the United States under INA guidelines as defined in PROWRA of 1996.

R. Definitions beginning with "R":

(1) Real property: means land, affixed improvements, and structures which include mobile homes. Grazing permits are also considered real property.

(2) Recertification: means a complete review of all conditions of eligibility which are subject to change and a redetermination of the amount of assistance payment for an additional period of time.

(3) Recipient: means a person receiving cash assistance benefits.

(4) Refugee: means a lawfully admitted individual granted conditional entry into the United States.

(5) Regular reporting: means a reporting requirement that requires a participating household to report a change within 10 days of the date a change becomes known to the household.

(a) A financial change becomes known to the household when the household receives the first payment attributed to an income or resource change, or when the first payment is made for a change in an allowable expense.

(b) A non-financial change including but not limited to, a change in household composition or a change in address, becomes known to the household on the date the change takes place.

(6) Resource standard: means the financial standard with respect to resources and property, $2,000 for non-liquid resources and $1,500 for liquid resources.

(7) Retrospective budgeting: means the computation of a benefit group's benefits for an issuance month based on actual income and circumstances that existed in the previous month.

(8) Resource planning session: means a planning session to ascertain the applicant's immediate needs and to assess the applicant's financial and non-financial options.

S. Definitions beginning with "S":

(1) School age: means any dependent child who turns six years prior to September first and is under 18 years of age.

(2) Secretary: means the secretary of the HCA.

(3) Self-employed: means an individual who engages in a self-managed enterprise for the purpose of providing support and income and who does not have the usual withholding deducted from this income.

(4) Services: means child-care assistance; payment for employment-related transportation costs; job search assistance; employment counseling; employment; education and job training placement; one-time payment for necessary employment-related costs; case management; or other activities whose purpose is to assist transition into employment.

(5) Shelter for battered persons: means a public or private nonprofit residential facility that serves battered persons. If such a facility serves other individuals, a portion of the facility must be set aside on a long-term basis to serve only battered persons.

(6) Simplified reporting: a change reporting requirement for households that receive TANF benefits.

(7) Single-parent benefit group: means any benefit group which does not include both parents of a child included in the benefit group and thus includes families in which there is only one parent or in which there are no parents.

(8) Sponsor: means a person who executed an affidavit of support or similar agreement on behalf of an non-citizen as a condition of the non-citizen's entry or admission to the United States as a permanent resident.

(9) Sponsored non-citizen: means an non-citizen lawfully admitted for permanent residence in the United States as an immigrant, as defined in Sections 101(a)(15) and 101(a)(2) of the Immigration and Nationality Act.

(10) Stale: means EBT accounts which have not been accessed, no withdrawal activity, by the household in the last 90 days from the most recent date of withdrawal.

(11) Standard of need: means an amount which is based on the number of individuals

included in the benefit group and allows for financial standard and basic needs.

(12) Standard work requirement hours: means the minimum number of hours in applicable core and non-core total work activities a participant must complete.

(13) State-funded non-citizen eligible: means a non-citizen who entered the United States on or after August 22, 1996, as one of the classes of non-citizens described in Subsection B of 8.102.410.10 NMAC, is eligible with respect to citizenship requirements for state-funded assistance under NMW and GA without regard to how long the non-citizen has been residing in the United States.

(14) Supplemental nutrition assistance program (SNAP): The Food and Nutrition Act of 2008 changed the federal name of the food stamp program to the supplemental nutrition assistance program. SNAP is synonymous with the food stamp program.

(15) Supplemental security income (SSI): means monthly cash payments made under the authority of:

(a) Title XVI of the Social Security Act, as amended, to the aged, blind and disabled;

(b) Section 1616(a) of the Social Security Act; or

(c) Section 212(a) of P.L. 93-66.

T. Definitions beginning with "T":

(1) Temporary total disability: means a physical or mental impairment, expected to last at least 30 days from date of determination, but less than one year from the date of application, that prevents gainful employment in any employment position within the individual's current employment capacity.

(2) Two-parent benefit group: means a benefit group which is considered to exist when both parents of any child included in the benefit group live in the home with the child and are included in the benefit group.

(3) Term limits: means NMW assistance (cash benefits and supportive services) is not provided to or for an adult or a minor head of household for more than 60 months during the individual's lifetime.

U. Definitions beginning with "U":

(1) Unearned income: means old age, survivors, and disability insurance payments (social security), railroad retirement benefits, veterans administration compensation or pension payments, military retirement and allotments, pensions, annuities and retirement benefits; lodge or fraternal benefits, any other public or private disability or retirement benefit or pension, shared shelter payments, individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income.

(2) Universal Basic Income: Universal basic income is a government-guaranteed program that provides a modest cash income at regular intervals (e.g., each month or year) to every individual or household to meet the basic needs.

V. Definitions beginning with "V":

(1) Vehicle: means a conveyance used for the transportation of individuals to or from employment, for the activities of daily living or for the transportation of goods; vehicle does not include any boat, trailer or mobile home used as the principal place of residence.

(2) Verification: means the use of third-party information or documentation to establish the accuracy of statements on the application, interim report and recertification.

(3) Vocational education: means an organized education program that is directly related to the preparation of a person for employment in a current or emerging occupation requiring training other than a baccalaureate or advance degree. Vocational education must be provided by an educational or training organization, such as a vocational-technical school, community college, or post-secondary institution or proprietary school.

W. Definitions beginning with "W": Wage subsidy program means a subsidized employment training opportunity through which a TANF cash assistance recipient is hired into full-time employment.

X. Definitions beginning with "X":

Y. Definitions beginning with "Y":

Z. Definitions beginning with "Z":

[8.102.100.7 NMAC - Rp, 8.102.100.7 NMAC 11/01/2023]

8.102.100.8 ABBREVIATIONS AND ACRONYMS:

A. ABBREVIATIONS AND ACRONYMS beginning with "A": AFDC: aid to families with dependent children (replaced by TANF effective July 1, 1997).

B. ABBREVIATIONS AND ACRONYMS beginning with "B":

(1) BG: benefit group;

(2) BIA: bureau of Indian affairs;

(3) BIA-GA: bureau of Indian affairs-general assistance.

C. ABBREVIATIONS AND ACRONYMS beginning with "C":

(1) CA: cash assistance;

(2) CE: categorical eligibility or categorically eligible;

(3) CFR: code of federal regulations;

(4) CS: child support;

(5) CSSD: (HCA) child support services division;

(6) CYFD: (New Mexico) children youth & families department.

D. ABBREVIATIONS AND ACRONYMS beginning with "D":

(1) DOH: (New Mexico) department of health;

(2) DOL: department of labor;

(3) DOT: dictionary of occupational titles.

E. ABBREVIATIONS AND ACRONYMS beginning with "E":

(1) E&T: employment and training (food stamp work program);

(2) EBT: electronic benefit transfer;

(3) EI: earned income;

(4) EW: eligibility worker (now caseworker);

(5) EWP: education works program.

F. ABBREVIATIONS AND ACRONYMS beginning with "F":

(1) FAP: financial assistance program;

(2) FAA: family assistance analyst (formally ISS);

(3) FFY: federal fiscal year;

(4) FMV: fair market value;

(5) FNS: food and nutrition service (previously FCS);

(6) FPL: federal poverty level.

G. ABBREVIATIONS AND ACRONYMS beginning with "G":

(1) GBI: guaranteed basic income;

(2) GED: general equivalency degree.

H. ABBREVIATIONS AND ACRONYMS beginning with "H":

(1) HHS: (U.S.) health and human services;

(2) HSE: high school equivalency formerly known as GED;

(3) HCA: (New Mexico) health care authority;

(4) HUD: (U.S.) housing and urban development.

I. ABBREVIATIONS AND ACRONYMS beginning with "I":

(**1**) **IDA:** individual development account;

(2) INS: (U.S.) immigration and naturalization service;

(3) IPV: intentional program violation;

(4) IRP: individual responsibility plan;

(5) IRU: incapacity review unit;

(6) ISD: (HCA) income support division;

(7) ISD2: integrated services delivery for ISD;

(8) ISS: income support specialist (now caseworker).

J. ABBREVIATIONS AND ACRONYMS beginning with "J": JTPA: Job Training Partnership Act (now WIA).

K. ABBREVIATIONS AND ACRONYMS beginning with "K": [RESERVED]

L. ABBREVIATIONS AND ACRONYMS beginning with "L":

(1) LIHEAP: low income home energy assistance program;

(2) LITAP: low income telephone assistance program.

M. ABBREVIATIONS AND ACRONYMS beginning with "M":

(1) MAD: (HCA) medical assistance division;

(2) MVD: (New Mexico) motor vehicle division.

N. ABBREVIATIONS AND ACRONYMS beginning with "N":

(1) NADA: national automobile dealers association;

(2) **NMAC:** New Mexico administrative code;
(3) **NMW:** New Mexico works;
(4) **NOAA:** notice of adverse action.

O. ABBREVIATIONS AND ACRONYMS beginning with "O": [RESERVED]

P. ABBREVIATIONS AND ACRONYMS beginning with "P": POS: point of sale.

Q. ABBREVIATIONS AND ACRONYMS beginning with "Q": QC: quality control;

R. ABBREVIATIONS AND ACRONYMS beginning with "R":
(1) **RRP:** refugee resettlement program.
(2) **RR:** regular reporting or regular reporters.

S. ABBREVIATIONS AND ACRONYMS beginning with "S":
(1) **SAVE:** systematic non-citizen verification for entitlements;
(2) **SE:** self-employment;
(3) **SR:** simplified reporting;
(4) **SNAP:** supplemental nutrition assistance program formerly known as food stamps;
(5) **SSA:** social security administration;
(6) **SSI:** supplemental security income;
(7) **SSN:** social security number.

T. ABBREVIATIONS AND ACRONYMS beginning with "T": TANF: temporary assistance to needy families (block grant program under Title IV-A of the Social Security Act).

U. ABBREVIATIONS AND ACRONYMS beginning with "U":
(1) **UBI:** universal basic income**;**
(2) **UCB:** unemployment compensation benefits;
(3) **UEI:** unearned income;
(4) **USDA:** United States department of agriculture.

V. ABBREVIATIONS AND ACRONYMS beginning with "V": VA: Veterans administration.

W. ABBREVIATIONS AND ACRONYMS beginning with "W":
(1) **WIA:** Workforce Investment Act;
(2) **WID:** work incentive deduction;
(3) **WPA:** work participation agreement.

X. ABBREVIATIONS AND ACRONYMS beginning with "X";

Y. ABBREVIATIONS AND ACRONYMS beginning with "Y":

Z. ABBREVIATIONS AND ACRONYMS beginning with "Z":

[8.102.100.8 NMAC - Rp, 8.102.100.8 NMAC 11/01/2023]

History of 8.102.100 NMAC: [RESERVED]

History of Repealed Material:
8.102.100 NMAC, Cash Assistance Programs - Recipient Policies - Definitions And Acronyms, filed 06/18/2001 - Repealed effective 11/1/2023.

Other: 8.102.100 NMAC, Cash Assistance Programs - Recipient Policies - Definitions And Acronyms, filed 06/18/2001 - Replaced 8.102.100 NMAC, Cash Assistance Programs - Recipient Policies - Definitions And Acronyms, effective 11/1/2023.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 460 RECIPIENT POLICIES - COMPLIANCE REQUIREMENTS

8.102.460.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.460.1 NMAC - Rp, 8.102.460.1 NMAC, 04/01/2012; A, 7/1/2024]

8.102.460.2 SCOPE: The rule applies to the general public.
[8.102.460.2 NMAC - Rp, 8.102.460.2 NMAC, 04/01/2012]

8.102.460.3 STATUTORY AUTHORITY:

A. Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, Section 27-2B-1, et seq., NMSA 1978, the New Mexico works program was created.

C. In coordination with the NMW program, the health care authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

D. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.460.3 NMAC - Rp, 8.102.460.3 NMAC, 04/01/2012 ; A, 7/1/2024]

8.102.460.4 DURATION: Permanent.
[8.102.460.4 NMAC - Rp, 8.102.460.4 NMAC, 04/01/2012]

8.102.460.5 EFFECTIVE DATE: April 1, 2012, unless a later date is cited at the end of a section.
[8.102.460.5 NMAC - Rp, 8.102.460.5 NMAC, 04/01/2012]

8.102.460.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. Family income is increased through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one participant is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.460.6 NMAC - Rp, 8.102.460.6 NMAC, 04/01/2012]

8.102.460.7 DEFINITIONS: [Reserved]

8.102.460.8 [Reserved]

8.102.460.9 NMW COMPLIANCE REQUIREMENTS: Work program requirements apply to each adult and minor head of households benefit group member whether the benefit group is a two-parent or single-parent benefit group.

A. All adult and minor head of household participants are required to complete an assessment, individual responsibility plan (IRP), work participation agreement (WPA) applicable work requirement hours and timely submission of documentation showing completion of required work hours.

B. **Non-compliance with the NMW requirements:** Participants who are in non-compliance with any of the NMW requirements are subject to conciliation and sanction as outlined at 8.102.620 NMAC.
[8.102.460.9 NMAC - Rp, 8.102.460.12 NMAC, 04/01/2012; A, 07/01/2013]

8.102.460.10 ORIENTATION:

A. General:

(1) Participants of NMW shall be provided a work program orientation, which explains the work program and its objectives to the participant.

(2) Participants shall be given information concerning their rights, supportive services provided during participation, and transitional services available after the NMW case closes because of earnings from employment.

(3) Participants shall be informed of their responsibilities for complying with work program requirements and that failure to do so, without good cause, shall result in the reduction or loss of NMW benefits.

B. Elements: The orientation session provides each participant with the following information:

(1) an explanation that NMW is a temporary program intended to briefly assist the family while preparing themselves for employment;

(2) an explanation of the opportunities available to the participant through the program, including education, training, work experience, and help in job search;

(3) reminder of participant's rights and responsibilities, program regulations and requirements, and the consequences for failure to meet requirements;

(4) overview of supportive services currently available;

(5) explanation of participant's obligation to obtain an assessment from the NMW service provider and return it to ISD within 15 days of the date of approval of application;

(6) explanation of participant's obligation to request approval in writing of participant's work participation activities and secure approval of activities by the HCA or the NMW service provider; and

(7) overview of transitional services available to participants whose NMW case closes due to employment/earnings.

[8.102.460.10 NMAC - Rp, 8.102.460.18 NMAC, 04/01/2012]

8.102.460.11 ASSESSMENT:

A. Requirements: No later than 15 calendar days after an application is approved, participants shall have an assessment done by the NMW service provider of their education, skills, prior work experience, barriers, and employability. The assessment is a necessary pre-cursor to the IRP, development of WPA, and is a crucial and necessary element in meeting work program requirements. The assessment is also used in making determinations for requests for limited participation status. Failure to participate in or to complete the assessment may result in work program noncompliance and payment sanctions, unless good cause exists.

B. Elements: The assessment includes the following elements:

(1) a referral by the caseworker to a local agency or agencies that act on behalf of the HCA to carry out the assessment; and

(2) a face-to-face meeting between the participant and the agency no later than 15 calendar days following approval of assistance for the participant in which the assessment is carried out; there are a variety of assessment tools and forms that may be used, provided that they address the participant's education, skills, prior work experience and employability.

C. Participants must provide a copy of the assessment or a certification of completion of the assessment to the HCA by the expiration of the 15 day time period.

[8.102.460.11 NMAC - Rp, 8.102.460.14 NMAC, 04/01/2012]

8.102.460.12 INDIVIDUAL RESPONSIBILITY PLAN (IRP):

A. Requirement: All participants are required to develop an IRP with the assistance of the NMW service provider no later than 15 days from the date of approval of assistance.

B. General purpose: The IRP is:

(1) a personal planning tool, intended to assist the participant in long-term career planning, address barriers and secure and maintain employment;

(2) intended to assist the participant in setting realistic long-term employment goals and to identify those steps which must be taken to achieve the stated goals;

(3) not intended to fulfill the limited purpose of identifying work activities which will meet NMW work program participation requirements; the participant is encouraged to use the IRP to choose work activities which will meet work program participation requirements and, at the same time, will assist in setting long-

term employment goals; and

(4) designed to move the participant into whatever employment the participant is capable of handling, and to provide the support services necessary to increase the responsibility and amount of work the participant will handle over time.

C. Elements: The IRP shall include the following:

(1) a specific achievable employment goal or goals and a plan for securing and maintaining employment;

(2) commitments by the participant which will assist in meeting long-term goals; such commitments may include, but are not limited to: school attendance, maintaining certain grades, keeping school-age children in school, immunizing children, undergoing substance abuse treatment, or any other activity that will help the participant become and remain employed;

(3) a signature by the participant acknowledging the importance of the IRP, the identified activities and goals which will assist in achieving self-sufficiency and the commitment to participate in activities which will achieve the stated goals; and

(4) a signature by the HCA's representative certifying that there was a discussion of the activities and goals with the participant, and that the HCA shall provide on-going support services as needed so that the participant may achieve the participant's stated goals.

D. IRP reviews: The HCA, the NMW service provider and the participant shall review and update the IRP at least every six months. The review consists of a meeting to review the activities and goals set forth in the IRP, to review and document the participant's progress in achieving the stated goals, and to amend activities and goals as determined necessary and appropriate by the participant. The participant and NMW service provider must initial or sign the updated IRP.

E. Conciliation and sanction: Failure or refusal to develop, sign or attend the six-month review of the IRP may result in conciliation or sanction, unless good cause exists. See 8.102.620 NMAC.

F. HUD family self-sufficiency agreements: Some housing authorities administer self-sufficiency programs under which residents develop a self-sufficiency plan and agreement with the housing authority. A participant with a HUD family self-sufficiency plan may use the plan for their IRP. The participant must supply a copy of the plan to the HCA.

[8.102.460.12 NMAC - Rp, 8.102.460.15 NMAC, 04/01/2012]

8.102.460.13 WORK PARTICIPATION AGREEMENT (WPA):

A. General: The purpose of the WPA is to assure the participant and the HCA that the work activities in which the participant is engaged meet the standard or limited work requirement hours and the participant is referred to receive all available support services.

B. Contents of the agreement: At a minimum, the WPA shall:

(1) list the participant's proposed work activities;

(2) list the level of effort for each activity;

(3) list the support services to be provided by the HCA;

(4) list the reasonable accommodations that may be necessary to ensure meaningful engagement;

(5) be signed by the participant; and

(6) upon approval of the activities and support services, signed by the NMW service provider.

C. Submission of a WPA: The participant must submit a WPA, as developed with the NMW service provider and signed by the participant to the HCA, its contractor or its designee:

(1) no later than 15 calendar days from date of approval for benefits; or

(2) prior to requesting support services associated with such activity;

(3) no later than 30 calendar days from approval for benefits only if good cause criteria applies to untimely completion; or

(4) no later than five days after the expiration of an existing WPA.

D. Limited work participation status requests: Participants requesting a limited work participation status must submit a preliminary WPA to the IRU in accordance with regulation 8.102.420.11 NMAC.

E. Conciliation and sanction: Failure or refusal to develop, sign or meet the activities outlined in the WPA may result in conciliation or sanction, unless good cause exists. See 8.102.620 NMAC.

F. Reopened cases: A participant whose NMW/TANF case is approved for benefits with less than a 12-month break in certification, shall have their case reopened and shall be required to:

(1) submit a revised WPA within 15 calendar days of approval for benefits;

(2) be engaged in an allowable work activity as specified on the participant's WPA at the participation standard specified in 8.102.460.14 or 8.102.460.15 NMAC within 15 calendar days of approval for benefits; and

(3) submit the participation report to the NMW service provider no later than the fifth calendar day of the month following the month in which the 15-day time limit expires.

[8.102.460.13 NMAC - Rp, 8.102.460.16 NMAC, 04/01/2012]

8.102.460.14 NMW STANDARD WORK PARTICIPATION HOURS: The following work participation requirement hours apply to all participants unless the participant is granted limited work participation status.

A. General: Participation activities may be met through those activities listed in 8.102.461 NMAC.

(1) A parent subject to participation shall maintain the participation standards based on their status and provide verification of participation at a rate at least equaling the applicable participation standard.

(2) Participants granted a limited work participation status must meet the limited work participation requirement hours on their WPA and provide verification of participation.

B. Two-parent participation requirement hours: Two parent families must meet the all family and two parent participation requirement hours to avoid being subject to conciliation or sanction. If the benefit group does not meet the federal work program definition of a two parent benefit group, then both parents must meet the standard work participation hours for a single parent benefit group.

(1) Two-parent family receiving CYFD child care: Listed below are the family's total monthly work participation hours that are required in a two parent family to be considered meeting the two parent rate. This standard work participation rate also applies to families where one participant is disqualified, sanctioned, or granted a limited work participation status.

(a) total combined monthly hours: 237

(b) minimum core hours: 215

(2) All family rate: Individual monthly work participation hours are required in a two participant family to be considered meeting the all family rate.

(a) total combined monthly hours: 129

(b) minimum core hours: 86

(3) Two-parent family not receiving CYFD child care: Listed below are the family's total monthly work participation hours that are required in a two parent family to be considered meeting the two parent rate. This standard applies to families where one parent is disqualified, sanctioned, or granted limited work participation requirements by the IRU or NMW.

(a) total combined monthly hours: 151

(b) minimum core hours: 129

(4) All family rate: Individual monthly work participation hours are required in a two parent family to be considered meeting the all family rate.

(a) total combined monthly hours: 129

(b) minimum core hours: 86

(5) Two parent family not meeting the definition of two parent: A two-parent family where one parent receives SSI, is an ineligible non-citizen, or is a caretaker for a household member as determined by the IRU, must meet the work participation standard as prescribed by the single parent work participation hours based on the age of the child.

(6) Two parent family where both parents are under age 20: The participation standard shall be met for each parent if the parent is maintaining satisfactory attendance in secondary school or its equivalent during the month. Satisfactory attendance shall be based on the requirements of the school and on enrollment in sufficient course work to assure completion of secondary education before turning age 20. Compliance with attendance requirements is deemed during school breaks lasting no longer than four consecutive weeks.

C. Single-parent benefit group: The parent in a single-parent or caretaker relative benefit group shall participate in work activities as prescribed below or be subject to conciliation or sanction.

(1) Single parent with a child age six or older:

(a) total monthly hours: 129

(b) minimum core hours: 86

(2) Single parent with a child under age six:

(a) total monthly hours: 86

(b) minimum core hours: 86

(3) **Single parent under age 20:** A single parent under age 20 shall meet the single parent's total program participation standard, as outlined above when the parent:

(a) is enrolled in school with enough hours to ensure graduation prior to turning age 18; and

(b) reports on a monthly basis attendance at a secondary school or in a GED program; or

(c) participates in education directly related to employment for at least the average number of hours per week specified above based on the child's age.

(d) Compliance with attendance requirements is deemed during school breaks lasting no longer than four consecutive weeks.

[8.102.460.14 NMAC - Rp, 8.102.460.13 NMAC, 04/01/2012]

8.102.460.15 LIMITED WORK PARTICIPATION STATUS: A participant may request a limited work participation status reducing their individual standard work participation to no less than one hour per week, as determined by the HCA at 8.102.420 NMAC. Individuals who demonstrate extraordinary circumstances may be granted a zero hour limited work participation status. Participants granted a limited work participation status are required to meet the NMW compliance requirements as indicated at 8.102.460.9 NMAC. Failure to complete the assessment, IRP and WPA may be considered non-compliance with program requirements.

[8.102.460.15 NMAC - N, 04/01/2012]

8.102.460.16 CALCULATING HOURS:

A. Total monthly hours are calculated by a weekly average of core and non-core hours.

B. Time spent traveling to and from the work-site, location where child care is provided, or both, do not count as hours of participation.

C. For paid work activities:

(1) paid leave and holiday time count as actual hours;

(2) hours shall be anticipated prospectively and verification provided no more than every six months.

D. For non-paid activities allowable excused absences count as actual hours when:

(1) the absence occurs on a day that the participant is scheduled to participate in an activity; and

(2) is considered excused by the institution or sponsoring agency.

E. For non-paid activities allowable holiday absences count as actual hours when:

(1) the absence scheduled holiday occurs on a day that the participant would have been scheduled to participate in an activity; and

(2) the absence is a scheduled holiday as recognized by the HCA and determined at the beginning of each federal fiscal year.

F. A participant may be granted no more than 80 hours of excused absences within a 12 month period and no more than 16 hours in any one month. Any excused absence cannot exceed the number of hours the participant was scheduled to work during the period of the absence.

G. Non-paid work experience and community service participation hours are limited to the Fair Labor Standards Act (FLSA) rules. The FLSA is used to determine the maximum number of hours the HCA can require a participant to meet. Upon receipt and verification of meeting the maximum number of hours required by the FLSA calculation and the number is less than the core work hour requirement, the remaining hours may be deemed up to the core hour requirement. The maximum amount of weekly hours required by the FLSA is calculated as follows:

(1) **Single parent:** Add the monthly TANF cash assistance grant amount (prior to any reductions) to the monthly food stamp benefit and divide by the federal or state minimum wage, whichever is higher, and divide by 4.3.

(2) **Two-parent:** The calculation of participation requirement hours is the same as a single parent.

[8.102.460.16 NMAC - N, 04/01/2012]

HISTORY OF 8.102.460 NMAC:

NMAC History:

8 NMAC 3.FAP.460, Work Program Activities, filed 06/16/1997.

8 NMAC 3.FAP.460, Work Program Activities, filed 06/16/1998.

History of Repealed Material:
8.102.460 NMAC, Recipient Policies - Defining Group Work Program Activities, filed 03/02/2001 - Repealed effective 07/01/2001.
8.102.460 NMAC, Recipient Policies - Defining Group Work Program Activities, filed 06/18/2001 - Repealed effective 07/16/2007.
8.102.460 NMAC, Recipient Policies - Defining Group Work Program Activities, filed 07/02/2007 - Repealed effective 04/01/2012.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 461 WORK PROGRAM ACTIVITIES

8.102.461.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.461.1 NMAC - N, 04/01/2012; A, 7/1/2024]

8.102.461.2 SCOPE: The rule applies to the general public.
[8.102.461.2 NMAC - N, 04/01/2012]

8.102.461.3 STATUTORY AUTHORITY:

A. Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, Section 27-2B-1 et seq. NMSA 1978, the New Mexico works program was created.

C. In coordination with the NMW program, the health care authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

D. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.461.3 NMAC - N, 04/01/2012; A, 7/1/2024]

8.102.461.4 DURATION: Permanent.
[8.102.461.4 NMAC - N, 04/01/2012]

8.102.461.5 EFFECTIVE DATE: April 1, 2012, unless a later date is cited in this section.
[8.102.461.5 NMAC - N, 04/01/2012]

8.102.461.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one participant is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.461.6 NMAC - N, 04/01/2012]

8.102.461.7 DEFINITIONS: [**RESERVED**]

8.102.461.8 [RESERVED]

8.102.461.9 PROGRAM ACTIVITIES: The following sections describe the various work program activities in which participants may participate. A participant may participate in multiple work program activities at the same time or one after the other. The activities to be completed during an established period are identified in a work participation agreement by the participant and approved by ISD.
[8.102.461.9 NMAC - Rp, 8.102.460.9 NMAC, 04/01/2012]

8.102.461.10 WORK ACTIVITIES - CORE AND NON-CORE:

A. Core work activities: Core activities are allowable for a participant to meet the standard work participation requirement hours for a single or two parent household or to meet the minimum standard work

participation requirement hours as defined at 8.102.460.14 NMAC. For purposes of meeting the participant's standard work participation requirement hours core work activities are defined in 8.102.461.11 NMAC thru 8.102.461.19 NMAC.

B. Non-core work activities: Non-core activities are allowable for a participant to address barriers or to meet the work requirement hours. A non-core activity may include, but is not limited to, an activity as defined in 8.102.461.20 NMAC thru 8.102.461.22 NMAC.

C. Limited participation status: Participants with limited participation status shall participate in the qualified activities best suited to their abilities as listed on their work participation agreement. The activities will be based upon the participant's individual circumstances as per 8.102.420.15 NMAC.

[8.102.461.10 NMAC - Rp, 8.102.460.19 NMAC, 04/01/2012]

8.102.461.11 UNSUBSIDIZED EMPLOYMENT (Core Activity):

A. Unsubsidized employment is full- or part-time employment in the public or private sector that is not funded directly or in part by TANF or any other public program. Unpaid apprenticeships and unpaid internships are included as unsubsidized employment.

B. General:

(1) Hours for participants who are employed for wages at or above minimum wage will be determined by actual hours worked and will include paid leave and holidays.

(2) Hours for participants who are self- employed will be determined by subtracting business expenses from gross income for the term reported and divided by the federal minimum wage.

C. Component activities: The following shall be considered as qualified participation hours for unsubsidized employment.

(1) A participant who is employed less than 30 hours per week in unsubsidized employment is considered to be participating in the part-time employment.

(2) A participant who is employed 30 or more hours per week is considered to be participating in the full-time employment.

(3) A participant whose employer claims a tax credit for hiring economically disadvantaged workers in lieu of public sector subsidies, will be considered unsubsidized.

(4) Child care as self-employment: Participants may meet the standard work requirement hours by providing child care services as self-employment. Participants choosing to provide child care for income shall meet the requirements as indicated below:

(a) A participant electing to participate as a child care provider is referred to CYFD to enroll in the family nutrition program and to become a registered child care provider with the state prior to placement of any children there by the HCA. Participants must also agree to obtain 20 hours of child care training within six months of approval.

(b) The participant is considered employed, upon placement of any child for pay, by CYFD or by a parent.

D. Supervision and documentation: Hours of participation in an employment- related activity will be projected, based on actual hours worked, for up to six months at which time current documentation shall be required in order to evaluate any changes in the prospective hours of participation.

[8.102.461.11 NMAC - Rp, 8.102.460.20 NMAC, 04/01/2012]

8.102.461.12 SUBSIDIZED PRIVATE SECTOR EMPLOYMENT (Core Activity):

A. Employment for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing a participant is considered to be subsidized private sector employment.

B. General: New Mexico will use TANF funds to offset the wages of employing a TANF participant for an established period of time. Upon expiration of the subsidized term of employment, the employer is expected to hire the participant. This income will be excluded for determining TANF eligibility.

C. Component activities: The following shall be considered as qualified participation hours for subsidized private sector employment.

(1) Employment will be considered subsidized if the employer receives TANF or other public sector funding for an employee.

(2) Public sector paid apprenticeships and paid internships shall be considered subsidized employment.

D. Supervision and documentation: Hours of participation in an employment- related activity will

be projected, based on actual hours worked, for up to six months at which time current documentation shall be required in order to evaluate any changes in the prospective hours of participation.
[8.102.461.12 NMAC - Rp, 8.102.460.21 NMAC, 04/01/2012; A, 1/1/2023]

8.102.461.13 SUBSIDIZED PUBLIC SECTOR EMPLOYMENT (Core Activity):

A. Employment for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing a participant is considered subsidized employment. The employment will be considered subsidized if an employer receives a TANF or other public sector subsidy for an employee.

B. General: A participant is ineligible for NMW/TANF cash assistance while participating in subsidized public sector employment. Subsidized public sector employees will be paid no less than the greater of federal or state minimum wage.

C. Component activities: The following shall be considered as qualified participation hours for subsidized public sector employment:

(1) Paid apprenticeships and paid internships.

(2) Participation in various support services designed to remove barriers towards employment shall be considered countable hours as long as the participant is paid for involvement.

D. Supervision and documentation: Hours of participation in an employment- related activity will be projected, based on actual hours worked, for up to six months at which time current documentation shall be required in order to evaluate any changes in the prospective hours of participation.
[8.102.461.13 NMAC - Rp, 8.102.460.22 NMAC, 04/01/2012]

8.102.461.14 ON-THE-JOB TRAINING (Core Activity):

A. Training in the public or private sector that is given to a paid employee that provides knowledge and skills essential to the full and adequate performance of the job shall be considered on-the-job training. On-the-job training (OJT) may be subsidized or unsubsidized. The employer of an OJT participant will retain the employee after the successful completion of the OJT contract and the existence of a written training plan; these plan requirements distinguish OJT from other subsidized employment.

B. General:

(1) Hours in an on-the-job-training activity will be determined by actual hours worked or upon the contract the HCA
has with the employer including paid leave and holidays and projected for up to six months.

(2) The HCA will coordinate with the department of workforce solutions, Workforce Investment Act (WIA), one-stops or the New Mexico in-plant-training program to engage TANF participants in this work activity.

(3) To qualify as OJT there must be a contractual agreement with the employer and HCA may pay no more than 50 percent of the participant's wage and benefit package.

C. Component activities: The following shall be considered as qualified participation hours for OJT:

(1) on-the-job training as paid employment; or

(2) professional certification; or

(3) practicum, internship, and clinical training.

D. Supervision and documentation:

(1) Hours for this activity will be projected for up to six months at which time current documentation shall be required in order to evaluate any changes in the prospective hours of participation.

(2) This activity must be supervised by an employer, work site sponsor, or other responsible party on a daily basis.
[8.102.461.14 NMAC - Rp, 8.102.460.23 NMAC, 04/01/2012]

8.102.461.15 JOB SEARCH AND JOB READINESS ASSISTANCE (Core Activity):

A. Job search includes the acts of seeking or obtaining employment, and preparation to seek or obtain employment.

B. General:

(1) Countable hours for looking for job openings, making contact with potential employers, applying for vacancies and interviewing for jobs, and in labor market training will be determined by actual hours spent engaged in these activities. Travel time between these activities does count as actual hours of participation,

except the travel time to and from home.

(2) Job search hours are countable in meeting the core work requirement hours for an individual with the following limitations:

(a) a single parent with a child under the age of six cannot participate for more than 80 consecutive hours and not to exceed 120 hours in the preceding 12 months; or

(b) a single parent with a dependent child over age six cannot participate for more than 120 consecutive hours and not to exceed 180 hours in a preceding 12 months;

(c) in either of the above circumstances participation shall not exceed four consecutive weeks of engagement in job search and job readiness; and

(d) in either of the above circumstance participation shall not exceed six weeks of engagement in job search and job readiness.

(3) **Needy state status:** If New Mexico is determined to be a needy state as determined by the United States department of health and human services the maximum number of hours allowed for participation is as follows:

(a) a single parent with a child under age of six cannot participate for more than 80 consecutive hour and not to exceed 240 hours in the preceding 12 months; and

(b) a single parent with a dependent child over age six cannot participate for more than 120 consecutive hours and not to exceed 360 hours in the preceding 12 months.

C. **Component activities:** The following shall be considered as qualified participation hours for job search and job readiness.

(1) Participation in parenting classes, money management classes or life skills training.

(2) Participation in an alcohol or drug addiction program where a qualified health or social professional provides verification that such treatment or activity is necessary.

(3) Participation in job search including searching for job openings, applying for jobs and interviewing for positions.

(4) **Addressing domestic violence issues/barriers:**

(a) Participants who have significant barriers to employment because of domestic violence or abuse may participate in domestic violence work activity to receive services focused on assisting the participant to overcome the effects of domestic violence and abuse. Participants engaged in this activity may reside in a domestic violence shelter or may receive services while residing elsewhere. The primary focus of such services is on helping the participant to move into employment. Domestic violence activity is a temporary work-readiness activity limited to no more than 24 weeks.

(b) The need for domestic violence services can be identified at any point, starting with the resource planning session up to the point at which the case is scheduled for closure. Services are provided by local agencies or programs through referral.

(c) Domestic violence activity can include a mix of domestic violence services and other work program activities. At no point shall a victim of domestic violence be required to carry out any activity which puts the participant at risk of further violence. Domestic violence participation can include:

(i) emergency shelter or re-location assistance;

(ii) child care;

(iii) personal, family and career counseling; and

(iv) participating in criminal justice activities directed at prosecuting the perpetrator.

D. **Supervision and documentation:**

(1) Verification of activities shall be required to determine that a participant has satisfactorily completed the hours by participating in one or several of the component criteria.

(2) Participation requirement hours shall be considered based on actual supervised hours documented on a monthly timesheet.

(3) Job search and job readiness assistance activities must be supervised by the NMW service provider or other responsible party on an ongoing basis no less frequently than daily.

[8.102.461.15 NMAC - Rp, 8.102.460.24 NMAC, 04/01/2012]

8.102.461.16 **WORK EXPERIENCE (Core Activity):**

A. Work experience is an unpaid activity. The purpose of work experience is to improve the employability of those who cannot find employment. Work experience may be in a public or private sector setting.

B. **General:**

(1) The type of work experience placement needed by a participant may be identified during

the assessment or the development of the IRP. Participants in a work experience placement can either be subsidized employees or trainees, depending upon the nature of the placement.

(2) Sponsoring agencies: Participants may be placed in either a public or private sector work site. The work site is selected based on a participant's individual needs. Sponsoring agencies provide supervision in a safe and healthy work environment and must ensure that the environment is free of discrimination based on race, gender, national origin, handicap, age, religion, or political affiliation.

(a) The sponsoring agency must enter into an agreement with the HCA which details the expectations and responsibilities of each party and ensures an appropriate work setting.

(b) The sponsoring agency may not displace any current employee in layoff status or infringe on the promotional opportunities of any current employee.

(c) The sponsoring agency shall be encouraged to give a hiring preference consideration to participants assigned to their agency.

(3) Liability insurance: All work providers must sign a work experience agreement and provide trainees with liability insurance. Participants in a trainee activity are covered by medicaid except for injuries caused on the job not covered by medicaid. Work-site accidents must be reported to the ISD office within 24 hours of occurrence. A written accident report must be obtained from the work site by the ISD office and submitted to the HCA's central office within five working days.

C. Component activities: Placement provides a participant with an opportunity to acquire the general skills, training, knowledge, and work habits necessary to obtain employment. Unpaid apprenticeships and unpaid internships are included as work experience.

D. Supervision and documentation:

(1) This activity must be supervised by an employer, work site sponsor, or NMW service provider on an ongoing basis no less frequently than daily.

(2) The Fair Labor Standards Act (FLSA) standards are used to determine the maximum number of hours the HCA can require a participant to meet. When the participant meets the maximum number of hours required by the FLSA calculation and the number is less than the core work hour requirement, the remaining hours may be deemed up. The maximum amount of weekly hours required by the FLSA are calculated as follows:

(a) Single parent: Add the monthly TANF cash assistance benefit (prior to the sanction amount) to the monthly food stamp benefit and divide by the federal or state minimum wage, whichever is higher, and divide by four and three-tenths.

(b) Two-parent: The initial calculation of participation requirement hours is the same as a single parent. Both parents can simultaneously participate in an activity subject to FLSA NMW standard work participation requirement hours.

(c) Limited participation status: A participant in a limited work participation status may use the FLSA calculation or lesser hours to meet the hours prescribed in their work participation agreement.

[8.102.461.16 NMAC - Rp, 8.102.460.25 NMAC, 04/01/2012]

8.102.461.17 COMMUNITY SERVICE PROGRAMS (Core Activity):

A. Community service is a non-paid work activity. Participants provide services needed by their community. Sponsoring agencies may be either public sector or private nonprofit entities such as libraries, charities, churches, and schools. The HCA will review each placement and take into account, to the extent possible, the prior training, experience, and skills of a participant in making appropriate community service assignments.

B. General: To qualify as a community services placement, the activities carried out must be similar to those which would normally be carried out by a volunteer working with the agency rather than those carried out by an employee. Federal guidelines for determining whether a placement is a "volunteer" versus an "employee" must be followed by the sponsoring agency.

C. Component activities: The following shall be considered as qualified participation hours for community service programs.

(1) Community service programs will be limited to projects that serve a useful community purpose in fields such as health, social service, environmental protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and child care.

(2) Head-start, schools and child care centers: Some educational and child care programs allow, or require, parents to contribute time in the classroom or on class activities outside the classroom. Time spent in such activities is considered to be community service time and is countable as a core work activity.

(3) Liability insurance: All work providers must sign a community service agreement and

provide trainees with liability insurance. Participants in a trainee activity are covered by medicaid and additional medical insurance for injuries caused on the job that may not be covered by medicaid. Work-site accidents must be reported to the ISD office within 24 hours of occurrence. A written accident report must be obtained from the work site by the ISD office and submitted to the HCA's central office within five working days.

D. Supervision and documentation:

(1) This activity must be supervised by an employer, work site sponsor, or NMW service provider on an ongoing basis no less frequently than daily.

(2) The Fair Labor Standards Act (FLSA) standards are used to determine the maximum number of hours the HCA can require a participant to meet. When the participant meets the maximum number of hours required by the FLSA calculation and the number is less than the standard work participation requirement hours, the standard work participation requirement hours may be deemed as met due to compliance with FLSA standards. The maximum amount of monthly hours required by the FLSA is calculated as follows:

(a) Single parent: Add the monthly TANF cash assistance benefit (prior to the sanction amount) to the monthly food stamp benefit and divide by the federal or state minimum wage, whichever is higher, and divide by four and three-tenths.

(b) Two-parent: The initial calculation of standard work participation requirement hours is the same as a single parent. Both parents can simultaneously participate in an activity subject to FLSA NMW standard work participation requirement hours.

(c) Limited participation status: A participant in a limited work participation status may use the FLSA calculation or lesser hours to meet the hours prescribed in their work participation agreement.

[8.102.461.17 NMAC - Rp, 8.102.460.26 NMAC, 04/01/2012]

8.102.461.18 CHILD CARE FOR COMMUNITY SERVICE PARTICIPANTS (Core Activity):

A. NMW participants may meet the NMW standard work participation requirement hours by providing child care services, at no cost, to other NMW participants engaged in community services.

B. General: Use of a child care provider by a participant, as provided in this section, is at the sole discretion of the participant.

(1) The HCA will make a good faith effort to assure the provision of quality care and a safe environment by referring community service participants only to childcare providers who have been certified by CYFD. The HCA makes no claim as to the quality of care which will be provided, and assumes no liability, for the physical or emotional condition of children referred to a home certified by CYFD.

(2) The minimum number of children a participant may care for is determined based on the number of families needing child care while participating in a community service component. However, at no time will the number exceed child-care standards established by CYFD. A participant electing to participate as child care provider is referred to CYFD to enroll in the family nutrition program and to become a registered child care provider with the state prior to placement of any children there by the HCA. Participants must also agree to obtain 20 hours of child care training within six months of approval.

(3) After successful registration, meeting safety regulations, and receiving training, NMW participants shall become registered child care providers. NMW participants shall then become eligible to receive payments from CYFD for providing child care services.

(4) Hours of participation are based on the number of hours each day the participant is actually providing care for the children, plus one hour before and one after the children leave for the purposes of clean-up and preparation.

(5) Upon placement of any child for pay, by CYFD or by a parent, the participant is considered to be employed.

C. Supervision and documentation:

(1) The provider is required to maintain attendance records to verify the hours of work. Also included in participation hours is time spent registering with CYFD, time spent correcting any deficiencies necessary to complete registration as well as any time spent in attendance at child care training activities.

(2) The NMW service provider or ISD office shall maintain a list of registered child care providers who are providing non-paid child care and refer to them any participant in community services who needs child care in order to participate.

[8.102.461.18 NMAC - Rp, 8.102.460.27 NMAC, 04/01/2012]

8.102.461.19 VOCATIONAL EDUCATION AND TRAINING (Core Activity):

A. Organized career and technical educational programs that are directly related to the preparation of a participant for employment in current or emerging occupations requiring training, to include a baccalaureate or advanced degree are considered to be vocational education and training. Engagement shall be reported as core participation for not more than 12 months in a lifetime.

(1) A course of vocational education or training is one whose purpose is to provide the specific knowledge and skills needed by a participant to carry out the functions and activities of an occupation or class of occupations listed in the DOT (dictionary of occupational titles). A participant will be granted a degree or certificate at the end of the program which names the occupation.

(2) Vocational educational training must be provided by education or training organizations, which may include, but are not limited to, vocational-technical schools, community colleges, postsecondary institutions, proprietary schools, non-profit organizations, and secondary schools that offer vocational education and are certified to provide the participant a certificate of completion by an accredited agency.

B. Approval of vocational education training:

(1) A fixed number of vocational education training education slots shall be authorized by the HCA and shall not exceed 30 percent of the total number of persons subject to work program participation. For a participant in a slot, all approved hours of participation in vocational education activities shall count in meeting the participant's core work participation requirement.

(2) No more than 12 months in a lifetime of such activity are countable in meeting the standard work participation requirement hours.

(3) Enrollment in an agreed-upon vocational training program is the responsibility of the participant.

(4) **Level of effort:** Participation requirement hours shall be considered based on:

(a) actual supervised class time hours;

(b) labs and similar activities are considered class time;

(c) actual hours of completed supervised study-time;

(d) one hour of unsupervised study time per hour of class not to exceed the educational program requirements; and

(e) holiday time and excused absences.

C. Component activities: Vocational educational training programs should be limited to component activities that give participants the knowledge and skills to perform a specific occupation. The following shall be considered as qualified participation hours for vocational education and training.

(1) **Vocational associate degree programs:** Programs consisting of both academic and vocational for credit course work that requires 60 credits for completion. Completion of these programs can provide an associate of arts, associates of science or associates of applied science degree in fields defined as vocational as per Subsection A of this section.

(2) **Instructional certificate programs:** Programs designed to upgrade job related skills which generally require up to a year to complete and involve less academic work than associate degrees.

(3) **Industry skills certifications:** Industry developed certificates for students who demonstrate specific skills often thru testing. Preparation for tests include both self-study and courses offered at post secondary institutions or other training providers.

(4) **Non-credit course work:** Curriculum designed to accommodate those who want specific job related skills at an accredited institution.

(5) **English as a second language (ESL) and basic education:** these courses of study can count as part of the vocational training component only if they are included in the embedded activities in the curriculum. In order to count as a work activity, basic remedial education or ESL must be required subjects by counseling or evaluative services provided by the educational facility.

(6) **Distance education and online certificate programs:** Distance education and online certificate programs in the associate degree and certificate programs listed above must be taken through an institution accredited by an accrediting agency and recognized by the council for higher education accreditation or by the U.S. department of education in order to qualify as a work activity and approved on a case-by-case basis by the NMW service provider.

(7) Class and homework hours must be reported on timesheets and verified as supervised by the attended institution's instructor or aide.

D. Supervision and documentation:

(1) Verification of level of effort shall be required to determine that a participant has satisfactorily completed the hours by one or several of the component criteria.

(2) Participation requirement hours shall be considered based on actual supervised and unsupervised hours documented on a monthly timesheet.
[8.102.461.19 NMAC - Rp, 8.102.460.28 NMAC, 04/01/2012]

8.102.461.20 JOB SKILLS TRAINING (Non Core Activity):

A. Job skills training required by an employer to provide a participant with the ability to obtain employment or to advance within the workplace is considered job skills training.

B. General: Non-core work activities are countable towards the total work participation requirement hours for a participant who has completed the core work activity hours.

C. Component activities: Participation in the following is considered as meeting work participation requirement hours when combined with a core work activity:

(1) full-time training for adult basic education (ABE), English as a second language (ESL);

(2) post-secondary education; or

(3) any other job related training that can not be considered vocational education as outlined in 8.102.461.19 NMAC.

D. Supervision and documentation:

(1) Verification of activities shall be required to determine that a participant has satisfactorily completed the hours by participating in one or several of the component criteria.

(2) Participation requirement hours shall be considered based on actual supervised hours documented on a monthly timesheet.

(3) Job skills training directly related to employment must be supervised on at least a daily ongoing basis.

(4) Countable work participation requirement hours shall be determined by actual hours spent in class time, completion of supervised and unsupervised study hours to include holidays and excused absences. One hour of unsupervised study time for each hour of classroom time will be counted, as long as the amount of study time does not exceed the educational program requirements.
[8.102.461.20 NMAC - Rp, 8.102.460.30 NMAC, 04/01/2012]

8.102.461.21 EDUCATION RELATED TO EMPLOYMENT (Non Core Activity):

A. Any organized activity which is designed to improve the participant's knowledge or skills for the specific purpose of increasing the participant's ability to perform in the workplace is considered to be education directly related to employment.

B. General: NMW participants may engage in this activity if they have not received a high school diploma or a certificate of high school equivalency or needs specific education related to current employment or job offer. Non-core work activities are countable towards the total work participation standard for a participant who has completed the core work activity hours.

C. Component activities: Participation in the following is considered as meeting work participation requirement hours when combined with a core work activity:

(1) English as a second language (ESL) for participants who are unable to or uncomfortable with their ability to communicate in English, either spoken or written; or

(2) literacy training for participants who have trouble understanding written English and is based on a demonstrated or acknowledged difficulty in reading comprehension, regardless of the level of education completed; or

(3) adult basic education (ABE) to assist participants who need classes providing basic educational training before working on a general equivalency degree (GED); or

(4) GED classes for participants who have completed a general equivalency diploma pre-test and the results indicate the participant is ready; or

(5) high school attendance for participants who are attending an accredited high school, a participant who has recently dropped out of high school shall be encouraged to re-enroll or required to pursue a GED; or

(6) post-secondary institution for participants who are enrolled in advanced educational training activity through colleges, technical institutes or universities and who are attending classes in order to complete a two- or four-year college degree; or

(7) education directly related to employment shall include any other job-related class provided by a facility or organization.

D. Supervision and documentation:

(1) Verification of activities shall be required to determine that a participant has completed the hours by participating in one or several of the component criteria.

(2) Countable work participation requirement hours shall be determined by actual hours spent in class time, completion of supervised and unsupervised study hours to include holidays and excused absences. One hour of unsupervised study time for each hour of classroom time will be counted, as long as the amount of study time does not exceed the educational program requirements. Hours will be documented on a monthly timesheet.

[8.102.461.21 NMAC - Rp, 8.102.460.31 NMAC, 04/01/2012]

8.102.461.22 SECONDARY SCHOOL/GED (Non Core Activity):

A. The secondary school/GED work program activity serves participants who are age 18 or older. This may be a qualified activity for a participant who is under age 20, but cannot enroll in high school if the participant has:

(1) successfully completed a previous education work program activity - English as a second language or adult basic education; or

(2) completed a general equivalency diploma pre-test and the results indicate the participant is ready for GED classes.

B. Participation must be supervised on no less than a daily basis. Non-core work activities are countable towards the total work participation standard for a participant who has completed the standard work participation requirement hours with a core work activity.

C. Component activities: Participation in the following is considered as meeting work participation requirement hours when combined with a core work activity:

(1) ABE or ESL; or

(2) GED or high school shall only be included when they are prerequisites for employment.

D. Supervision and documentation:

(1) Verification of activities shall be required to determine that a participant has completed the hours by participating in one or several of the component criteria.

(2) Participation requirement hours shall be considered based on actual supervised hours documented on a monthly timesheet.

(3) Countable work participation requirement hours shall be determined by actual hours spent in class time, completion of supervised and unsupervised study hours to include holidays and excused absences. One hour of unsupervised study time for each hour of classroom time will be counted, as long as the amount of study time does not exceed the educational program requirements.

[8.102.461.22 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

HISTORY OF 8.102.461 NMAC:

NMAC History:

8 NMAC 3.FAP.460, Work Program Activities, filed 06/16/1997.
8 NMAC 3.FAP.460, Work Program Activities, filed 06/16/1998.

History of Repealed Material:

8.102.460 NMAC, Recipient Policies - Defining Group Work Program Activities, filed 03/02/2001 - Repealed effective 07/01/2001.
8.102.460 NMAC, Recipient Policies - Defining Group Work Program Activities, filed 06/18/2001 - Repealed effective 07/16/2007.
8.102.460 NMAC, Recipient Policies - Defining Group Work Program Activities, filed 07/02/2007 - Repealed effective 04/01/2012.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 462 NEW MEXICO WAGE SUBSIDY PROGRAM

8.102.462.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.462.1 NMAC - N, 04/01/2012; A, 7/1/2024]

8.102.462.2 SCOPE: The rule applies to the general public.
[8.102.462.2 NMAC - N, 04/01/2012]

8.102.462.3 STATUTORY AUTHORITY:

A. Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, Section 27-2B-1 et seq. NMSA 1978, the New Mexico works program was created.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.462.3 NMAC - N, 04/01/2012; ; A, 7/1/2024]

8.102.462.4 DURATION: Permanent.
[8.102.462.4 NMAC - N, 04/01/2012]

8.102.462.5 EFFECTIVE DATE: April 1, 2012, unless a later date is cited at the end of a section.
[8.102.462.5 NMAC - N, 04/01/2012]

8.102.462.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment. This is achieved by participation in, and successful completion of the activities described in this part.

B. The New Mexico wage subsidy program is a subsidized employment opportunity where a TANF cash assistance participant is employed full time. The HCA or its agents may subsidize the up to fifty percent of the employee's salary with funds from the TANF block grant. Funding of the program is contingent on specific appropriation of state and federal funding.
[8.102.462.6 NMAC - N, 04/01/2012]

8.102.462.7 DEFINITIONS: [Reserved]

8.102.462.8 CASE ADMINISTRATION FOR THE NEW MEXICO WAGE SUBSIDY PROGRAM: The New Mexico wage subsidy program is a subsidized employment opportunity where a TANF cash assistance participant is employed full-time. Payments to employers are made from TANF block grant funds.

A. Initial eligibility: Active participants in the TANF/NMW program may be referred to participating employers to be considered for a New Mexico wage subsidy position. To be eligible for these positions, the participant must meet the following criteria:

(1) have sufficient work experience;

(2) be a registered participant in NMW;

(3) is not in current conciliation or being sanctioned for non-cooperation with the NMW work requirements or child support requirements;

(4) have citizenship documentation and a social security number; and

(5) have verification of their highest educational level attained.

B. Certification period: A participant may be employed through the New Mexico wage subsidy

program for up to 12 months.

C. Effects on TANF cash assistance:

(1) the participant is ineligible for TANF cash assistance while participating in the wage subsidy program;

(2) the months of participation in the wage subsidy program will not count against a participant's 60 month term limit;

(3) the participant remains eligible for medicaid;

(4) the participant's wages count against as income for determining food stamp eligibility.

(5) the participant may be eligible for a supplemental cash assistance payment if the wage subsidy employment is lost during the month, or if the net monthly full-time wage paid to the participant is less than the TANF cash assistance to which the participant would otherwise be eligible; and

(6) the participant's earnings are exempt from HUD housing determinations.

D. Continued eligibility: the following requirements must be met for to ensure continued participation in the New Mexico wage subsidy program:

(1) the participant must remain eligible for TANF for the duration of the wage subsidy employment term;

(2) must maintain satisfactory attendance at the employment site; and

(3) continued NMW participation by the second parent in a two parent family.

[8.102.462.8 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

8.102.462.9 PROGRAM LIMITATIONS:

A. Failure to comply with other requirements: The benefit group shall be transitioned back to the NMW cash assistance and appropriate sanctions applied if a participant fails or refuses to comply with child support enforcement, or school attendance, or reporting requirements in the NMW cash assistance program. The transition is effective in the month following the month the failure or refusal to comply is established.

B. Two-parent family: In a two-parent family where only one of the parents is a participant in the New Mexico wage subsidy program, the other parent, if considered as a mandatory participant in the NMW work program, shall be required to participate in qualified work activities for a minimum of 30 hours per week. At least 20 hours a week must be spent in qualified primary work activities.

C. If a wage subsidy participant voluntarily quits a job without good cause, as determined by the NMW service provider or the HCA, the participant will no longer be considered for participation in the wage subsidy program. Refer to 8.102.620 NMAC for good cause provisions.

D. The TANF cash assistance participant will then have 10 days to notify the NMW service provider and renew work participation activities or be subject to the conciliation/sanction process for non-compliance with the work program.

[8.102.462.9 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

8.102.462.10 REQUIREMENTS FOR PARTICIPATING EMPLOYERS: Participating employers shall:

A. hire NMW participants for subsidized positions and offer a reasonable possibility of unsubsidized employment after the subsidy period;

B. not require participants to work in excess of 40 hours per week;

C. pay a wage that is equal to the wage paid to permanent employees performing the same job duties and no less than the federal minimum wage;

D. ensure that the subsidized employment does not impair an existing contract or collective bargaining agreement;

E. ensure that the subsidized employment does not displace currently employed persons or fill positions that are vacant due to a layoff;

F. maintain health, safety and work conditions at or above levels generally acceptable in the industry and not less than those of comparable jobs offered by the employer;

G. provide on-the-job training necessary for subsidized participants to perform their duties;

H. sign an agreement for each placement outlining the specific job offered to a subsidized employee and agreeing to abide by all of the requirements of the wage subsidy program;

I. provide workers' compensation coverage for each subsidized employee;

J. provide other benefits (includes but is not be limited to, health care coverage, paid sick leave, holiday and vacation pay) equal to those for new employees, or as required by state and federal law, whichever is greater; and

K. inform the HCA of any absences resulting in leave without pay; and

L. proceed with termination of any New Mexico wage subsidy employee who has used an excess of 16 hours excused absences in a month or 80 cumulative hours over the course of the wage subsidy term.

[8.102.462.10 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

8.102.462.11 HEALTH CARE AUTHORITY REQUIREMENTS: The HCA shall:

A. suspend regular TANF cash assistance payments to the benefit group for the calendar month in which an employer makes the first subsidized wage payment to a participant in the benefit group;

B. pay employers each month, from the TANF block grant, an amount that equals fifty percent of the wages paid by the employer to program participants;

C. issue a supplemental TANF cash assistance payment if the net monthly full-time wage paid to the participant is less than the TANF cash assistance amount for which the participant would otherwise be eligible;

D. reimburse the participating employer each month through current invoice procedures; and

E. assist the work program contractor by referring participants who may be eligible for the New Mexico wage subsidy program.

[8.102.462.11 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

8.102.462.12 NMW SERVICE PROVIDER REQUIREMENTS: The HCA's NMW service provider shall:

A. provide an orientation for all participants who are accepted into the wage subsidy program;

B. identify eligible participants and refer them to potential employers;

C. submit a list of referrals to the local ISD office to verify eligibility for NMW cash assistance;

D. assist the TANF cash assistance participant in submitting applications for employment; and

E. provide case management by monitoring employee work efforts and production to ensure job retention.

[8.102.462.12 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012]

8.102.462.13 LEAVE BALANCES AND ABSENCES:

A. **Annual and sick leave:** While participating in the NMW wage subsidy program, the participant is entitled to accrue a balance of both sick and annual leave, as provided by the employer.

B. **Excused absences:** Participants are entitled to unpaid excused absences at the discretion of the site supervisor or NMW service provider. A participant may not be allowed more than 16 hours of unpaid excused absences in any month or 80 hours cumulatively during the wage subsidy term, without good cause. Absences are approved by the site supervisor or by the NMW service provider.

C. Absences in excess of the accrued annual, sick and the unpaid excused absence totals will result in termination of the NMW wage subsidy activity and the participant will be subject to the conciliation and sanction process in accordance with regulation at 8.102.620 NMAC. The appropriate termination process dictated by the employer's human resources procedures shall be followed.

[8.102.462.13 NMAC - Rp, 8.102.460.32 NMAC, 04/01/2012; A, 11/01/14]

HISTORY OF 8.102.462 NMAC:

NMAC History:

8 NMAC 3.FAP.460, Work Program Activities, filed 06/16/1997.

8 NMAC 3.FAP.460, Work Program Activities, filed 06/16/1998.

History of Repealed Material:

8.102.460 NMAC, Recipient Policies - Defining Group Work Program Activities, filed 03/02/2001 - Repealed effective 07/01/2001.

8.102.460 NMAC, Recipient Policies - Defining Group Work Program Activities, filed 06/18/2001 - Repealed effective 07/16/2007.

8.102.460 NMAC, Recipient Policies - Defining Group Work Program Activities, filed 07/02/2007 - Repealed effective 04/01/2012.

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 100 RECIPIENT POLICIES - DEFINITIONS AND ACRONYMS

8.106.100.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.100.1 NMAC - Rp, 8.106.100.1 NMAC, 11/01/2023; A, 7/1/2024]

8.106.100.2 SCOPE: The rule applies to the general public.
[8.106.100.2 NMAC - Rp, 8.106.100.2 NMAC, 11/01/2023]

8.106.100.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.100.3 NMAC - Rp, 8.106.100.3 NMAC, 11/1/2023; A, 7/1/2024]

8.106.100.4 DURATION: Permanent.
[8.106.100.4 NMAC - Rp, 8.106.100.4 NMAC, 11/01/2023]

8.106.100.5 EFFECTIVE DATE: November 1, 2023, unless a later date is cited at the end of a section.
[8.106.100.5 NMAC - Rp, 8.106.100.5 NMAC, 11/01/2023]

8.106.100.6 OBJECTIVE:

A. The objective of general assistance is to provide cash assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched cash assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.
[8.106.100.6 NMAC - Rp, 8.106.100.6 NMAC, 11/01/2023]

8.106.100.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) Adult residential shelter care home (ARSCH): means a shelter care home for adults that is licensed by the department of health.

(2) Application: means a written request for assistance, on the appropriate ISD form, signed by or on behalf of an individual or family.

(3) Attendant: means an individual needed in the home for medical, housekeeping or child care reasons.

(4) Authorized beneficiary: means the surviving spouse of a disabled adult or the caretaker of an unrelated child, who has the ability to use a deceased recipient's issued payment.

(5) Authorized representative: means an adult who is designated in writing by the applicant and is sufficiently knowledgeable about the applicant/benefit group's circumstances to complete the application form correctly and represent the benefit group.

B. Definitions beginning with "B":

(1) Basic needs: means food, clothing, shelter, utilities, personal requirements and the individual's share of household supplies.

(2) Benefit group: means an individual or group of individuals authorized to receive cash assistance financed by state or local funds.

(3) Benefit month: means the month for which cash assistance benefits are issued.

(4) Budget month: means the calendar month for which income and other circumstances of the benefit group shall be determined in order to calculate the cash assistance amount.

C. Definitions beginning with "C":

(1) Capacity to work: the effects of impairment(s), work-related factors, functionality on

the ability for an individual to engage in gainful employment.

(2) Capital gains: means the proceeds from the sale of capital goods or equipment.

(3) Cash assistance: means state-funded cash assistance in the general assistance program, the adult residential shelter care home program (ARSCH), or the burial assistance program for the indigent.

(4) Categorical eligibility (CE): means a SNAP household that meets one of the following conditions is considered to be CE and have limited eligibility requirements.

(a) Financial CE: Any SNAP household in which all members receive Title IV-A assistance (TANF), general assistance (GA), or supplemental security income (SSI) benefits is considered to be categorically eligible for SNAP benefits.

(b) Broad-based CE: Any SNAP household, in good standing, in which at least one member is receiving a non-cash TANF/MOE funded benefit or service and household income is below one hundred sixty-five percent FPG.

(5) Certification: means the authorization of eligibility of a benefit group for the issuance of cash assistance benefits.

(6) Certification period: means the time period in calendar months that is assigned to a benefit group that is approved to receive cash assistance benefits.

(7) Collateral contact: means an individual or agency designated to provide information concerning eligibility.

(8) Contingency: means requirement(s) an individual must accept as a condition of eligibility such as, treatment available outside the GA program, unless a determination is made that good cause exists for the individual's inability to comply.

(9) Conversion factor: means anticipated monthly income received on a weekly or bi-weekly basis shall be converted to a monthly amount.

D. Definitions beginning with "D":

(1) Date of admission: means the date established by the immigration and naturalization service as the date a non-citizen (or sponsored non-citizen) was admitted for permanent residence.

(2) Date of application: means the date the application is received by the income support division offices during regular business hours, this includes applications that are dropped off, submitted in person and electronically. Applications that are dropped off or submitted electronically after regularly scheduled business hours, holidays and weekends will be considered received as of the next business day.

(3) Date of authorization: means the date when action is taken to approve a cash payment for a benefit group.

(4) Date of entry: means the date established by the immigration and naturalization service as the date a non-citizen (or sponsored non-citizen) was admitted for permanent residence.

(5) Day(s): means working days, unless otherwise defined in this chapter.

(6) Department: means the health care authority (HCA).

(7) Dependent child: means an individual who is 17 years of age or younger; 18 years of age and enrolled in high school; or between 18 and 22 years of age and is receiving special education services regulated by the state public education department.

(8) Director: means the director of the income support division.

(9) Disability: means the definitions of disability related to the general assistance program and the disability determination process found at 8.106.420.7 NMAC.

E. Definitions beginning with "E":

(1) Earned income: means cash or payment in-kind that is received as wages from employment or payment in lieu of wages; and earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services.

(2) Emancipated: means an individual under the age of 18 who is legally recognized as no longer under parental control due to the individual's marriage, active duty in the armed forces or by the order of a court.

(3) Encumbrance: means debt owed on property.

(4) Equity value: means the fair market value of property, less any encumbrances owed on the property.

(5) Essential person: means an individual responsible for the care of a disabled general assistance recipient to the extent that placement into institutional care would be required were it not for care provided by this individual.

(6) Expungement: means the permanent deletion of cash benefits from an EBT account that

is stale.

F. Definitions beginning with "F":

(1) Fair hearing: means an administrative proceeding that a claimant or the claimant's representative may request if:

(a) an application is not acted on within the application time limits at 8.106.110.12 NMAC; or

(b) an application is denied in whole or in part; or

(c) cash assistance or services are modified, terminated or not provided.

(2) Fair market value (FMV): means the amount an item can be expected to sell for on the open market at the prevailing rate of return. For vehicles, the term FMV means the amount a dealer would buy a vehicle for wholesale or as a trade-in, not the amount the dealer would sell the vehicle for at retail.

(3) Federal act: means the federal Social Security Act and rules promulgated pursuant to the Social Security Act.

(4) Federal fiscal year: means the time period beginning on October 1 and ending on September 30 of the calendar year.

(5) Federal poverty guidelines: means the level of income defining poverty by family size, published annually in the federal register by the United States department of health and human services.

G. Definitions beginning with "G":

(1) Gainful employment: means any job or class of jobs in the state that would provide an income equaling or exceeding eighty-five percent of the federal poverty guidelines to the benefit group.

(2) Government entity: means any federal, state, tribal or local unit of government as well as any non-government entity that receives public funds for the purpose of meeting the needs of its clientele.

(3) Gross income: means the total amount of earned or unearned income before any voluntary or involuntary deductions are made, such as, but not limited to, federal and state taxes, FICA, garnishments, insurance premiums (including medicare), and monies due and owing the benefit group but diverted by the provider. Gross income does not include specific income exclusions, such as but not limited to, the cost of producing self-employment income and income excluded by federal law.

(4) Gross income test: means the income test applied to the maximum income eligibility limit for participation in a particular cash assistance program based on the size of the household or benefit group.

(5) Guaranteed basic income: Guaranteed basic income provides an individual or household a one time or recuring cash payment or transfer funded from a public or private source intended to support the basic needs of individuals or households by reducing poverty, promoting economic mobility, or increasing the financial stability.

H. Definitions beginning with H": Head of household means an individual who is the responsible case head for the benefit group. The head of household may be the parent, guardian, sole adult member, specified relative, pregnant woman, a recipient of general assistance, or caretaker.

I. Definitions beginning with "I":

(1) Immigrant: means an individual who is a non-citizen as defined in title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act (PROWRA) and within the technical meaning at 8 U.S.C. 1101(a)(15).

(2) Ineligible non-citizen: means an individual who does not meet the eligible non-citizen requirements or has not been admitted for permanent residence.

(3) Initial month: means the first month for which a benefit group is certified for participation in the cash assistance program. An initial month is also a month in which a benefit group is certified following a break in participation of one calendar month or longer.

(4) Inquiry: means a request for information about eligibility requirements for a financial, medical, or food assistance program that is not an application for that program.

(5) Interim assistance reimbursement: means the program within the social security administration that will reimburse the state through the HCA for payments made to an individual receiving GA disability during the period the individual's application for SSI was pending.

(6) Institution of higher education: means any education institution which normally requires a high school diploma or equivalency certificate for enrollment, including, but not limited to, colleges, universities, and vocational or technical schools at the post-high school level.

(7) Institutionalized: Living in a facility licensed as an adult residential shelter care home (ARSCH).

(8) Irrevocable trust funds: means an arrangement to have monies held by one person for

the benefit of another that cannot be revoked.

(9) Issuance month: means the calendar month in which cash assistance is issued.

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

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

L. Definitions beginning with "L": Limited state funds means that the standard of need for a one person benefit group is calculated at $150 per month or less.

M. Definitions beginning with "M":

(1) Maintenance of effort: means the amount of general funds the state agency must expend annually on the four purposes of temporary assistance to needy families (TANF) to meet the minimum expenditure requirement based on a state's historical assistance for families with dependent children (AFDC) expenditures

(2) Mandatory benefit group member: The income and resources of mandatory members will always be considered to determine need, but not payment. In order to be included in the assistance group, members must individually meet eligibility requirements. Members mandatory for inclusion are: spouses residing in the home with the applicant, a caretaker of the applicant, and the father of an unborn child residing in the home with the applicant.

(3) Medicaid: means medical assistance under title XIX of the Social Security Act, as amended.

(4) Minor unmarried parent: means an unmarried parent who is under the age of 18 years or is age 18 and enrolled in high school.

(5) Month of approval: means the first month in which a benefit group is eligible for cash assistance.

N. Definitions beginning with "N":

(1) Net income test: means the income test applied to eligibility for a particular program, after all allowable deductions are taken from the gross income for the household or benefit group. To be eligible, the benefit group's net earned income must be less than the standard of need applicable to the benefit group after allowable deductions have been made to the earned and unearned income.

(2) Net monthly income: means gross non-exempt income minus the allowable deductions. Net monthly income is the figure used to determine eligibility and cash assistance benefit amount.

(3) New Mexico works: means the federally funded temporary cash assistance program for needy families that carries a sixty-month term limit for adults in the state.

(4) Non-benefit group members: means persons residing with a benefit group but who are specifically excluded by regulation from being included in the benefit group certification.

(5) Non-cash TANF/MOE benefit or service: means a non-cash TANF/MOE benefit or services including programs or services that do not provide cash to recipients, but are funded by the TANF program, either by the federal TANF block grant or the state MOE share. These services may include transportation, childcare, counseling programs, parenting programs, pamphlets or referrals to other TANF/MOE-funded services.

(6) Notice: means written correspondence that is generated by any method including handwritten, typed or electronic, delivered to the client or their authorized representative by hand, U.S. mail, professional delivery or by any electronic means. The term "written notice" and "notice" are used interchangeably.

(7) Notice of adverse action (NOAA): means a written or electronic notice sent 13 days in advance of an action to reduce, suspend or terminate benefits that includes a statement of the action the HCA intends to take, the reason for the action, the benefit group's right to a fair hearing, who to contact for additional information, the availability of continued benefits, and liability of the benefit group for any overpayment received if the hearing decision is adverse to the benefit group.

O. Definitions beginning with "O": Overpayment/over-issuance means the amount by which cash assistance benefits issued to a benefit group exceed the amount the benefit group was eligible to receive.

P. Definitions beginning with "P":

(1) Parent: means a natural parent, adoptive parent, or stepparent.

(2) Payment: means the amount of the cash assistance benefit, after the countable net earned and unearned income of the benefit group has been subtracted from the benefit group's standard of need, and before any reduction by sanction or recoupment.

(3) Permanently residing under color of law (PRUCOL): means non-citizens lawfully admitted for permanent residence or permanently residing in the United States under color of law as follows.

(a) The individual may be eligible for medicaid if the individual is a non-citizen residing in the United States with the knowledge and permission of the immigration and naturalization services

(INS) and the INS does not contemplate enforcing the non-citizen's departure. The INS does not contemplate enforcing a non-citizen's departure if it is the policy or practice of INS not to enforce the departure of non-citizens in the same category, or if from all the facts and circumstances in a particular case it appears that INS is otherwise permitting the non-citizen to reside in the United States indefinitely, as determined by verifying the non-citizen's status with INS.

(b) Non-citizens who are permanently residing in the United States under color of law are listed below. None of the categories include applicants for an immigration and naturalization service status other than those applicants listed in Item (vi) of Subparagraph (b) of Paragraph (2) of Subsection A of 8.200.410.11 NMAC or those covered under Item (xvi) of Subparagraph (b) of Paragraph (2) of Subsection A of 8.200.410.11 NMAC. None of the categories allow medicaid eligibility for non-immigrants; for example, students or visitors. Also listed are the most commonly used documents that the INS provides to non-citizens in these categories:

(i) non-citizens admitted to the United States pursuant to 8 U.S.C. 1153(a)(7)(Section 203(a)(7) of the Immigration and Nationality Act); ask for a copy of INS Form I-94 endorsed "refugee-conditional entry";

(ii) non-citizens, including Cuban/Haitian entrants, paroled in the United States pursuant to 8 U.S.C. 1182(d)(5)(Section 212(d)(5)) of the Immigration and Nationality Act; for Cuban/Haitian entrant (Status Pending) reviewable January 15, 1981; (although the forms bear this notation, Cuban/Haitian entrants are admitted under section 212(d)(5) of the Immigration and Nationality Act);

(iii) non-citizens residing in the United States pursuant to an indefinite stay of deportation; ask for an immigration and naturalization service's letter with this information or INS Form I-94 clearly stated that voluntary departure has been granted for an indefinite period of time;

(iv) non-citizens residing in the United States pursuant to an indefinite voluntary departure; ask for an immigration and naturalization service's letter or INS Form I-94 showing that voluntary departure has been granted for an indefinite time period;

(v) non-citizens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure (under 8 CFR 242.5(a)(2)(vi)) and whose departure the immigration and naturalization service does not contemplate enforcing; ask for a copy of INS Form I-94 or Form I-210 or a letter clearly stating that status;

(vi) non-citizens who have filed applications for adjustment of status pursuant to Section 245 of the Immigration and Nationality Act (8 U.S.C. 1255) that the immigration and naturalization services has accepted as properly filed (within the meaning of 8 CFR 245.2(a)(1) or (2) and whose departure the immigration and naturalization service does not contemplate enforcing; ask for a copy of INS Form I-94 or I-181 or a passport appropriately stamped;

(vii) non-citizens granted stays of deportation by court order, statute, or regulation, or by individual determination of the immigration and naturalization service pursuant to Section 106 of the Immigration and Nationality Act (8 U.S.C. 1105 a) or relevant immigration and naturalization service's instructions, whose departure that agency does not contemplate enforcing; ask for a copy of INS Form I-94 or a letter from the immigration and naturalization service, or a copy of a court order establishing the non-citizen's status;

(viii) non-citizens granted asylum pursuant to Section 208 of the Immigration and Nationality Act (8 U.S.C. 1158); ask for a copy of INS Form I-94 and a letter establishing this status;

(ix) non-citizens admitted as refugees pursuant to Section 207 of the Immigration and Nationality Act (8 U.S.C. 1157) or Section 203(a)(7) of the Immigration and Nationality Act (8 U.S.C. 1153(a)(7)); ask for a copy of INS Form I-94 properly endorsed;

(x) non-citizens granted voluntary departure pursuant to Section 242(b) of the Immigration and Nationality Act (8 U.S.C. 1252(b)) or 8 CFR 242.5 whose departure the Immigration and Naturalization Service does not contemplate enforcing; ask for a Form I-94 or Form I-210 bearing a departure date;

(xi) non-citizens granted deferred action status pursuant to Immigration and Naturalization Service Operations Instruction 103.1(a)(ii) prior to June 15, 1984 or 242.1(a)(22) issued June 15, 1984 and later; ask for a copy for INS Form I-210 or a letter showing that departure has been deferred;

(xii) non-citizens residing in the United States under orders of supervision pursuant to Section 242 of the Immigration and Nationality Act (8 U.S.C. 1252(d)); ask for a copy of Form I-220 B;

(xiii) non-citizens who have entered and continuously resided in the United States since before January 1, 1972, (or any date established by Section 249 of the Immigration and Nationality Act, 8 U.S.C. 1259); ask for any proof establishing this entry and continuous residence;

(xiv) non-citizens granted suspension for deportation pursuant to Section 244

of the Immigration and Naturalization Act (8 U.S.C. 1254) and whose departure the immigration and naturalization service does not contemplate enforcing; ask for an order from an immigration judge showing that deportation has been withheld;

(xv) non-citizens whose deportation has been withheld pursuant to Section 243(h) of the Immigration and Nationality Act (8 U.S.C. 1253(h)); ask for an order from an immigration judge showing that deportation has been withheld;

(xvi) any other non-citizens living in the United States with the knowledge and permission of the immigration and naturalization service and whose departure the agency does not contemplate enforcing (including permanent non-immigrants as established by Public Law 99-239, and persons granted extended voluntary departure due to conditions in the non-citizen's home country based on a determination by the secretary of state).

(4) **Person:** means an individual.

(5) **Prospective budgeting:** means the computation of a benefit group's eligibility and benefit amount based on an estimate of income and circumstances that will exist in the current month and future months.

Q. **Definitions beginning with "Q": Qualified non-citizen** includes any of the classes of immigrant status granted by USCIS below:

(1) a non-citizen who is lawfully-admitted for permanent residence (LPR) under the Immigration and Nationality Act (INA);

(2) a non-citizen granted asylum under section 208 of the INA;

(3) a non-citizen admitted into the United States as a refugee under section 207 of the INA;

(4) a non-citizen paroled into the United States for a period of at least one year under section 212(d)(5) of the INA;

(5) a non-citizen whose deportation has been withheld under section 243(h) of the INA as in effect prior to April 1, 1997, who whose removal has been withheld under section 241(b)(3) of the INA;

(6) a non-citizen who has been granted conditional entry pursuant to section 203(a)(7) of the INA as in effect prior to April 1, 1980;

(7) a non-citizen who was a Cuban or Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980;

(8) a non-citizen, a non-citizen parent or non-citizen child, who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent or by a member of the spouse or parent's family residing in the same home as the non-citizen at the time of the abuse and there is a petition pending under 204(a)(1)(A) or (B) or 244(a)(3) of the INA, as long as the non-citizen has begun the process of becoming a lawful permanent resident under the Violence Against Women Act;

(9) a non-citizen who is a victim of a severe form of trafficking, regardless of immigration status, under the Trafficking Victims Protection Act of 2000.

R. **Definitions beginning with "R":**

(1) **Real property:** means land and affixed improvements and structures, which include mobile homes. Grazing permits are also considered real property.

(2) **Recertification:** means a complete review of all conditions of eligibility and a redetermination of the amount of the cash assistance benefits for an additional period of time.

(3) **Recipient:** means a person receiving cash assistance benefits.

(4) **Reconsideration:** means a re-evaluation of disability based on additional medical evidence provided by the client.

(5) **Refugee:** means a lawfully admitted individual granted conditional entry into the United States.

(6) **Resource standard:** means the financial standard with respect to an applicant's/recipient's resources and property, which is set at $2,000 for non-liquid resources and $1,500 for liquid resources.

(7) **Retrospective budgeting:** means the computation of a benefit group's benefits for an issuance month based on actual income and circumstances that existed in the previous month.

S. **Definitions beginning with "S":**

(1) **Secretary:** means the secretary of the health care authority.

(2) **Self-employed:** means an individual who engages in a self-managed enterprise for the purpose of providing support and income.

(3) **Set term GA:** The certification period shall be for a set length of time dependent upon

conditions, beginning from the month of approval and is not subject to review.

(4) Shelter for battered persons: means a public or private nonprofit residential facility that serves battered persons. If such a facility serves other individuals, a portion of the facility must be set aside on a long-term basis to serve only battered persons.

(5) Simplified reporting: a reporting requirement for households that receive GA benefits in accordance with 8.106.431 NMAC.

(6) Single-parent benefit group: means a benefit group that does not include both parents of a child who is included in the benefit group and thus includes families in which there is only one parent or in which there are no parents.

(7) Sponsor: means a person who executed an affidavit of support or similar agreement on behalf of a non-citizen as a condition of the non-citizen's entry or admission into the United States as a permanent resident.

(8) Sponsored non-citizen: means a non-citizen lawfully admitted for permanent residence in the United States as an immigrant, as defined in Sections 101(a)(15) and 101(a)(2) of the Immigration and Nationality Act.

(9) Spouse: means an individual legally bound by marriage.

(10) Stale: means EBT accounts which have not been accessed (no withdrawal activity) by the household in the last 90 days from the most recent date of withdrawal.

(11) Standard of need: means the amount provided to each GA cash assistance benefit group on a monthly basis and is based on legislative funding, the number of individuals included in the benefit group, number of cases, number of applications processed and approved, application approval rate, number of case closures, IAR case number and expenditures, and number of pending applications.

(12) Supplemental nutrition assistance program (SNAP): The Food and Nutrition Act of 2008 changed the federal name of the food stamp program to the supplemental nutrition assistance program. SNAP is synonymous with the food stamp program.

(13) Supplemental security income (SSI): means monthly cash payments made under the authority of:

(a) Title XVI of the Social Security Act, as amended, to the aged, blind and disabled;

(b) Section 1616(a) of the Social Security Act; or

(c) Section 1382 of the Social Security Act.

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

U. Definitions beginning with "U":

(1) Unavailable state funds: means the funds are not sufficient to provide all GA benefit groups with a one dollar monthly cash payment.

(2) Unearned income: Means old age, survivors and disability insurance payments (social security); railroad retirement benefits; veterans administration compensation or pension payments; military retirement and allotments; pensions, annuities and retirement benefits; lodge or fraternal benefits; other public or private disability or retirement benefits or pension; shared shelter payments; individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income.

(3) Universal basic income: Universal basic income is a government-guaranteed program that provides a modest cash income at regular intervals (e.g., each month or year) to every individual or household to meet the basic needs.

(4) Unrelated caretaker: means an individual who is not a specified relative within the fifth degree of relationship of a dependent child and has assumed responsibility for care, support and supervision of an unrelated child and for meeting the child's physical and emotional needs.

(5) Unrelated child: means a minor, under 18 years of age, residing with a caretaker who is not a specified relative within the fifth degree of relationship.

V. Definitions beginning with "V":

(1) Variable term GA: The certification period shall be set for a length of time, not to exceed 12 months, beginning from the month of approval and is subject to review.

(2) Verification: means the use of third-party information or documentation to establish the accuracy of statements on the application or recertification.

W. Definitions beginning with "W": Work related factors means factors taken into account in the

disability determination process such as age, education, training, work experience, language ability, appearance, marital status, living situation, as well as relevant social history and minimal employment and activities that would be required in a work setting such as sitting, standing, walking, lifting, carrying, handling, seeing, hearing, communicating and understanding and following directions.

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

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

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

[8.106.100.7 NMAC - Rp, 8.106.100.7 NMAC, 11/01/2023]

8.106.100.8 ABBREVIATIONS AND ACRONYMS:

A. Abbreviations and acronyms:

(1) ARSCH: adult residential shelter care home
(2) BG: benefit group
(3) BIA: bureau of Indian affairs
(4) BIA-GA: bureau of Indian affairs-general assistance
(5) CA: cash assistance
(6) CE: categorical eligibility or categorically eligible
(7) CFR: code of federal regulations
(8) CS: child support
(9) CSSD: (HCA) child support services division
(10) CYFD: (New Mexico) children, youth & families department
(11) DOH: (New Mexico) department of health
(12) DVR: division of vocational rehabilitation
(13) DOT: dictionary of occupational titles
(14) E&T: employment and training (food stamp work program)
(15) EBT: electronic benefit transfer
(16) EI: earned income
(17) EWP: education works program
(18) FAP: financial assistance program
(19) FFY: federal fiscal year
(20) FMV: fair market value
(21) FPL: federal poverty level
(22) GA: general assistance
(23) GBI: guaranteed based income;
(24) GED: general equivalency degree;
(25) HCA: (New Mexico) health care authority
(26) HHS: (U.S.) health and human services;
(27) HUD: (U.S.) housing and urban development;
(28) IDA: individual development account;
(29) IPV: intentional program violation;
(30) IRP: individual responsibility plan;
(31) IRU: incapacity review unit;
(32) ISD: (HCA) income support division;
(33) ISD2: integrated services delivery for income support division (ISD);
(34) MAD: (HCA) medical assistance division;
(35) MVD: (New Mexico) motor vehicle division;
(36) NADA: national automobile dealers association;
(37) NMAC: New Mexico administrative code;
(38) NMDWS: New Mexico department of workforce solutions;
(39) NMW: New Mexico works;
(40) NOAA: notice of adverse action;
(41) POS: point of sale;
(42) PED: (New Mexico) public education department;
(43) QC: quality control;
(44) RR: regular reporting;
(45) RRP: refugee resettlement program;

(46) **SAVE:** systematic alien verification for entitlements;
(47) **SE:** self-employment;
(48) **SR:** simplified reporting;
(49) **SSA:** social security administration;
(50) **SSI:** supplemental security income;
(51) **SSN:** social security number;
(52) **TANF:** temporary assistance to needy families (block grant program under title IV-A of the Social Security Act);
(53) **UBI**: Universal basic income;
(54) **UCB:** unemployment compensation benefits;
(55) **UEI:** unearned income;
(56) **USCIS:** United States immigration and naturalization services;
(57) **USDA:** United States department of agriculture;
(58) **VA:** veterans administration;
(59) **WIA:** Workforce Investment Act;
(60) **WID:** work incentive deduction;
(61) **WPA:** work participation agreement.
[8.106.100.8 NMAC - Rp, 8.106.100.8 NMAC, 11/01/2023]

HISTORY OF 8.106.100 NMAC:

History of Repealed Material:
8.106.100 NMAC, Recipient Policies - Definitions and Acronyms, filed 06/17/2004 - Repealed 12/01/2009.
8.106.100 NMAC, Recipient Policies - Definitions and Acronyms, filed 11/17/2009- Repealed 11/01/2023.

Other: 8.106.100 NMAC, Recipient Policies - Definitions and Acronyms, filed 06/17/2004 - Replaced 8.106.100 NMAC, Recipient Policies - Definitions and Acronyms effective 12/01/2009.
8.106.100 NMAC, Recipient Policies - Definitions and Acronyms, filed 11/17/2009 - Replaced 8.106.100 NMAC, Recipient Policies – Definitions and Acronyms effective 11/1/2023.

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 400 RECIPIENT POLICIES - DEFINING THE BENEFIT GROUP

8.106.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.400.1 NMAC - Rp, 8.106.400.1 NMAC, 12/01/2009; A, 7/1/2024]

8.106.400.2 SCOPE: The rule applies to the general public.
[8.106.400.2 NMAC - Rp, 8.106.400.2 NMAC, 12/01/2009]

8.106.400.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.400.3 NMAC - Rp, 8.106.400.3 NMAC, 12/01/2009; A, 7/1/2024]

8.106.400.4 DURATION: Permanent.
[8.106.400.4 NMAC - Rp, 8.106.400.4 NMAC, 12/01/2009]

8.106.400.5 EFFECTIVE DATE: December 1, 2009, unless a later date is cited at the end of a section.
[8.106.400.5 NMAC - Rp, 8.106.400.5 NMAC, 12/01/2009]

8.106.400.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.400.6 NMAC - Rp, 8.106.400.6 NMAC, 12/01/2009]

8.106.400.7 DEFINITIONS: [**RESERVED**]

8.106.400.8 WHO CAN BE A RECIPIENT: To be a recipient of general assistance, an individual must be eligible according to the regulations for the GA program. An individual for whom an application has been or must be made may receive cash assistance as long as the individual also meets individual eligibility requirements of the GA program and is otherwise eligible.
[8.106.400.8 NMAC - Rp, 8.106.400.8 NMAC, 12/01/2009]

8.106.400.9 BASIS FOR DEFINING THE BENEFIT GROUP:

A. Request for assistance: The request for assistance is the first step in determining those individuals who must be included in the benefit group. At the request of the head of the benefit group, non-mandatory members may be included or removed from the benefit group, this may require the inclusion or removal of other individuals as well.

B. Benefit group members: The head of benefit group is required to apply for any person who is a mandatory benefit group member, failure shall result in ineligibility for the entire benefit group. Changes in benefit group circumstances shall be reviewed and may affect who is considered a mandatory benefit group member.

C. Mandatory for inclusion: The income and resources of mandatory members will always be considered to determine need, but not payment. In order to be included in the assistance group, members must individually meet eligibility requirements. Members mandatory for inclusion are: spouses residing in the home with the applicant, a caretaker of the applicant, and the father of an unborn child residing in the home with the applicant.

[8.106.400.9 NMAC - Rp, 8.106.400.9 NMAC, 12/01/2009]

8.106.400.10 CONSTRUCTING THE BENEFIT GROUP:

A. General: To be eligible for inclusion in a GA benefit group, a person must be individually eligible according to requirements set forth in 8.106.410 NMAC, 8.106.420 NMAC and 8.106.430 NMAC, and not otherwise disqualified from participation. The person or persons meeting individual eligibility requirements and for whom an application has been or must be made constitute the benefit group.

B. Disability: The benefit group for the GA-disabled adult program consists of the disabled adult and may include the needs of other adults living in the home. An adult who shares custody of their biological child may apply for GA-disabled adults in their own right, provided that the adult who is applying has less than half time custody of the child.

(1) Spouse: The spouse, residing in the home with the disabled adult must be included in the benefit group to determine need, but not payment. The spouse may be included in payment if the spouse is determined disabled.

(2) Essential person: An individual, regardless of relation, is considered essential to the well being of a disabled GA applicant and may be included in the GA benefit group to determine need and payment. An essential person is capable of providing the physical care needed by the GA disabled recipient to the extent that placement into institutional care would otherwise be required without this care.

(3) Pregnant individual: An emancipated unmarried pregnant woman, age 17 or younger, or a pregnant adult, who has not reached her third trimester and has been determined to be disabled, may be considered a benefit group member in the GA disabled adult program. The father of the unborn child that resides in the home, must be included in the benefit group to determine need, but not payment.

(4) SSI: An individual receiving SSI, or who would be receiving SSI except for recovery by the social security administration of an overpayment, is not eligible to be included in a GA benefit group.

C. State supplement for adult residential care: To be eligible for inclusion in an ARSCH supplemental payment benefit group, an individual must be eligible for SSI. The benefit group consists of the SSI recipient. Two SSI recipients who would constitute a family if living at home, but who reside in an adult residential shelter care facility, are considered to be two separate benefit groups.

D. Unrelated child: The benefit group for the GA-dependent child program consists of a dependent child who lives in a family setting with a non-related adult caretaker, and all of that dependent child's full, half, step- or adopted siblings living in the home. An adult caretaker may be an individual who is not a specified relative within the fifth degree of relationship and who is not eligible for NMW in their own right.

(1) Caretaker: The unrelated caretaker shall be included in the benefit group upon request. The spouse of the unrelated caretaker, if living in the home, shall be included in the benefit group when the unrelated caretaker is included in the benefit group.

(2) Need and payment: The unrelated caretaker and spouse shall be included in the benefit group to determine need and payment only if they request inclusion.

(3) Fifth degree of relationship: The following relatives are within the fifth degree of relationship to the dependent child:

(a) father (biological or adoptive);

(b) mother (biological or adoptive);

(c) grandfather, great grandfather, great-great grandfather, great-great-great grandfather;

(d) grandmother, great-grandmother, great-great-grandmother, great-great-great grandmother;

(e) spouse of child's parent (stepparent);

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

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

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

(i) uncle of the whole or half-blood, uncle-in-law, great uncle, great-great uncle;

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

(k) first cousin and spouse of first cousin;

(l) son or daughter of first cousin (first cousin once removed);

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

(n) nephew/niece and spouses.

(4) A second cousin is a child of a first cousin once removed or child of a child of a great

aunt or uncle and is not within the fifth degree of relationship.

(5) Effect of divorce or death on relationship: A relationship based upon marriage, such as the "in-law", or "step-" relationships, continues to exist following the dissolution of the marriage by divorce or death.

(6) Unrelated child adult only benefit group: An adult only benefit group may consist of the non-related adult caretaker when all of the dependent children are receiving SSI.

[8.106.400.10 NMAC - Rp, 8.106.400.11, 12 & 16 NMAC, 12/01/2009; A, 07/01/2013]

8.106.400.11 LIVING ARRANGEMENT:

A. Disability:

(1) An individual shall not be eligible for inclusion in the benefit group if the individual is institutionalized for any reason such as:

(a) medical or mental health treatment;

(b) an inmate in a public non-medical institution, including facilities in the state prison system, jails and detention centers, as well as juvenile correction facilities;

(c) a person shall be considered an inmate if residing in a public facility at the order or discretion of a court, such as a person sentenced to a prison or committed under court order.

(2) An individual shall be eligible for inclusion in the benefit group if the individual is:

(a) attending a public educational or vocational training institution, who lives in housing provided by the institution; or

(b) residing in a homeless shelter or other supportive living program administered by a homeless services provider.

(3) To be eligible for inclusion the essential person, spouse or father of the unborn child, must be considered to be living with the disabled recipient.

B. State supplement for adult residential care: To be eligible for the ARSCH supplemental payment program, an individual must be living in a facility licensed as an adult residential shelter care facility.

C. Dependent child: The determination whether the dependent child meets the living arrangement is discussed with the caretaker and carefully documented in the case record.

(1) The dependent child must be living or considered to be living, in the home with an unrelated caretaker. A dependent child is considered to be living with a caretaker if:

(a) the caretaker has assumed responsibility for care, support and supervision of an unrelated child and for meeting the child's physical and emotional needs;

(b) the caretaker has demonstrated an intent to maintain the caretaker-child relationship and to provide a home for the child;

(c) the caretaker is not the legal guardian of the dependent child;

(d) the dependent child is not physically absent from the home and is not under the care, control or supervision of himself, a relative or another adult, a social services or correctional agency, or other agency of state, local or tribal government; and

(e) the dependent child actually spends the majority of time with one caretaker.

(2) Absence from the home: The caretaker of a dependent child included in the benefit group must report when a dependent child leaves the home of the caretaker. The dependent child's needs shall be removed from the cash assistance payment if the benefit group includes only one dependent child, eligibility shall be terminated for the benefit group. A child may be physically absent from the home, for a period of time and may remain a member of the benefit group if:

(a) the absence is related to the well being of the child;

(b) the caretaker continues to exercise care, financial support, maintains living quarters, makes decisions on the behalf of the child and remains in contact with the child in order to provide supervision of the child; and

(c) the length of the absence is less than 45 days, provided that the child is not simultaneously participating in another cash assistance program.

(3) Absences related to the well being of a child: A child shall retain living-in-the-home status while receiving any of the services described below.

(a) Rehabilitation services, including psychosocial treatment services:

(i) the program must be family-based with one objective being the strengthening of family ties;

(ii) treatment plans must provide for a significant level of continuing

authority, responsibility, and participation by the caretaker; and

(iii) the caretaker must retain the authority to decide when the child should leave the facility, must approve necessary treatment, and must retain responsibility for provision of pocket money.

(b) **Boarding school:** A child who is attending school away from home regardless of the length of the absence, when the caretaker retains responsibility for care, support and supervision of the child. The child must have been living in the home before attending boarding school.

(c) **Residence in a medicaid facility:** A child hospitalized for care or treatment in a title facility may retain living-in-the-home status, without regard to the length of hospitalization, provided that:

(i) the child must have been living in the home before hospitalization;

(ii) the caretaker continues to be the person with primary responsibility for care, support and supervision of the child and for meeting the child's physical and emotional needs.

(d) Treatment centers may include acute care hospitals, freestanding psychiatric hospitals and rehabilitation hospitals as well as residential treatment centers and group homes reimbursed by medicaid for psychosocial rehabilitation services. The status of a residential treatment center or group home as a medicaid provider may be made by contacting the medical assistance division of the HCA.

(e) A child receiving treatment in a title XIX facility or placed in other substitute care living arrangements by juvenile authorities as the result of a sentence or commitment by a judicial authority does not meet the definition of living in the home, as the caretaker no longer has significant responsibility of the care, support and supervision of the child.

(f) A child retains living-in-the-home status as long as the caretaker has the authority to control the child's treatment and duration of stay. Should a court order be issued placing the child in a psychiatric facility, a caretaker may be prevented from removing the child from the facility. In such a circumstance, the child cannot retain living-in-the-home status.

(4) **Caretaker's absence from the home:** The caretaker may be physically absent from the home and still retain status as the primary caretaker for purposes of eligibility, provided the caretaker is absent from the home due to illness or hospitalization for 30 days or less.

(a) **Primary responsibility:** In order for the caretaker to retain living-in-the-home status, they must retain primary responsibilities for providing care, support and supervision for the child.

(b) **Residence in a medicaid facility**: A caretaker receiving treatment in a Title XIX facility remains a member of the benefit group of which the caretaker was a member at the time of hospitalization until the caretaker leaves the facility and returns to the home. If the caretaker does not return to the home following hospitalization, the living-in-the-home determination shall be terminated.

[8.106.400.11 NMAC - Rp, 8.106.400.10, 14 & 15 NMAC, 12/01/2009]

HISTORY OF 8.106.400 NMAC:

History of Repealed Material:

8.106.400 NMAC, Recipient Policies - Defining the Benefit Group, filed 06/17/2004 - Repealed 12/01/2009.

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 410 RECIPIENT POLICIES - GENERAL RECIPIENT REQUIREMENTS

8.106.410.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.410.1 NMAC - Rp, 8.106.410.1 NMAC, 12/01/2009; A, 7/1/2024]

8.106.410.2 SCOPE: The rule applies to the general public.
[8.106.410.2 NMAC - Rp, 8.106.410.2 NMAC, 12/01/2009]

8.106.410.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.410.3 NMAC - Rp, 8.106.410.3 NMAC, 12/01/2009; A, 7/1/2024]

8.106.410.4 DURATION: Permanent.
[8.106.410.4 NMAC - Rp, 8.106.410.4 NMAC, 12/01/2009]

8.106.410.5 EFFECTIVE DATE: December 1, 2009, unless a later date is cited at the end of a section.
[8.106.410.5 NMAC - Rp, 8.106.410.5 NMAC, 12/01/2009]

8.106.410.6 OBJECTIVE:
A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).
B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.
C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.
[8.106.410.6 NMAC - Rp, 8.106.410.6 NMAC, 12/01/2009]

8.106.410.7 DEFINITIONS: [**RESERVED**]

8.106.410.8 REQUIREMENTS:
A. An applicant or recipient who fails to meet an individual eligibility requirement is not eligible to be included in the benefit group. The individual's ineligibility does not make the entire benefit group ineligible, unless the ineligible individual is the only member of the benefit group.
B **Application moratorium:** When the HCA has issued a public notice regarding the limitation of state funds, the caseworker shall deny the general assistance without consideration of eligibility requirements.
[8.106.410.8 NMAC - Rp, 8.106.410.8 NMAC, 12/01/2009]

8.106.410.9 ENUMERATION:
A. To be eligible for inclusion in the benefit group, the recipient, or the caretaker on behalf of a dependent child, must report the individual's social security number (SSN) within 60 days of approval for the GA program.
B. An SSN card shall not be required to validate the individual's SSN, but shall be requested if an individual's SSN becomes questionable or cannot be validated by the social security administration.
C. Failure to meet the enumeration requirement shall result in ineligibility of the benefit group member whose SSN has not been reported or cannot be verified.
[8.106.410.9 NMAC - Rp, 8.106.410.9 NMAC, 12/01/2009]

8.106.410.10 CITIZENSHIP AND NON-CITIZEN STATUS: To be eligible for inclusion in a GA benefit group, if otherwise eligible, an individual must be:
A. a citizen of the United States;

B. a naturalized citizen;

C. a non-citizen who entered the United States before August 22, 1996, and who meets the definition of a qualified immigrant at 8.106.100 NMAC or meets the definition of a PRUCOL; or

D. a non-citizen who entered the United States on or after August 22, 1996, and who meets the definition of a qualified non-citizen at 8.106.100 NMAC.

[8.106.410.10 NMAC - Rp, 8.106.410.10 NMAC, 12/01/2009]

8.106.410.11 RESIDENCY:

A. To be eligible for inclusion in a GA benefit group, an individual must be living in the state of New Mexico and have demonstrated an intent to remain in the state. For applicants, the residency determination shall be made on the date eligibility is determined

B. Residence shall not be considered to exist if the person is just passing through the state or is present in the state for purposes such as vacation, family visits, medical care, temporary employment, or other similar short-term stays and the person does not intend to remain. Residence shall not exist if an individual claims residence in another state.

C. **Establishing residence:** Residence in New Mexico shall be established by being present in the state on an ongoing basis and carrying out the types of activities associated with normal day-to-day living, such as occupying a house (paying rent or mortgage and utilities, receiving mail at that address, etc.), enrolling children in school, renting a post office box, obtaining a state driver's license, joining a church or other local organization, obtaining or seeking employment in the state, registering to vote in the state, etc.

D. **Homeless persons:** Homeless persons must meet the residence requirement; however, their personal situations may prevent them from establishing the types of residence indicators listed above. In such cases, as much information as possible shall be obtained and entered into the case record, but absence of the more common types of verifications, including but not limited to residence, shall not be a barrier to eligibility.

E. **Temporary absence from the state:**

(1) A temporary absence from the state shall not be considered an interruption of residence. Temporary absence occurs when an individual leaves the state for a specific, time-limited purpose, with the intention of returning to the state.

(2) Absences related to the following purposes shall be considered temporary:

(a) short-term visits with family or friends lasting less than 30 days;

(b) out-of-state stays for medical treatment; or

(c) attendance at an out-of-state school, returning to the state during vacations.

(3) **Residency DVR training out-of-state:** If plans are made in conjunction with DVR for a recipient's participation in a training course in another state, cash assistance may be continued for the duration of the training course provided that the recipient or benefit group intends to return to New Mexico when the training is completed.

(4) **Illness:** If a recipient who is temporarily visiting outside New Mexico is unable to return to New Mexico due to illness, cash assistance may continue until such time as the recipient is able to return. The recipient's inability to return to New Mexico due to illness must be verified by a physician's report.

(5) A statement by a recipient of intent to return to the state will be accepted, provided that the recipient does not take action in another state to establish permanent residence.

F. **Residency abandonment:** Residence shall be considered to have been abandoned when an individual:

(1) leaves the state and indicates that he intends to establish residence in the other state; or

(2) leaves the state for no specific purpose and with no clear intention to return; or

(3) leaves the state and applies for food, financial or medical assistance from another state; or

(4) has been absent from the state for a period of 30 days or more and has not notified the HCA of the absence or of an intention to return.

G. **Residence of children:** A dependent child shall be considered to be a resident of the same state as the caretaker adult with whom the child is living.

[8.106.410.11 NMAC - Rp, 8.106.410.11 NMAC, 12/01/2009]

8.106.410.12 NONCONCURRENT RECEIPT OF ASSISTANCE:

A. **Assistance from another state:** An individual who is receiving assistance from another state shall be considered a resident of that state until the state is notified of the individual's intention to abandon residence. An individual who received GA from another state shall be considered to be in receipt of concurrent assistance for

that month.

B. Concurrent receipt of assistance: To be eligible for inclusion in a GA benefit group, the individual cannot already be:

(1) included as a benefit group member and receiving cash assistance from another HCA cash assistance program;

(2) an SSI recipient;

(3) a recipient of benefits from a federally-funded TANF program (including a tribal program) or BIA-GA program;

(4) a recipient of a government-funded adoption subsidy program; or

(5) a recipient of benefits from a TANF or GA program in another state.

C. An individual may not be the payee for more than one GA cash assistance payment.

D. Supplemental security income:

(1) Ongoing SSI eligibility: An individual eligible for SSI on an ongoing basis is not eligible for GA benefits based on concurrent receipt of assistance. The SSI recipient shall not be included in the benefit group for purposes of GA eligibility or benefit calculation. The income, resources and needs of the SSI recipient are excluded in determining benefit group eligibility and benefit amount.

(2) SSI applicants: An individual receiving GA cash assistance benefits from the HCA may apply for and receive SSI benefits for the same months for which the HCA has already issued GA benefits. Cash assistance benefits issued by the HCA are considered in determining the amount of retroactive SSI benefits to be paid to the SSI applicant. GA ineligibility or overpayments shall not be established for any month for which the SSA issues an SSI retroactive payment. When notice is received that a benefit group member is approved for SSI on an ongoing basis, that member shall be immediately removed from the benefit group.

(3) Retroactive SSI payments:

(a) A state funded GA recipient who receives retroactive SSI payments is required to reimburse the HCA under general assistance program interim assistance reimbursement (IAR) provisions set forth at 8.106.420.17 NMAC.

(b) There may be some situations in which only retroactive SSI benefits are approved. Such approvals do not result in GA ineligibility due to concurrent receipt of assistance, since the SSI benefits will not be received on an ongoing basis but may result in GA ineligibility on the basis of resources (see 8.106.510 NMAC).

(4) Adult residential shelter care program: Receipt of SSI is a requirement for receiving adult residential shelter care payments.

E. Other HCA programs: The food stamp program, medicaid, LIHEAP and other similar programs are not considered concurrent assistance and shall not make an individual ineligible for GA cash assistance programs.

[8.106.410.12 NMAC - Rp, 8.106.410.12 NMAC, 12/01/2009]

8.106.410.13 ADDITIONAL ELIGIBILITY REQUIREMENTS FOR DISABILITY:

A. Compliance with IAR requirements: The state of New Mexico is a participant in the interim assistance reimbursement (IAR) program administered by the social security administration (SSA). The U.S. secretary of health and human services, through the SSA, has agreed to reimburse the state through HCA for general assistance payments made to an individual receiving GA disability during the period the individual's application for SSI was pending. Upon approval of SSI, SSA sends the first retroactive SSI payment due an individual to HCA as repayment for the state-funded GA payments made to the individual. The repayment of GA benefits from SSI is referred to as interim assistance reimbursement (IAR).

(1) Interim assistance authorization: An individual applying for disability based on set or variable term disability must, as a condition of eligibility, authorize in writing the reimbursement to HCA for the amount of GA benefits paid on the individual's behalf for any month in which the SSA pays retroactive SSI benefits to the individual.

(a) Completing the IAR authorization: The IAR authorization shall be completed and signed by the applicant and the HCA representative at the time the individual is interviewed. Refusal to sign an IAR authorization shall result in immediate denial of a GA application.

(b) The HCA shall not approve an application for GA without a completed and valid IAR.

(c) The completed and signed IAR authorization form must be received by SSA within 30 days from the date of signature in order to be valid.

(d) **Duration of authorization:** The authorization for IAR shall remain in effect from the date of signature until:

(i) SSA releases the SSI retroactive payment to HCA and HCA recovers the full amount to which it is entitled; or

(ii) HCA and the individual agree to terminate the authorization.

(2) Termination of GA benefits does not constitute termination of the IAR authorization. HCA shall receive the first retroactive SSI payment for an individual who has received GA in the past and for whom an IAR authorization is in effect.

(3) **Validity of an IAR authorization:** In order for the IAR authorization to remain in effect, an individual must have filed an application for SSI within 12 months of signing the authorization.

(4) **Determination of repayment amount:**

(a) The amount of repayment of GA benefits from SSI shall be determined by comparing the months and amounts of GA paid to the individual to the months and amounts of the SSI retroactive payment issued by the SSA. The amount available for reimbursement to the HCA shall be calculated from the first day the individual is eligible for SSI benefits and shall end with (and include) the month the retroactive SSI payment is made.

(b) For each month that GA and SSI were both paid, the HCA shall recoup the amount of the GA benefit, not to exceed the amount of SSI for that month.

(c) The HCA shall not recoup an SSI payment for any month in which a GA payment was not issued.

(d) Emergency advance SSI payments shall not be available for recoupment. Presumptive disability SSI payments shall not be available for recoupment.

(5) **Issuance of balance of SSI payment:** When the amount of the total SSI payment exceeds the total GA payment, the balance of the remaining SSI retroactive payment(s) shall be sent to the individual within 10 calendar days of the date the HCA received the SSI retroactive payment from SSA. The balance shall be paid in the form of an HCA warrant. The individual shall be informed in writing of the retroactive SSI payment amount, how the repayment amount was computed by the HCA, and the balance being sent to the individual.

(6) **Returned checks:** When the HCA is issued an amount greater than the amount of GA benefits paid to an individual, and the excess payment cannot be issued because the individual is deceased or cannot be located, the balance of the SSI retroactive payment shall be returned to SSA.

(7) **When the individual dies before eligibility is determined:** The HCA has the right to receive repayment for GA benefits paid to an individual who dies before a determination of SSI eligibility is made. In such a circumstance, SSA will make a determination of eligibility or ineligibility for payment. Any excess payment after recovery by HCA will be returned to SSA.

B. **Compliance with SSI status requirements:**

(1) Any individual who is potentially eligible for SSI on the basis of either age or disability must apply for and accept SSI if approved by the social security administration.

(2) GA benefits shall be terminated when a determination is made that an individual has failed or refused to follow through with the initial SSI application interview or failed or refused to file a timely request for reconsideration or appeal of an SSI denial.

(3) **Ongoing SSI:** An individual receiving SSI, or who would be receiving SSI except for recovery of an overpayment by the social security administration, is not eligible for GA.

C. **SSI application requirement for disabled individuals:**

(1) An individual who is approved for GA based on a set or variable term GA must file an application for SSI or OASDI within 60 days following approval. The GA recipient must follow through with the SSI application process and maintain an active SSI or OASDI application.

(2) An individual whose SSI or OASDI application has been denied or terminated must request and pursue their right to a hearing and appeal through the administrative law judge (ALJ) appeal level of the social security administration (SSA). If an individual has allowed their hearing rights to expire, the individual must file a new application with the SSA.

(3) An individual who has pursued their hearing rights through the SSA and who has not been approved shall not be required to pursue SSI or OASDI benefits any further.

(4) A GA recipient who has not applied for SSI by the end of the month in which the 60th day occurs shall be ineligible to continue receiving GA. In such a situation, a notice of adverse action must be issued. If

the individual files an application for OASDI, SSI or both by the end of the month in which the notice of adverse action expires, the individual's benefits will be reinstated.

(5) GA benefits shall be terminated when a determination is made that an individual has failed or refused to follow through with the initial SSI application interview or failed or refused to timely request for consideration or appeal of an SSI denial, unless the individual can demonstrate good cause.

D. Contingency requirements: To remain eligible for variable term disability assistance, an individual must accept treatment available outside the GA program, unless a determination is made that good cause exists for the individual's inability to comply. The HCA shall make a determination of whether a contingency requirement is warranted and must be met to maintain eligibility for GA.

(1) The GA recipient shall be informed of any ongoing conditions or contingency requirements that must be met in order to ensure ongoing eligibility.

(2) If appropriate, the individual shall be referred to the division of vocational rehabilitation (DVR). A recipient must accept vocational rehabilitation services if offered by DVR.

(3) The HCA shall not impose a time limit or deadline for a contingency requirement to be met that cannot realistically be met in the community in which the GA recipient resides.

(4) Failure to comply: Failure to comply with out good cause shall result in termination of GA benefits and ineligibility until contingency requirements have been met or good cause can be established.

(5) If a recipient of GA fails or refuses a referral, treatment or rehabilitation services, the case shall be reviewed by the HCA to determine if the refusal was for good cause. A determination that the failure or refusal to accept corrective treatment was for good cause will not result in termination of benefits. A determination that the failure or refusal was not for a good cause reason shall result in termination of GA benefits.

E. Good cause: Good cause is determined on an individual basis. There may be situations in which good cause exists for a GA recipient's inability to comply with a contingency requirement, including but not limited to:

(1) the treatment is not available without cost or minimal cost to the recipient;

(2) the treatment is totally unavailable or not available at the frequency required due to lack of providers in the project area in which the recipient resides;

(3) the failure of ISD to provide written notice or sufficient information to the recipient about the contingency requirement;

(4) the recipient's inability to participate because of documented barriers, such as lack of transportation, an inability to leave work, illness, or death in the immediate family;

(5) the contingency requirement was made in error;

(6) a good cause reason approved by the HCA;

(7) treatment that involves more than reasonable risk to correct the impairment;

(8) treatment that conflicts with the individual's sincere religious beliefs;

(9) fear of additional treatment that could interfere with or reduce the benefits of current treatment interventions; or

(10) treatment that may cause further limitations or loss of a function or organ and the recipient is not willing to take the risk.

[8.106.410.13 NMAC - N, 12/01/2009]

8.106.410.14 PROGRAM DISQUALIFICATIONS:

A. Dual state benefits: An individual who has been convicted of fraud for receiving TANF, SNAP, Medicaid or SSI in more than one state at the same time shall not be eligible for inclusion in the GA cash assistance benefit group for a period of 10 years following such conviction. The conviction must have occurred on or after August 22, 1996.

B. Fugitive and probation and parole violators: An individual who is a fugitive felon or who has been determined to be in violation of conditions of probation or parole shall not be eligible for inclusion in the GA cash assistance benefit group.

C. Certain convicted felons. An individual who is or has been determined to be convicted on or before February 7, 2014, as an adult of the following crimes shall not be eligible for inclusion in the cash assistance benefit group:

(1) aggravated sexual abuse under section 2241 of title 18, United States Code;

(2) murder under section 1111 of title 18, United States Code;

(3) an offense under chapter 110 of title 18, United States Code;

(4) a federal or state offense involving sexual assault, as defined in section 40002(a) of the

Violence Against Women Act of 1994 (42 U.S.C. 13925(a)); or

(5) an offense under state law determined by the attorney general to be substantially similar to an offense described in clause (i), (ii), or (iii); and

(6) the individual is not in compliance with the terms of the sentence of the individual or the restrictions under 8.139.400.12 C NMAC.

[8.106.410.14 NMAC - Rp, 8.106.410.13 NMAC, 12/01/2009; A, 04/01/2022]

HISTORY OF 8.106.410 NMAC:

History of Repealed Material:

8.106.410 NMAC, Recipient Policies - General Recipient Requirements, filed 06/17/2004 - Repealed 12/01/2009.

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 420 RECIPIENT POLICIES - REQUIREMENTS FOR DETERMINING DISABILITY

8.106.420.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.420.1 NMAC - Rp, 8.106.420.1 NMAC, 12/01/2009; A, 7/1/2024]

8.106.420.2 SCOPE: The rule applies to the general public.
[8.106.420.2 NMAC - Rp, 8.106.420.2 NMAC, 12/01/2009]

8.106.420.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.420.3 NMAC - Rp, 8.106.420.3 NMAC, 12/01/2009; A, 7/1/2024]

8.106.420.4 DURATION: Permanent.
[8.106.420.4 NMAC - Rp, 8.106.420.4 NMAC, 12/01/2009]

8.106.420.5 EFFECTIVE DATE: December 1, 2009, unless a later date is cited at the end of a section.
[8.106.420.5 NMAC - Rp, 8.106.420.5 NMAC, 12/01/2009]

8.106.420.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.420.6 NMAC - Rp, 8.106.420.6 NMAC, 12/01/2009]

8.106.420.7 DEFINITIONS: [**RESERVED**]

8.106.420.8 DISABILITY DETERMINATION PROCESS

A. Disability determination: The HCA must find:

(1) medical evidence of physical or mental impairment(s), and

(2) medical and non-medical evidence to support that the severity of the impairment(s) is sufficient to significantly restrict the applicant's capacity to perform basic work-related activities or prevent engagement in gainful employment; or

(3) that, absent the above findings, an unsubstantiated statement of impairment or inability to work shall not be adequate to establish disability.

B. Case development process:

(1) all eligibility factors must be met prior to determining disability;

(2) complete a medical/social summary describing the applicant's health history; appearance, work and personal situation;

(3) assist, if appropriate, the applicant with obtaining documentary evidence;

(4) schedule, if appropriate, appointments for the applicant; and

(5) determine the need for additional documents for evidence.

C. The HCA may use the following alternative methodology to determine disability for set and variable term general assistance.

(1) Documentation requirements:

(a) The medical information must be documented on the HCA's standardized and approved medical release/physician's statement or may be documented on a physician's statement that includes all the information required to make a disability determination.

(b) The medical information used to substantiate impairment and finding of disability must include, but shall not be limited to:

(i) a record or narrative report resulting from examinations or diagnostic procedures;

(ii) a statement of the impairment;

(iii) a projected time period of the length of the disability; and

(iv) certification that the impairment precludes employment within the individual's capacity.

(2) **Duration of an impairment:** The duration of the impairment shall be evaluated by the HCA based on medical documentation.

(a) An impairment substantiated by medical documentation that precludes the individual's capacity to engage in gainful employment that is expected to last at least 30 days from the date of disability and for less than eight months shall be eligible for a set term certification.

(b) An impairment substantiated by medical documentation that precludes the individual's capacity to engage in gainful employment that is expected to last at least 30 days from the date of disability and for an indefinite period exceeding six months shall be eligible for a period of no more than six months without substantiating medical evidence consistent with Subsection D of 8.106.420.8 NMAC below.

(3) The alternative methodology shall be used no more than once in any 12 month period.

D. **Development of evidence:** The applicant is responsible to obtain and provide evidence of the nature and severity of the impairment(s) as well as the capacity to work. Non-medical evidence will not be considered in the absence of medical evidence.

(1) **Medical evidence:** Medical evidence must be submitted and considered to verify the existence of physical, mental impairment(s) or both.

(a) **Source:** Medical evidence must be obtained from approved source(s), limited to: medical doctors, physician assistants, doctors of osteopathy or podiatry, ophthalmologists, psychiatrists or psychologists, state-licensed providers, and individuals that meet the minimum mental health professional qualifications set by their community mental health services employer.

(b) **Timeliness of report:** Medical evidence over six months old from the date of application may be useful to support a pattern of recurring impairment but should be accompanied by current medical evidence.

(c) **Health care authority assistance:**

(i) **Requests for reports:** When necessary the HCA shall assist in obtaining medical evidence by making no more than two written requests per medical provider, for copies of relevant existing medical reports.

(ii) **Examinations:** The HCA shall schedule and, based on available funding, pay for a medical examination or other appropriate procedure(s) for purposes of obtaining current medical evidence. The applicant shall first be referred to the individual's own physician or provider.

(2) **Non-medical evidence:** Non-medical evidence may be submitted and considered from public and private agencies, schools, parents and caregivers, social workers and employers, and other sources to assist in the determination of whether the impairment(s) are of sufficient severity to restrict the applicant's capacity to perform basic work-related activities or prevent engagement in gainful employment.

E. **Case disposition:** Once an impairment is established, all the medical and non-medical evidence is considered in assessing impairment severity to determine disability. Case disposition shall include:

(1) a thorough review of documentary evidence;

(2) a determination as to whether disability is supported;

(3) the anticipated duration of the impairment;

(4) specific contingency requirements; and

(5) the certification review period for disability review.

F. **Certification period:** The certification period is primarily based on the prognosis and anticipated duration of the impairment(s), as established by medical evidence.

(1) **Set term:** A set term is assigned where medical evidence supports that a significant improvement in the impairment(s) is anticipated or probable in the six months following application. A set term certification shall not exceed eight months in total duration. A new application may be submitted for consideration of a new term.

(2) **Variable term:** A variable term is assigned where medical evidence supports that a significant change in the impairment(s) is not anticipated or probable in the six months following application.

G. Contingencies: Eligibility for benefits may be made contingent upon satisfactory completion of written condition(s) that may include, but are not limited to:

(1) follow treatment plans as prescribed by a physician or mental health provider;

(2) seek and utilize available community based resources;

(3) accept treatment as recommended by a physician or mental health provider;

(4) pursue a referral for DVR, or other available, services.

[8.106.420.8 NMAC - N, 12/01/2009]

8.106.420.9 VERIFYING IMPAIRMENT(S)

A. General: The nature of the physical and mental impairment(s) must be verified by a medical or mental health diagnosis from an acceptable medical source and supported by current medical evidence based on acceptable clinical and laboratory diagnostic techniques.

B. Evaluation of report(s): Reports shall be reviewed for completeness and detail sufficient to identify the limiting effects of impairment(s), probable duration of the impairment(s), and capacity to perform work-related activities.

(1) Anatomical and physiological reports shall be reviewed for a description of the medical history, clinical findings, laboratory findings, diagnosis, prescribed treatment and prognosis, and to identify the applicant's ability to sit, stand, move, lift, carry, handle objects, hear, speak and travel.

(2) Psychological assessments shall be reviewed for a description of the applicant's behavior, affect, orientation, capacity for appropriate decision-making, response to stress, cognitive function (awareness, memory and intellectual capacity), contact with reality and need for occupational, personal and social adjustment(s).

[8.106.420.9 NMAC - N, 12/01/2009]

8.106.420.10 ASSESS CAPACITY FOR WORK

A. General: The applicant's capacity for work shall be determined by evaluating the severity of the impairment(s) and by applicant's work-related factors with regarding to the impact on the applicant's ability to perform basic work-related activities and to engage in gainful employment.

B. Capacity to perform basic work-related activities

(1) Sedentary work: Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers and small tools. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally, and sedentary standards are met.

(2) Light work: Light work involves lifting no more than 20 pounds at a time, with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is placed in this category if it requires a good deal of walking or standing, or if it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities

(3) Medium work: Medium work involves lifting no more than 50 pounds at a time, with frequent lifting or carrying of objects weighing up to 25 pounds.

(4) Heavy work: Heavy work involves lifting no more than 100 pounds at a time, with frequent lifting or carrying of objects weighing up to 50 pounds.

(5) Very heavy work: Very heavy work involves lifting objects weighing more than 100 pounds at a time, with frequent lifting or carrying of objects weighing 50 pounds or more.

C. Capacity for gainful employment: An applicant's verified employment status shall be taken into consideration in determining disability based on the type, nature, and duration of employment. Disability may still be determined where the applicant is employed minimally or for rehabilitative purposes.

(1) Minimal employment: An individual who is minimally employed may still be considered disabled if the individual cannot reasonably be expected to be self-supporting by at least the standard of need for the size of the benefit group.

(2) Rehabilitative employment: Work made available to an individual through the interest or compassion of others, or to rehabilitate an individual (as in a sheltered workshop), but which would not ordinarily exist on the open labor market, shall not be considered employment in a disability determination.

D. Other work-related factors: Other work-related factors may be considered to establish the applicant's capacity to perform basic work-related activities and engage in gainful employment, including but not limited to the following.

(1) Language barriers: An applicant's ability to speak, read and write in English.

(2) Educational level:

(a) Illiteracy: Inability to read or write English. Illiterate individuals are considered suitable for the general labor work force.

(b) Marginal: Eight years of education or less. Marginally educated individuals are considered suitable for the semi-skilled work force.

(c) Limited: Lack of a high school diploma or GED, but more than eight years of education. Individuals with limited education are considered suitable for the semi-skilled to skilled work force.

(d) High school, GED and above: Indicates an individual's ability to compete in all levels of the job market.

(e) Training program: Completion of training in a particular field of employment may offset limited education in some instances.

(3) Job experience: Experience in a job field can overcome a lack of education, training or both. Jobs held in the last ten years shall be considered. Work experience shall be evaluated based on the type of work previously performed, the length of employment and the potential for transferring the experience to other types of employment. Inability to continue working in one's prior field of work does not constitute a disability. Job experience is classified in the following categories.

(a) General labor: Does not require the ability to read or write.

(b) Semi-skilled labor: Requires a minimal ability to read, write and do simple calculations.

(c) Skilled labor: Ability to do work in which the ability to read, write and do calculations of a complex nature is needed. Specialized training in the area is also considered.

(4) Appearance: An individual's appearance may not be heavily weighted in a disability determination. On rare occasions, an impairment is disfiguring and may interfere with employment.

(5) Age: The older an individual is, the less potential there is for overcoming an impairment. Recovery is more difficult and, often, total recovery may not be achieved. There may be very little chance that the individual will ever return to functioning effectively in their previous job duties.

[8.106.420.10 NMAC - Rp, 8.106.420.13 NMAC, 12/01/2009]

HISTORY OF 8.106.420 NMAC:

History of Repealed Material:

8.106.420 NMAC, Recipient Policies - Requirements for Determining Disability, filed 06/17/2004 - Repealed 12/01/2009]

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 430 RECIPIENT POLICIES - REQUIREMENTS FOR DEPENDENT CHILDREN

8.106.430.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.430.1 NMAC - N, 07/01/2004 A, 7/1/2024]

8.106.430.2 SCOPE: The rule applies to the general public.
[8.106.430.2 NMAC - N, 07/01/2004]

8.106.430.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.430.3 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.430.4 DURATION: Permanent.
[8.106.430.4 NMAC - N, 07/01/2004]

8.106.430.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.430.5 NMAC - N, 07/01/2004]

8.106.430.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.

[8.106.430.6 NMAC - N, 07/01/2004]

8.106.430.7 DEFINITIONS: [**RESERVED**]
[8.106.430.7 NMAC - N, 07/01/2004]

8.106.430.8 AGE - DEPENDENT CHILDREN: To be eligible for inclusion in the GA dependent child benefit group with respect to age, a dependent child is defined as an individual who is;

A. seventeen years of age or younger;

B. eighteen years of age and enrolled in high school; or

C. between 18 and 22 years of age and receiving special education services regulated by the public education department (PED).

[8.106.430.8 NMAC - N, 07/01/2004]

8.106.430.9 SCHOOL ATTENDANCE:

A. Requirement: A child of school age, as defined by PED, must attend school and have satisfactory attendance to meet the personal responsibility requirements of the parent, specified relative, or caretaker.

B. Student status:

(1) A dependent child of school age must be a full-time student at a certified educational facility or participating and fully complying with a home-schooling program approved by the New Mexico PED. School age means any dependent child who turns six years of age prior to September first and is under 18 years of age.

(2) A participant who is 18 years of age may be included in the NMW benefit group if the individual is enrolled in high school, or the high school equivalent level of vocational or technical training. Such an individual may be eligible to be included in the NMW benefit group until the end of the month in which the individual graduates or until the end of the month in which the individual turns 19 years of age, whichever occurs

first.

(3) A student who is between 18 and 21 years of age may be included in the NMW benefit group as long as the student is enrolled in high school and is receiving special education services regulated by the PED. There must be a current valid individual education plan (IEP) for the student to verify the special education services.

(4) A dependent child age 17 years of age or younger who has graduated from high school or has obtained a GED shall be deemed to be a full-time student and to fulfill attendance requirements.

(5) A minor unmarried parent who does not have a child under the age of 12 weeks, must attend school full time to obtain a high school diploma or must participate in a GED program full-time or participate in approved alternate schooling unless the minor unmarried parent has already graduated from high school or obtained a GED.

C. School attendance:

(1) Full time attendance: A child is considered a full-time student based on the below criteria:

(a) School attendance is defined by the standards of the educational facility or program in which the child is enrolled including regularly scheduled vacations and breaks provided the child:

(i) has not been removed for non attendance; and

(ii) resumes attendance when classes start again;

(b) is currently enrolled in a home schooling programming approved by the New Mexico PED.

(2) Verification:

(a) Verification of school attendance must be provided at time application and certification for any:

(i) minor unmarried parent; and

(ii) dependent child 18 years of age and over.

(b) The statement of the parent or caretaker is acceptable verification of school attendance for all other dependent children, unless otherwise questionable.

D. Unsatisfactory attendance:

(1) A child shall be considered not meeting the school attendance requirement when the child:

(a) is not enrolled in school;

(b) has accumulated three unexcused absences in a grading period, but not on the same day;

(c) has dropped out of school during the current grading period; or

(d) has one or more unexcused absences during the time period covered by a current school attendance plan.

(2) Reporting requirement: Within 14 days of the date it becomes known, the parent, specified relative, or caretaker must report to ISD if a child is not enrolled in school, has accumulated three unexcused absences during the current grading period, or has dropped out of school. Failure to report that a child has not met school attendance requirements shall not result in a non-reporting sanction for the parent, or the specified relative or caretaker if included in the benefit group.

(3) Failure to meet: In the absence of good cause for failure to meet the school attendance requirements the conciliation process shall be initiated.

(a) Conciliation process: Prior to removing the child's needs from the benefit group's standard of need, the parent, specified relative or caretaker shall have a 10 working day conciliation period to address school non-attendance. The conciliation period is a 10 working day period affording an opportunity for the parent, child, and the school to develop a plan to ensure regular attendance by the child and comply with NMW requirements.

(i) Within 10 days of receipt of verification that a child has not met school attendance requirements, the caseworker shall take action to initiate a conciliation period by issuing a notice of action.

(ii) The benefit group shall have 10 working days from the date of issuance of the notice to provide a school attendance plan indicating the school's confirmation of satisfactory arrangements.

(iii) If a benefit group fails to provide a school attendance plan, a notice of adverse action shall be sent within five working days.

(iv) If the school confirms that satisfactory arrangements have been made to

ensure regular attendance by the child, the child shall remain eligible.

(b) **Benefit reduction:**

(i) The child shall be removed from the benefit group effective the month following the month the notice of adverse action expires.

(ii) If there is one or more unexcused absence following successful submission of a school attendance plan (the school's confirmation of satisfactory arrangements), the caseworker shall remove the child from the benefit group effective the month following the month the notice of adverse action expires.

(c) **Case closure:** If the child is the only child included in the benefit group, the cash assistance case shall be subject to closure in the month following the notice of adverse action.

(4) **Good cause:** A child with unsatisfactory school attendance or enrollment shall be warranted good cause based on the following circumstances:

(a) periods of personal illness or convalescence;

(b) family emergencies, for a period not to exceed 30 days;

(c) participation in or attendance at cultural and religious activities as long as the child has parental consent; or

(d) a minor parent has a child under 12 weeks of age.

E. **Regaining eligibility:** Once a child has been removed from the benefit group due to failure to comply with school attendance requirements, the child cannot be considered a member of any benefit group. Changes in school attendance must be reported by the parent/caretaker. Eligibility may be regained when:

(1) the child has attended school with no unexcused absences for the 30 days;

(2) circumstances of good cause apply as listed in Paragraph (4) of Subsection D; or

(3) during the summer months if the child is promoted, attending summer school or graduating.

[8.106.430.9 NMAC - N, 07/01/2004; A, 02/27/2009]

8.106.430.10 CHILD SUPPORT ENFORCEMENT

A. **Assignment of support rights:** A caretaker who receives cash assistance for an unrelated dependent child, whether or not the caretaker is included in the benefit group, automatically assigns to HSD the right to child support for any individual included in the benefit group. The assignment shall be:

(1) effective with respect to any dependent child included in the benefit group;

(2) valid as long as the caretaker receives GA payments on the child's behalf; and

(3) includes any child support amount for which the caretaker is or may become eligible on behalf of any dependent child included in the benefit group.

B. **Cooperation:**

(1) The caretaker who is responsible for each child included in the benefit group must cooperate with the child support services division (CSSD) in obtaining child support. The caretaker shall be required to cooperate regardless of whether the caretaker is included in the benefit group.

(2) Failure to cooperate with a child support enforcement requirement will result in payment reduction through the sanction process.

(3) Failure to cooperate shall result in the personal ineligibility of the caretaker if the caretaker is included in the GA benefit group, and in a payment sanction against the benefit group, as described in 8.106.620.10 NMAC.

(4) The caretaker must turn over to CSSD any child support payment which the caretaker receives directly from a noncustodial parent of the unrelated dependent child.

C. **Determining that cooperation exists:**

(1) A caretaker who signs an application or other applicable child support-related forms, on behalf of an unrelated dependent child indicates an understanding of the requirement to assign support rights to the HCA.

(2) The caretaker shall be considered to have met the cooperation requirement until such time as CSSD reports to the caseworker that the caretaker has failed to cooperate.

(3) The determination whether the caretaker has cooperated with CSSD shall be made by CSSD based on CSSD requirements.

(4) The cooperation requirement may be partially or fully waived by CSSD upon demonstration of good cause by the caretaker.

D. **Action upon receiving notice of noncompliance:** Within 10 days after notification by CSSD of

the failure of a caretaker to cooperate, the caseworker shall take action that is appropriate to the status of the case, including:

(1) issuing a conciliation notice that allows a period of time for the caretaker to cooperate and avoid payment reduction; or

(2) removing the needs of the dependent child from the cash assistance payment; and

(3) imposing a noncompliance sanction, in cases where the caretaker is included in the benefit group;

(4) in a cases where the dependent child is the only benefit group member, GA benefits shall be terminated upon a determination that the caretaker has failed to cooperate with the assignment of rights to child support.

E. Good cause:

(1) In some situations, it is not in the best interests of the child or caretaker to pursue support or to require that the caretaker cooperate with CSSD in pursuing such support. A caretaker shall be:

(a) notified that the requirement to cooperate may be waived,

(b) informed of the requirements involved in the waiver, and

(c) given an opportunity to request a waiver that would exempt the caretaker from the cooperation requirement.

(2) If a caretaker requests a waiver of the cooperation requirement, assistance shall not be delayed pending determination of good cause, nor may enforcement of support begin or continue while the waiver of the requirement is under consideration.

(3) **Granting a good cause exemption:** The decision whether to grant a good cause exemption shall be made according to the following:

(a) **ISD-domestic violence exemption:** ISD shall exempt a caretaker from CSSD cooperation requirements where a trained counselor, such as a domestic violence counselor or social worker, has certified that cooperation would make it more difficult to escape a domestic violence situation involving a parent of the dependent child, or would unfairly penalize the caretaker or child in light of current circumstances.

(b) **CSSD-other good cause exemptions:** All other good cause exemptions from cooperation with CSSD requirements shall be made by the director of the CSSD or designee.

(4) **Notification:** The caseworker shall send a caretaker a written notice when a waiver has been granted due to domestic violence.

(a) The caretaker shall be informed whether CSSD has determined that support can be pursued without danger or risk to the caretaker or child. If pursuit is planned, the caretaker shall be notified that they must cooperate to the extent of providing necessary information and documents and that, if the caretaker does not comply to the extent possible, a noncompliance sanction will be imposed or benefits will be terminated.

(b) A caretaker shall be notified of the right to a fair hearing, and that the caretaker may ask for such a hearing within 90 days of the date on the written notice.

(c) If CSSD determines that good cause does not exist, the caseworker shall notify the caretaker within 10 working days that:

(i) the request has been denied;

(ii) the caretaker is expected to cooperate fully in pursuing support; and

(iii) the caretaker may request an administrative hearing, but that the caretaker is expected to begin cooperating within 10 days after the date of the notice.

[8.106.430.10 NMAC - N, 07/01/2004]

History of 8.106.430 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE
PART 431 PRE CERTIFIED VICTIMS OF HUMAN TRAFFICKING

8.106.431.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.431.1 NMAC - N, 12/01/2013; A, 7/1/2024]

8.106.431.2 SCOPE: The rule applies to the general public.
[8.106.431.2 NMAC - N, 12/01/2013]

8.106.431.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978, along with Subsection 52 of Section 30 NMSA, authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare function as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.431.3 NMAC - N, 12/01/2013; A, 7/1/2024]

8.106.431.4 DURATION: Permanent.
[8.106.431.4 NMAC - N, 12/01/2013]

8.106.431.5 EFFECTIVE DATE: December 1, 2013, unless a later date is cited at the end of a section.
[8.106.431.5 NMAC - N, 12/01/2013]

8.106.431.6 OBJECTIVE: The objective of the pre-certified victim of human trafficking assistance program is to provide financial assistance to non-citizen victims of human trafficking that are not eligible for existing federal assistance pending the federal certification under the Trafficking Victims' Protection Reauthorization Act of 2003.
[8.106.431.6 NMAC - N, 12/01/2013]

8.106.431.7 DEFINITIONS:

A. Pre-certified victim of human trafficking (PCVHT): means a non-citizen who is a victim of human trafficking, who has not received the federal certification of a victim of human trafficking.

B. Cooperating: means is willing to assist in every reasonable way in the investigation and prosecution of the person charged with the crime of human trafficking, unless the identified victim is unable to cooperate with such a request due to physical or psychological trauma.

C. Institutionalized: means to be in the care of an institution, including but not limited to:

(1) a medical or mental health treatment facility; or

(2) a public non-medical institution, including facilities in the state prison system, jails and detention centers, as well as juvenile correction facilities.

[8.106.431.7 NMAC - N, 12/01/2013]

8.106.431.8 CONSTRUCTING THE BENEFIT GROUP:

A. To be eligible for inclusion in the PCVHT benefit group, the individual must not be eligible for any other federal or state cash assistance program. The benefit group consists of the individual and their non-citizen dependents.

B. An individual shall not be eligible for inclusion in the benefit group if the individual is institutionalized.

[8.106.431.8 NMAC - N, 12/01/2013]

8.106.431.9 APPLICATION SUBMITTAL:

A. The application shall be submitted on a form designated by the HCA either electronically or in writing and shall be made under oath by an applicant or by an applicant on behalf of a dependent child who resides in the home. The application must contain:

(1) a statement of the age of the applicant or dependent child;

(2) a statement of residence in New Mexico;

(3) all property in which the applicant has an interest;

(4) the income of the applicant or other benefit group members at the time the application is filed;

(5) the signature of the applicant; and

(6) other information required by the HCA.

B. Applications submitted for the pre-certified victims of human trafficking cash assistance will be referred to the service provider.

[8.106.431.9 NMAC - N, 12/01/2013]

8.106.431.10 APPLICATION PROCESSING TIME LIMITS: Pre certified victims of human trafficking cash assistance program applications shall be processed no later than 30-calendar days after receipt by the HCA or it's designee.

[8.106.431.10 NMAC - N, 12/01/2013]

8.106.431.11 APPROVAL EFFECTIVE DATE: Pre certified victims of human trafficking cash assistance for approved applications shall be effective the first day of the month the application was submitted to the HCA or its designee, for a full month benefit.

[8.106.431.11 NMAC - N, 12/01/2013]

8.106.431.12 REPORTING REQUIREMENTS:

A. HCA responsibilities: The HCA or its designee shall inform the benefit group of its responsibility to report changes. Appropriate action shall be taken to determine if the change affects eligibility or benefit amount. The date the change is reported and the action taken shall be documented. In some circumstances the HCA shall request clarification during a certification period whenever information becomes known to the HCA indicating a possible change in a benefit group's circumstances that may affect eligibility or benefit amount. Circumstances that may require follow-up review include, but are not limited to:

(1) cooperation with law enforcement or prosecution of the person charged with the crime of human trafficking; and

(2) verification and status of application for federal certification of victim of human trafficking.

B. Benefit group responsibilities at application: A benefit group must report all changes affecting eligibility and benefit amount that may have occurred since the date the application was filed and before the date of the interview. Changes occurring after the interview, but before the date of the approval notice, must be reported by the benefit group within 10 days of the date the change becomes known to the benefit group.

C. Responsibility to report: Within 10 days of the date the change becomes known to the benefit group, a recipient of the pre-certified victims of human trafficking cash assistance is required to report the following changes:

(1) a benefit group's income in excess of eighty-five percent of federal poverty guidelines for the size of the benefit group;

(2) a benefit group, or the HCA receives evidence that the eligible recipient has received the federal certification of a victim of human trafficking by the federal office of refugee resettlement;

(3) the victim of human trafficking is no longer cooperating with law enforcement or the prosecution of the person charged with the crime of human trafficking;

(4) the benefit group has moved from the state or intends to move from the state on a specific date;

(5) a benefit group requests closure; or

(6) the HCA receives documented evidence that the head of benefit group has died.

D. Effective date of change: Changes to eligibility based on reported changes shall be effective pursuant to 8.106.630.9 NMAC.

[8.106.431.12 NMAC - N, 12/01/2013]

8.106.431.13 CERTIFICATION PERIODS: The certification period will be one year with simplified reporting requirements.

[8.106.431.13 NMAC - N, 12/01/2013; A, 09/01/2017]

8.106.431.14 ELIGIBLITY RECERTIFICATION:

A. Recertification of eligibility: The HCA shall provide notice of recertification 45 days prior to the

end of the certification and make a prospective determination of eligibility beginning the month following the month the certification period expires. The recertification shall consist of a determination of eligibility for an additional period of time, redetermination of the amount of cash assistance payment and a complete review of all conditions of eligibility. Current financial eligibility must be reviewed at the end of the certification period for the specific program to determine continued eligibility for a new period of time.

B. Interview: A face-to-face interview shall take place at the end of the certification period, unless the recipient's physical or mental condition makes the interview impossible or inadvisable. The interview may be waived on a case-by-case basis for hardship reasons found in 8.106.110.11 NMAC. During the interview the HCA shall review with the recipient the possible changes in circumstances that must be reported and may affect the client's eligibility or benefit amount.

C. Recertification timeliness:

(1) Timely recertification: Recertification forms submitted before the 15th of the expiration month will be considered timely.

(2) Untimely reapplication: Recertification forms submitted after the 15th but before the end of a benefit group's certification period expires have lost the right to uninterrupted benefits.

D. Verification: A benefit group that has recertified timely, completed an interview and provided required verification specific to eligibility, will be given 10 days to provide the verification or until the certification period expires, whichever is longer. If the certification period expires before the 10-day deadline for submitting the required verification, the benefit group will be entitled to a full month's benefits, if eligible, within five days after verification is submitted.

E. Agency failure to act: A benefit group that has made a timely recertification, but due to agency error, is not determined eligible in sufficient time to provide for issuance by the benefit group's normal issuance date in the following month, will be entitled to restoration of lost benefits.

[8.106.431.14 NMAC - N, 12/01/2013]

8.106.431.15 RESOURCE STANDARDS: Refer to 8.106.510 NMAC

[8.106.431.15 NMAC - N, 12/01/2013]

8.106.431.16 INCOME: Refer to 8.106.520 NMAC

[8.106.431.16 NMAC - N, 12/01/2013]

HISTORY OF 8.106.431 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 500 ELIGIBILITY POLICY - GENERAL INFORMATION

8.106.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.500.1 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.500.2 SCOPE: The rule applies to the general public.
[8.106.500.2 NMAC - N, 07/01/2004]

8.106.500.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.500.3 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.500.4 DURATION: Permanent.
[8.106.500.4 NMAC - N, 07/01/2004]

8.106.500.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.500.5 NMAC - N, 07/01/2004]

8.106.500.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI). The general assistance program is not intended to be an unemployment or general relief program.

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.
[8.106.500.6 NMAC - N, 07/01/2004]

8.106.500.7 DEFINITIONS: [RESERVED]
[8.106.500.7 NMAC - N, 07/01/2004]

8.106.500.8 GA - GENERAL REQUIREMENTS:

A. Limited state funds may result in a suspension or reduction in general assistance benefits without eligibility and need considered.

B. **Need determination process:** Eligibility for the GA program based on need requires a finding that the:

(1) countable resources owned by and available to the benefit group do not exceed either the $1,500 liquid or $2,000 non-liquid resource limit;

(2) benefit group's countable gross earned and unearned income does not equal or exceed eighty-five percent of the federal poverty guideline for the size of the benefit group; and

(3) benefit group’s countable net income does not equal or exceed the standard of need for the size of the benefit group.

C. **GA payment determination:** The benefit group’s cash assistance payment is determined after subtracting from the standard of need the benefit group's countable income and any payment sanctions or recoupments.

D. **Gross income test:** The total countable gross earned and unearned income of the benefit group cannot exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

(1) Income eligibility limits are revised and adjusted each year in October.

(2) The gross income limit for the size of the benefit group is as follows:

(a) one person $1,033

(b) two persons $1,397
(c) three persons $1,761
(d) four persons $2,125
(e) five persons $2,490
(f) six persons $2,853
(g) seven persons $3,217
(h) eight persons $3,582
(i) add $365 for each additional person.

E. Standard of need:

(1) As published monthly by the HCA, the standard of need is an amount provided to each GA cash assistance benefit group on a monthly basis and is based on availability of state funds, the number of individuals included in the benefit group, number of cases, number of applications processed and approved, application approval rate, number of case closures, IAR caseload number and expenditures, and number of pending applications.

(2) Basic needs include food, clothing, shelter, utilities, personal requirements and an individual benefit group member's share of supplies.

(3) **Notice:** The HCA shall issue prior public notice identifying any change(s) to the standard of need amounts for the next quarter, as discussed at 8.106.630.11 NMAC.

F. Net income test: The total countable earned and unearned income of the benefit group after all allowable deductions cannot equal or exceed the standard of need for the size of the GA benefit group. After the countable net income is determined it is rounded down prior to the comparison of the household's income to the standard of need to determine the households monthly benefit amount.

G. Special clothing allowance for school-age dependent children: A special clothing allowance may be issued to assist in preparing a child for school, subject to the availability of state or federal funds and a specific allocation of the available funds for this allowance.

(1) For purposes of determining eligibility for the clothing allowance, a child is considered to be of school age as defined by PED.

(2) The clothing allowance shall be allowed for each school-age child who is included in the GA cash assistance benefit group, subject to the availability of state or federal funds.

(3) The clothing allowance is not counted in determining eligibility for GA cash assistance.

H. Supplemental issuance: A one-time supplemental issuance may be distributed to recipients of GA for disabled adults based on the sole discretion of the secretary of the HCA and the availability of state funds.

(1) The one time supplemental issuance may be no more than the standard GA payment made during the month the GA payment was issued.

(2) To be eligible to receive the one time supplement, a GA application must be active and determined eligible no later than the last day of the month in the month the one time supplement is issued.

I. Minimum Benefit Amount: Benefits less than $10 will not be issued for the initial month or subsequent months. ISD shall certify household beginning the month of application.

[8.106.500.8 NMAC - N, 07/01/2004; A/E, 10/01/2004; A/E, 10/01/2005; A, 7/17/2006; A/E, 10/01/2006; A/E, 10/01/2007; A, 01/01/2008; A, 06/16/2008; A/E, 10/01/2008; A, 07/01/2009; A/E, 10/01/2009; A, 10/30/2009; A, 12/01/2009; A, 01/01/2011; A, 07/29/2011; A/E, 10/01/2011; A/E, 10/01/2012; A, 07/01/2013; A/E, 10/01/2013; A/E, 10/01/2014; A, 10/01/2015; A, 10/01/2016; A/E, 10/01/2017; A, 2/01/2018; A/E, 10/01/2018; A, 3/1/2019; A/E, 10/01/2019; A, 3/1/2020 A/E, 10/01/2020; A, 3/1/2021; A/E, 10/01/2021; A, 04/01/2022; A/E, 10/01/2022; A, 04/01/2023, A/E 10/1/2023; A, 03/1/2024]

8.106.500.9 PROSPECTIVE BUDGETING:

A. Initial eligibility: Eligibility for cash assistance programs shall be determined prospectively. The benefit group must meet all eligibility criteria in the month following the month of application. Eligibility and amount of payment shall be determined prospectively for each month in the certification period.

B. Changes in benefit group composition: A person added to the benefit group shall have eligibility determined prospectively, beginning in the month following the month the report is made.

C. Anticipating income: In determining the benefit group's eligibility and benefit amount, the income already received and any income the benefit group expects to receive during the certification period shall be counted.

(1) Income anticipated during the certification period shall be counted only in the month it is expected to be received, unless the income is averaged.

(2) Actual income shall be calculated by using the income already received and any other income that can reasonably be anticipated in the calendar month.

(3) If the amount of income or date of receipt is uncertain, the portion of the income that is uncertain shall not be counted.

(4) In cases where the receipt of income is reasonably certain but the amount may fluctuate, the income shall be averaged.

(5) Averaging is used to determine a monthly calculation, when there is fluctuating income within the weekly, biweekly or monthly pay period and to achieve a uniform amount for projecting future income.

D. Counting income in the certification period:

(1) For the purposes of cash assistance eligibility and determination of benefit amount, income is money received by or available to the benefit group in each month of the certification period.

(2) Only income which is actually received, or can reasonably be expected to be received, is counted for financial eligibility and benefit calculation.

(3) The benefit group must take appropriate steps to apply for and receive income from any other source to which the group may potentially be entitled.

(4) A benefit group may be found ineligible for failing or refusing to apply for or pursue potential income or assets from other sources.

(5) A benefit group member who is 62 years of age or older must apply for and take all necessary steps to receive a reduced OASDI benefit from the SSA.

E. Income availability:

(1) The availability of income to the benefit group is determined by who must be included in the benefit group and whether income must be deemed available to the benefit group.

(2) The earned and unearned income of an individual who is not a mandatory benefit group member shall not be considered available to the benefit group.

(3) Income belongs to the person who gains it, either through the person's own efforts, as in the case of earnings, or as a benefit, as in the case of a beneficiary of SSA benefits.

(4) Unearned income, such as child support or social security survivor's benefits and other similar payments for a child, are considered as belonging to the benefit group in which the child is included.

(5) Non-citizen sponsors: The gross income belonging to an individual who is the sponsor of a non-citizen included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and benefit amount if the sponsor has executed an affidavit of support pursuant to Subsection 213-A of the Immigration and Nationality Act. The income of the non-citizen sponsor and spouse shall be counted until the sponsored non-citizen achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

F. Unavailable income: In some situations, individuals who are included in the benefit group, either in applicant or recipient status, have a legal right to income but do not have access to it. Such income is not counted as available income for purposes of cash assistance eligibility and benefit calculation.

G. Ineligible non-citizen: The countable income belonging to an ineligible non-citizen who is a mandatory benefit group member is deemed available to the benefit group. The countable income shall be prorated according to the size of the benefit group to determine the eligibility and benefit amount for the benefit group.

H. Income received less frequently than monthly: The amount of gross income that is received less frequently than monthly is determined by dividing the total gross income by the number of months the income is intended to cover. This includes, but is not limited to, income from sharecropping, farming and self-employment. It also includes contract income as well as income of a tenured teacher who may not actually have a contract.

I. Contract income: A benefit group that derives its annual income in a period of less than one year shall have that income averaged over a 12-month period, provided that the income is not earned on an hourly or piecework basis.

J. Using exact income: Exact income, rather than averaged income, shall be used if:

(1) the benefit group has chosen not to average income;

(2) income is from a source terminated in the month of application;

(3) employment began in the application month and the income represents a partial month; or

(4) income is received more frequently than weekly.

K. Income projection for earned income:

(1) Income from the four-week period prior to the date of initial interview is used to project monthly income, provided that the income is expected to continue. If a determination is made that the prior income is not indicative of income anticipated to be received during the certification period, then income from a longer

period of past time may be used. If the longer period is not indicative of income anticipated to be received, then verification of anticipated income shall be obtained from the income source.

(2) The methods described above may not give the most accurate estimate of monthly earnings due to unique circumstances that may occur. In such cases, the caseworker shall use whichever method provides the most accurate estimate of earnings.

(3) An income projection shall be considered valid for the certification period unless changes are made that affect eligibility or benefit amount.

L. **Unearned income:** For purposes of anticipating future income, unearned income from the four-week period prior to the date of interview shall be used, provided that the income is expected to continue.

M. **Use of conversion factors:** Whenever a full month's income is anticipated and is received on a weekly or biweekly basis, the income shall be converted to monthly amount as follows:

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

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

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

[8.106.500.9 NMAC - N, 07/01/2004; A, 04/01/2010]

8.106.500.10 PAYMENTS TO ADULTS IN RESIDENTIAL CARE:

A. **Conditions:** Subject to the availability of state funding for the program, a payment may be made to an individual who resides in a shelter care home. The individual must be a recipient of supplemental security income (SSI) under title XVI of the Social Security Act.

B. **Licensing of the shelter care home:** The shelter care home must be licensed.

C. **Payment:** A cash payment may be made to an SSI recipient when the recipient resides in a licensed shelter care home because the recipient needs help with personal care, such as bathing, dressing, eating or taking prescribed medication.

(1) The payment shall be allowed only if the SSI recipient resides in a residential shelter care facility that is licensed.

(2) The payment made to an SSI recipient living in a licensed residential shelter care facility is $100 per month.

[8.106.500.10 NMAC - N, 07/01/2004]

8.106.500.11 [RESERVED]

[8.106.500.11 NMAC - N, 07/01/2004; A, 12/01/2009]

HISTORY OF 8.106.500 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 502 GENERAL INFORMATION - BURIAL ASSISTANCE

8.106.502.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.502.1 NMAC - N, 12/01/2009; A, 7/1/2024]

8.106.502.2 SCOPE: The rule applies to the general public.
[8.106.502.2 NMAC - N, 12/01/2009]

8.106.502.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.502.3 NMAC - N, 12/01/2009; A, 7/1/2024]

8.106.502.4 DURATION: Permanent.
[8.106.502.4 NMAC - N, 12/01/2009]

8.106.502.5 EFFECTIVE DATE: December 1, 2009, unless a later date is cited at the end of a section.
[8.106.502.5 NMAC - N, 12/01/2009]

8.106.502.6 OBJECTIVE:

A. The objective of general assistance is to provide cash assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched cash assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.502.6 NMAC - N, 12/01/2009]

8.106.502.7 DEFINITIONS: [**RESERVED**]

8.106.502.8 BURIAL ASSISTANCE - FUNERAL EXPENSES:

A. General: The HCA may provide up to $200 towards the funeral expenses recipients of financial and medical assistance if the deceased's available resources are insufficient to pay for the funeral, the persons legally responsible for the support of the deceased are unable to pay the funeral expenses, and no other person or organization, or state agency will undertake to pay for the expense. The spouse of the deceased with whom the deceased was living at the time of death and the parents of minor unmarried children are considered legally responsible relatives.

B. Applications and interviews: A request for payment of funeral expenses may come from the family, the mortuary, or other persons furnishing funeral services to any project area. In order to evaluate available resources it may be necessary to interview the family or requestor. Burial expenses for a deceased individual shall be processed no later than 30 calendar days after receipt.

C. Eligibility: Payment towards the burial expenses for a categorically eligible individual may be made when the resources considered available to meet the cost of the funeral are less than $600. Resources that shall be considered available include:

(1) cash available to the deceased at the time of death;

(2) any insurance benefits designated for use in meeting the individual's funeral costs;

(3) any other death or burial benefits from sources such as social security or railroad retirement benefits, veterans benefits, legally responsible relatives or the estate of the deceased;

(4) real property owned by the deceased, with no surviving heir, shall be considered a resource;

(5) gifts, contributions or written commitments to help pay the cost of the funeral, which are

made by any individual not having a legal support obligation for the deceased.

D. Constructing the benefit group: To be eligible for inclusion in the burial assistance benefit group, a deceased individual must have been a recipient of NMW, GA, refugee assistance, ARSCH or medicaid benefits from the state of New Mexico. The benefit group consists of the deceased individual.

E. Covered services: Funeral costs that are considered include necessary compulsory expenditures arising immediately upon and due to death, including:

(1) embalming;

(2) purchase of a coffin, burial shroud and burial plot;

(3) burial or cremation services, including the cost for opening and closing the grave;

(4) customary ceremonies, rites and services, excluding food, beverages or other similar consumables attendant on disposition of the remains; and

(5) transportation of the deceased from the mortuary to a nearby cemetery.

F. Payment: When resources are determined to be less than $600, a payment of up to $200 may be made towards the cost of the funeral. The amount of the payment is the difference between the cost of the funeral and available resources. The payment shall not exceed $200.

G. Payment procedures: Funeral payments are reimbursed by a payment voucher to the vendor providing the services.

[8.106.502.8 NMAC - Rp, 8.106.500.11 NMAC & 8.106.400.13 NMAC, 12/01/2009]

HISTORY OF 8.106.502 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 510 ELIGIBILITY POLICY - RESOURCES/PROPERTY

8.106.510.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.510.1 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.510.2 SCOPE: The rule applies to the general public.
[8.106.510.2 NMAC - N, 07/01/2004]

8.106.510.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.510.3 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.510.4 DURATION: Permanent.
[8.106.510.4 NMAC - N, 07/01/2004]

8.106.510.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.510.5 NMAC- N, 07/01/2004]

8.106.510.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.
[8.106.510.6 NMAC - N, 07/01/2004]

8.106.510.7 DEFINITIONS: [**RESERVED**]
[8.106.510.7 NMAC - N, 07/01/2004]

8.106.510.8 RESOURCE STANDARDS: To be eligible, the value of all countable personal and real property, belonging to or considered as belonging to or considered available to the benefit group, shall not exceed the liquid or non-liquid resource limits. Total resources that exceed the liquid or non-liquid resource limit result in benefit group ineligibility unless the nature of the property or an express condition of its ownership prohibits its transfer. Resources are evaluated based upon their equity value.

A. Liquid resources: The value of countable liquid resources shall not exceed $1,500.

B. Non-liquid resources: The value of countable non-liquid resources shall not exceed $2,000.
[8.106.510.8 NMAC - N, 07/01/2004]

8.106.510.9 COUNTABLE RESOURCES:

A. Non-liquid real property: means land and the structures (including mobile homes) and improvements affixed to it.

(1) The value of countable real property owned by or considered available to the benefit group, shall be considered in determining whether non-liquid resources exceed $2,000.

(2) Grazing permits are considered to be real property.

B. Personal property (liquid or non-liquid): means all property, other than real property, and includes such possessions as bank accounts, cash (other than the current month's income), motor vehicles, livestock, tools, equipment and rights to receive money, such as stocks, bonds, contract rights, insurance policies, etc. The types of personal property that must be counted in determining whether the benefit group's resources exceed the resource limits include, but are not limited to:

(1) Life insurance:

(a) Life insurance policies owned by a member of the benefit group shall be considered as a resource that may be converted into cash. The cash value of the life insurance policy shall be counted toward the liquid resource limit.

(b) Information about lapsed insurance shall be obtained , since many lapsed policies have a cash value.

(2) Cash, bank accounts and other readily negotiable assets:

(a) Readily available cash, such as cash on hand or money in a bank account and other readily negotiable assets, shall be considered as a liquid resource and shall be counted toward the liquid resource limit.

(b) "Other readily negotiable assets" include stocks, bonds, negotiable notes, purchase contracts and other similar assets. For purposes of cash assistance eligibility, the value of such assets is their current market value.

(3) Motor vehicles, equipment and tools:

(a) The equity value of all motor vehicles, equipment and tools is countable, unless specifically excluded.

(b) The value of motor vehicles, equipment and tools, except as set forth in Paragraph 1 of Subsection B of 8.106.510.10 NMAC below, is subject to the non-liquid resource test.

(4) Asset conversion:

(a) Money received from one-time-only or sporadic sales of real or personal property, such as crops, rugs, jewelry, etc., shall be considered an asset, rather than income, provided that the property is not sold or transferred in connection with a business or self-employment activity.

(b) Assets converted into money are subject to the $1,500 liquid assets limitation, regardless of whether they were fully or partially exempt prior to conversion.

(5) Lump sum payments: Payments of a one-time nature, such as retroactive monthly payments, payments in the nature of a windfall, personal injury and worker's compensation awards, gambling winnings, etc., shall be considered a resource subject to the liquid resource limit.

[8.106.510.9 NMAC - N, 07/01/2004]

8.106.510.10 RESOURCE EXCLUSIONS:

A. Real property:

(1) The home: The value of the benefit group's home is not considered in determining eligibility. The "home" is the dwelling place occupied by the benefit group. The home is considered to be occupied by the benefit group during a temporary absence, when there is a definite plan to return to the home and no one else is occupying it.

(2) "Home" includes, in addition to the residence building and the land upon which it is constructed, the following:

(a) a reasonable amount of land within reasonable proximity to the residence building, if that land is currently used by and useful to the client;

(b) outbuildings within reasonable proximity to the residence building, such as barn, garage and well, if the well is a principal source of water;

(c) buildings used for rental purposes, if located on land contiguous to the land upon which the residence building is constructed, and if these buildings cannot be divided from the residence land and sold separately;

(d) grazing permits currently being used to graze livestock owned by the client; and

(e) furniture, equipment and household goods necessary for the operation and maintenance of the home.

(3) Other real property - burial plots: One burial plot for each person included in the benefit group shall be excluded; a burial plot shall consist of the space needed to bury a member of the immediate family.

B. Exempt personal property: The value of the following items of personal property shall not be considered in determining eligibility for GA cash assistance:

(1) Vehicles: all vehicles used by the benefit group for transporting individuals to or from employment, for daily living activities, or for the transportation of goods shall be excluded from consideration as a resource subject to the non-liquid resource limit; recreational vehicles, such as boats or motor homes, shall not be excluded;

(2) Specially-equipped vehicles: a vehicle owned by the benefit group that is specially equipped for the handicapped shall not be considered in the determination of the liquid or non-liquid resource limit.

C. Exempt income: Any income that is exempt under income provisions is also exempt from consideration as a resource. To maintain its exempt status, exempt income that is accumulated must be kept separate from non-exempt savings.

D. Individual development account (IDA): Subject to the limitations set forth below, funds in an IDA are exempt from consideration as resources in determining benefit group eligibility. To be exempt from consideration, the IDA must be designated for a qualified purpose.

(1) Post-secondary education of a dependent child included in the benefit group: In order to be considered used for a qualified purpose, the post-secondary education funds must be paid from an IDA directly to an eligible education institution. For purposes of this regulation, post-secondary education expenses include:

(a) tuition and fees required for the enrollment or attendance of a student at an eligible education institution. An eligible institution is an institution described in section 481(a)(1) or 1201(a) of the Higher Education Act of 1965 (20 USC 1088(a)(1) or 1141(a)); an area vocational education school (as defined in section 521(4) of the Carl D. Perkins Vocational and Applied Technology Education Act (20 U.S.C. 2471(4)) located in any state; or

(b) books, fees, supplies and equipment required for courses of instruction at an eligible educational institution.

(2) Purchase of a principal residence for a first-time home buyer: The purpose of the IDA is to assist a qualified first-time home buyer to accumulate part of the cash necessary to initiate purchase of the individual's first home.

(a) Only IDA's established by qualified first-time home buyers shall be disregarded; a qualified first-time home buyer is one who has never had an ownership interest in a principal residence.

(b) The IDA may be used only for the purchase of a qualified principal residence; a qualified principal residence is one which qualifies as the principal home under subsection 1034 the federal internal revenue code, if the costs for which do not exceed one hundred percent of the average area purchase price applicable to such residence, determined in accordance with paragraphs (2) and (3) of subsection 143(e) of the internal revenue code.

(c) No more than $1,500 may be accumulated in an IDA for first-time home purchase. Any amount in excess of $1,500 is considered in determining whether the benefit group meets the cash resource limit.

(3) Business capitalization: In order to be considered used for a qualified purpose, the funds have to be paid directly from the IDA to a business capitalization account established in a federally insured financial institution that is restricted to use solely for qualified business capitalization expenses. A qualified business means any business that does not contravene any law or public policy. Qualified business capitalization expenses include capital, plant, equipment, working capital and inventory expenses. To be a qualified business, there must be a business plan which:

(a) is approved by a financial institution or a nonprofit loan fund having demonstrated fiduciary integrity;

(b) includes a description of services or goods to be sold, a marketing plan and projected financial statements; and

(c) may require the eligible individual to obtain the assistance of an experienced entrepreneurial advisor.

(4) To be disregarded, the IDA must meet the following requirements:

(a) the benefit group member must first establish and maintain a savings account with a balance of $1,500;

(b) the benefit group member must establish the IDA for one of the three purposes described above.

(c) in order for such accounts to be excludable, the IDA must be a trust created or organized in the United States, with trust language restricting use of account funds to the purposes as designated in this section; and

(d) the IDA must be funded exclusively with income earned by a benefit group member or by contributions made by a non-benefit group member.

(5) Funds withdrawn from the account and used for any purpose other than those specified under this section will cause the account to lose its status as an excluded resource, starting with the month in which

the funds are withdrawn from the IDA account.

E. Funeral agreements: The equity value of funeral agreements owned by a benefit group member shall be excluded from consideration as a resource. Funeral agreements include any arrangement under which prepaid funeral services are provided or cash benefits that are intended to pay for funeral services are paid upon the individual's death. Such agreements include contracts with funeral homes, life or burial insurance, and trust or escrow accounts in financial institutions or banks, provided that the trust or escrow accounts contain provisions making the funds payable only upon the death of a named individual. There is no limit on the amount of the funeral agreement that can be disregarded.

F. Contingent or unliquidated claims: A "contingent or unliquidated claim" is an undetermined right of an individual to receive, at some future time, a resource such as an interest in an unprobated estate or damages or compensation resulting from an accident or injury. Such a claim is not considered a resource if the individual (either applicant or recipient) can demonstrate that an attorney has been consulted, or that under the circumstances, it is reasonable not to have consulted an attorney, and that the individual is making every reasonable effort to prosecute the claim or to proceed with the probate. If the individual can demonstrate that their share in an unprobated estate would be less than the expense of the proceedings to probate the estate, the value is not considered a resource.

G. Work-related equipment exclusion: Work-related equipment, such as the tools of a trades person or the machinery of a farmer, which are essential to the employment or self-employment of a benefit group member, are excluded, in an amount not to exceed $1,000 per individual, and remain excludable if the trades person becomes disabled. Farm machinery retains this exclusion for one year if the farmer ends self-employment.

H. Livestock: The value of livestock is an excluded non-liquid resource.

I. Federally excluded resources: Certain resources are excluded pursuant to federal law. For a listing of federally-excluded resources, see 8.139.527 NMAC.

[8.106.510.10 NMAC - N, 07/01/2004]

8.106.510.11 RESOURCE AVAILABILITY:

A. Availability: Resources that are actually available or that are considered to be available to the benefit group are considered in determining eligibility for assistance.

(1) The resource amount used for determination of eligibility for an applicant benefit group shall be based upon the status of the resources on the date of the application interview.

(2) The resource amount used for determination of eligibility for an active case shall be made based on the amount available in the month following the month of expiration of a notice of adverse action.

B. Potentially available resources: The benefit group is required to take all appropriate steps to make available to itself any liquid or non-liquid resource to which the group may be entitled but whose value is not currently considered available, e.g., an inheritance from an unprobated estate. The fact that specific property is not readily marketable on the client's terms is not a condition prohibiting transfer. The current value of property, which must be partitioned in order to be accessible, is not considered available if the net value (after estimated costs of partition and other closing costs) is less than the resource limit. If the amount likely to be derived from the applicant's/recipient's share of the property exceeds the resource limit, the applicant/recipient will be required to initiate attempts to obtain the applicant's/recipient's share of the estate.

C. Resources of benefit group members: A countable liquid or non-liquid resource that belongs to any member of the benefit group is considered available to the entire benefit group.

D. SSI recipients and other non-members: The property of individuals receiving SSI or that of other non-members shall not be considered available, regardless of relationship to benefit group members, except as indicated in Subsection F below.

E. Non-citizen sponsor: The gross income and resources belonging to an individual who is the sponsor of a non-citizen included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and payment amount if the sponsor has executed an affidavit of support pursuant to subsection 213-A of the Immigration and Nationality Act. The income and resources of the non-citizen sponsor and spouse shall be counted until the sponsored non-citizen achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

F. Resources belonging to the unrelated caretaker: The liquid resources owned by an unrelated caretaker of a minor dependent child living in the home shall not be considered available to the child, unless the unrelated caretaker chooses to be included in the GA benefit group.

G. Jointly-owned resources: Resources owned jointly by the benefit group and any individual who is not a mandatory benefit group member shall be considered available in their entirety to the benefit group, unless it

can be demonstrated by an applicant or recipient that such resources are inaccessible. The benefit group must verify that:

(1) it does not have the use of the resource;

(2) it did not make the purchase or down payment associated with the resource;

(3) it does not make the continuing loan payments; and

(4) the title is transferred to, or retained by, the other joint owner;

(5) if a benefit group can demonstrate that is has access to only a part of the resource, the value of that part is counted toward the benefit group's resource level; a resource will be considered totally inaccessible, if it cannot be practically subdivided and the benefit group's access to the value of the resource is dependent on the agreement of a joint owner who refuses to comply; for purposes of this provision, ineligible non-citizens or disqualified individuals residing with a benefit group are considered benefit group members.

H. Joint bank accounts: If a bank account is owned jointly by a benefit group member and any other individual, the funds in the account are considered available to the benefit group to the extent that it has contributed to the account. If the participating benefit group has not contributed to the account, the funds are considered available only if there is clear and convincing evidence that the other joint owner of the account intends for the participating benefit group to have access to the funds.

[8.106.510.11 NMAC - N, 07/01/2004]

8.106.510.12 ELIGIBILITY DETERMINATION:

A. Determination: If, after determining what property is available to the benefit group and determining the value of that resource, the net value of the countable real and personal property exceeds resource limits, the benefit group shall be ineligible for assistance on the basis of need. The benefit group shall remain ineligible on the basis of need for as long as the value of the property exceeds the resource standards.

B. Receipt of resources: Resources acquired by a benefit group member after approval of an assistance grant shall be evaluated for purposes of financial assistance eligibility at the time of the change. Reporting requirements as indicated in Subsection D of 8.102.630.8 NMAC apply. If the benefit group becomes ineligible due to ownership or availability of resources, assistance is terminated effective the month following the month in which the notice of adverse action expires.

[8.106.510.12 NMAC - N, 07/01/2004]

8.106.510.13 NON-TRANSFER OF REAL PROPERTY:

A. Requirement:

(1) In order to include an individual in the benefit group, the individual must not have transferred real property for the purpose of becoming eligible for cash assistance within the two-year period preceding the date of application.

(2) A transfer is considered to be for the purpose of becoming eligible for cash assistance if:

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

(b) the individual had no reasonable plan for support at the time of the transfer other than assistance from the HCA.

B. Transfer:

(1) For the purpose of this provision, transfer includes the sale, conveyance by deed, or any other method of transferring the title to the property involved, including transfer by gift. The transfer may be for either the title to the real property or other interests or rights in the property, such as mineral or water rights.

(2) A child under the age of 18 cannot transfer property, except through a legal guardian. Normally, a child will not own property in the child's own right, but if facts indicate the existence of a trust, inheritance or prior gifts to the child, it must be determined whether a transfer has taken place within the two-year period.

C. Reasonable return: A reasonable return on the transfer of property is considered to have been received when the person who made the transfer received compensation in cash or in kind equal to the value of the property at the time of transfer. The determination as to whether a reasonable return was received is based on the individual's equity interest in the property at the time of the transfer.

(1) Equity less than $2,000: If the value of the equity interest, plus all other countable resources, was less than $2,000, the transfer is not considered to be for the purpose of becoming eligible for cash assistance.

(2) Reasonable value not received: If it is determined that the property was transferred for the purpose of becoming eligible, but the client has subsequently made efforts to obtain a reasonable return or to

regain title, and is willing to continue such efforts, eligibility on this condition exists. If the client is not willing to pursue a reasonable return, or to attempt to regain title to the property, the benefit group shall not be eligible for six months from the month ISD makes the determination that the transfer was made.
[8.106.510.13 NMAC - N, 07/01/2004]

History of 8.106.510 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 520 ELIGIBILITY POLICY - INCOME

8.106.520.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.520.1 NMAC - Rp, 8.106.520.1 NMAC 11/01/2023; A, 7/1/2024]

8.106.520.2 SCOPE: The rule applies to the general public.
[8.106.520.2 NMAC - Rp, 8.106.520.2 NMAC 11/01/2023]

8.106.520.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.520.3 NMAC - Rp, 8.106.520.3 NMAC 11/01/2023; A, 7/1/2024]

8.106.520.4 DURATION: Permanent.
[8.106.520.4 NMAC - 8.106.520.4 NMAC 11/01/2023]

8.106.520.5 EFFECTIVE DATE: November 1, 2023, unless a later date is cited at the end of a section.
[8.106.520.5 NMAC - Rp, 8.106.520.5 NMAC 11/01/2023]

8.106.520.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.
[8.106.520.6 NMAC - Rp, 8.106.520.6 NMAC 11/01/2023]

8.106.520.7 DEFINITIONS: [**RESERVED**]
[8.106.520.7 NMAC - Rp, 8.106.520.7 NMAC 11/01/2023]

8.106.520.8 GENERAL:

A. Income eligibility: To be eligible for GA cash assistance based on income the countable gross earned and unearned income available to the benefit group is considered to determine the income eligibility of the benefit group.

B. Gross income test: For the benefit group to be income eligible, the countable gross earned and unearned income considered available to the benefit group cannot exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

C. Net income test: For the benefit group to be income eligible, the countable net income after all allowable deductions must be less than the standard of need for the size of the benefit group.
[8.106.520.8 NMAC - Rp, 8.106.520.8 NMAC 11/01/2023]

8.106.520.9 EXEMPT INCOME: The following income sources or assistance types are not considered available for the gross income test, the net income test and the cash payment calculation:

A. medicaid;

B. food stamp benefits;

C. government-subsidized foster care, if the child for whom the payment is received is not included in the benefit group;

D. SSI;

E. government-subsidized housing or housing payment; government includes any federal, state, local or tribal government, or a private non-profit or for-profit entity operating housing programs or using government funds to provide subsidized housing or to make housing payments.

F. income excluded by federal law (described in 8.139.527 NMAC);

G. educational payments made directly to an educational institution;

H. government-subsidized child care;

I. earned income that belongs to a child 17 years of age or younger who is not the head of household; only earned income paid directly to the child is considered as belonging to the child;

J. up to $50 child support disregard and up to $100 for one child and $200 for two or more children per month, child support pass-through distributed to the benefit group by the CSED;

K. an emergency one-time only payment made by other agencies or programs;

L. reimbursements for past or future identified expenses, to the extent they do not exceed actual expenses and do not represent a gain or benefit to the benefit group, such as expenses for job or job training-related activities, travel, per diem, uniforms, transportation costs to and from the job or training site, medical or dependent care reimbursements and any reimbursement for expenses incurred while participating in NMW work program activities; reimbursements for normal living expenses, such as rent, mortgage, clothing or food eaten at home are not excluded;

M. utility assistance payments, such as from LIHEAP, LITAP or similar assistance programs.

N. subsidized private sector employment: as outlined at Subsection B of 8.102.461.12 NMAC.

O. guaranteed basic income: any payments that is funded solely with private funds or mixture of private and public funds will be excluded income.

P. universal basic income: any payments that is funded solely with private funds or mixture of private and public funds will be excluded income.

[8.106.520.9 NMAC - Rp, 8.106.520.9 NMAC 11/01/2023]

8.106.520.10 EARNED INCOME DEFINITION:

A. Earned income means cash or payment in kind that is received as wages from employment, payment in lieu of wages, earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services.

B. Earnings include gross profit from self-employment, which requires substantial effort on a continuous basis by the individual who is receiving the income.

(1) Income from rental property is considered earnings if the individual regularly does painting, plumbing, carpentry, maintenance, cleaning or repair work on the property, or if substantial time is spent each month in bookkeeping, collecting rent, or paying bills on the property.

(2) Income from livestock is considered earnings if the individual raises livestock for the purpose of making cash sales. Net income received from the sale of livestock shall be considered in determining the cash assistance benefit amount.

(a) The income received from the sale of livestock may be prorated and projected on a monthly basis over the certification period.

(b) Domestic pets (cats, dogs, etc.) are not considered livestock, and their value is not considered in determining income eligibility, except when they are bred and raised for sale.

C. The use of property, such as inhabiting a home or apartment, is considered as earnings if it is received in exchange for services provided to the person owning or controlling the property, and the

applicant or recipient would be legally obligated to make a payment for use of the property.
[8.106.520.10 NMAC - Rp, 8.106.520.10 NMAC 11/01/2023]

8.106.520.11 DETERMINING INCOME FOR SELF-EMPLOYED INDIVIDUALS:

A. Reporting of earnings as business or self-employment income to state or federal tax authorities is the usual indicator of business or self-employment income. Criteria for verification of business and self-employment income are set forth in Paragraph (2) of Subsection B of 8.100.130.14 NMAC.

(1) Tax returns from the previous year may be used, unless the amount of business and self-employment income reported on tax returns is no longer a good indicator of anticipated income.

(2) If the self-employment enterprise has been in operation for such a short time that there is insufficient information to make a reasonable projection, the benefit group shall be required to report income at shorter intervals until there is enough information to make a longer projection of anticipated income.

(3) When tax forms are used to annualize and project income, the expenses reported on the tax forms shall be used, allowing for adjustments for those expenses or costs that are treated differently or not allowed under cash assistance policy.

(4) Capital gains are counted in full as income to determine self-employment income. A capital gain is defined as proceeds from the sale of capital goods or equipment.

B. Averaging business or self-employment income: Business or self-employment income is averaged over the period the income is intended to cover, even if the benefit group receives income from other sources.

(1) An individual in a benefit group, who by contract or self-employment derives their annual income in a period of time shorter than one year, must have income averaged over a 12-month period.

(2) If significant changes have occurred because of a substantial increase or decrease in business and averaged income will not accurately reflect the self-employed individuals' income, the self-employment income shall be calculated on the basis of anticipated, not prior, earnings.

(3) If a self-employment enterprise has been in existence for less than one year, the income from self-employment shall be averaged over the period of time the business has been in operation. The resulting monthly amount shall be projected for the coming year.

(4) Seasonal income: Self-employment income that is intended to meet the benefit group's needs for only part of the year shall be averaged over the period of time the income is intended to cover.

C. Determining monthly business or self-employment income: For the period of time over which self-employment income is averaged, the individual's monthly self-employment income is determined by adding all self-employment income, including capital gains, and excluding allowable costs of producing the self-employment income, and dividing the resulting self-employment income by the number of months the income is intended to cover.
[8.106.520.11 NMAC - Rp, 8.106.520.11 NMAC 11/01/2023]

8.106.520.12 EARNED INCOME DEDUCTIONS:

A. Earnings deductions: Deductions from gross earned income shall be made in determining the net countable earned income of benefit group members.

(1) Earned income deductions may not exceed the amount of an individual's gross earned income.

(2) The earned income deductions may not be used to reduce unearned income, nor may deductions that are not used by one benefit group member be allocated against the earnings of another benefit group member.

(3) An allowable business expense or cost of producing self-employment income that has been used as a deduction from self-employment income shall not also be allowed as an earned

income deduction.

B. Business expenses and self-employment costs: Business expenses and self-employment costs shall be deducted from the gross earnings of a self- employed benefit group member. The income remaining after all allowable business expenses and self-employment costs have been deducted shall be counted as the gross income of the benefit group member. To be eligible for a business or self-employment expense deduction, a Tax ID shall be required.

(1) Allowable expenses and costs: Allowable costs of producing self-employment income include, but are not limited to:

(a) costs of materials and supplies;

(b) business travel, but not personal commuting expenses, calculated at $.025 per mile, unless the self-employed individual can prove that the actual expense is greater;

(c) business taxes, including occupational taxes, gross receipts taxes and property taxes on a place of business other than the home, and business licenses;

(d) rental of equipment, tools and machinery;

(e) rent expense for the place of business, except for the place of business when the individual operates the business out of the individual's residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines;

(f) payments on the principal of the purchase price of income-producing real estate and capital assets, machinery, equipment and other durable goods;

(g) interest paid to purchase income-producing property.

(2) Expenses and costs not allowed:

(a) costs for depreciation, personal business, entertainment expenses and personal transportation to and from work; and

(b) expenses or costs of self-employment that are reimbursed by other agencies cannot also be claimed as costs of self-employment, such as, but not limited to, reimbursements made through USDA to individuals who provide home child care.

(3) Expenses or costs that exceed self-employment income shall not be deducted from other income.

C. Living expense deduction:

(1) Allowing the deduction in the GA-disabled adult program: The living expense deduction is allowed with no time limit as follows:

(a) $125 and one-half of the remainder for a single-adult benefit group;

(b) $225 and one-half of the remainder for a benefit group that includes two adults.

(2) Allowing the deduction in a GA-unrelated child benefit group: The living expense deduction shall be allowed when the caretaker of an unrelated dependent child chooses to be included as a benefit group member. The living expense deduction is allowed with no time limit as follows:

(a) $125 and one-half of the remainder for a single-adult benefit group;

(b) $225 and one-half of the remainder for a benefit group that includes the unrelated caretaker and their spouse.

D. Child care costs: Out-of-pocket expenses for child care apply only to the GA-unrelated child benefit group. Expenses paid by the unrelated caretaker for the dependent child included in the benefit group that are necessary due to employment of the caretaker shall be allowed.

(1) From earnings remaining after allowing the work incentive deduction, deduct an amount not to exceed $200 per month for a child under age two and $175 per month for a child age two or older.

(2) If both the caretaker and spouse of the caretaker are working, child care expenses shall be allocated to maximize the available deduction to the benefit group.

(3) The total amount deducted per child shall not exceed the applicable limits set forth above.

[8.106.520.12 NMAC - Rp, 8.106.520.12 NMAC 11/01/2023]

8.106.520.13 UNEARNED INCOME:

A. Definition of unearned income: Unearned income means old age, survivors and disability insurance payments (social security), railroad retirement benefits, veterans administration compensation or pension payments, military retirement and allotments, pensions, annuities and retirement benefits; lodge or fraternal benefits, any other public or private disability or retirement benefit or pension, shared shelter payments, individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income.

B. Special considerations:

(1) Direct receipt of child support: Child support payments directly received by an unrelated caretaker and retained by the caretaker are considered available to the benefit group in their entirety, whether or not the caretaker chooses to be included in the benefit group.

(2) Real property income: Income from real property is considered as unearned income when an individual included in the benefit group engages in the management of the property less than 20 hours a week. Costs associated with maintenance of the property or the production of income for which the benefit group is responsible are deducted from the income received for the use of the property.

(3) Non-citizen sponsor income: All of the income of the non-citizen sponsor and sponsor's spouse is counted as unearned income to the benefit group.

[8.106.520.13 NMAC - Rp, 8.106.520.13 NMAC 11/01/2023]

8.106.520.14 NET COUNTABLE INCOME: The earned income remaining after all allowable exemptions and deductions shall be added to the unearned income belonging to the benefit group. The resulting amount shall be the net countable income of benefit group members. The net countable income shall be used to determine the cash assistance payment to the benefit group.

[8.106.520.14 NMAC - Rp, 8.106.520.14 NMAC 11/01/2023]

History of 8.106.520 NMAC: [**RESERVED**]

History of Repealed Material:

8.106.520 NMAC, State Funded Assistance Program - Eligibility Policy Income, filed 06/17/2004 - Repealed effective 11/01/2023.

Other: 8.106.520 NMAC, State Funded Assistance Program - Eligibility Policy Income, filed 06/17/2004 - was Replaced by 8.106.520 NMAC, State Funded Assistance Program - Eligibility Policy Income, effective 11/1/2023.

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 610 DESCRIPTION OF PROGRAM/BENEFITS - BENEFIT DELIVERY

8.106.610.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.610.1 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.610.2 SCOPE: The rule applies to the general public.
[8.106.610.2 NMAC - N, 07/01/2004]

8.106.610.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.610.3 NMAC - N, 07/01/2004 ; A, 7/1/2024]

8.106.610.4 DURATION: Permanent.
[8.106.610.4 NMAC - N, 07/01/2004]

8.106.610.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.610.5 NMAC - N, 07/01/2004]

8.106.610.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.
[8.106.610.6 NMAC - N, 07/01/2004]

8.106.610.7 DEFINITIONS: [**RESERVED**]
[8.106.610.7 NMAC - N, 07/01/2004]

8.106.610.8 METHOD OF PAYMENT

A. EBT: Cash assistance benefits are issued by deposit of funds into an electronic benefit transfer (EBT) account.

(1) EBT card issuance: EBT account cards shall be issued at time of application to the authorized payee or authorized representative.

(2) Replacement card: The caseworker, the HCA help desk or the contractor customer service help desk shall have a card deactivated upon request of an adult participant in the benefit group or authorized payee. The card will be deactivated immediately and a replacement card provided to the participant. Once a card is deactivated it cannot be reactivated for any reason.

B. Authorizing and issuing payments:

(1) Payment authorization: Cash payments are authorized when action is taken to approve a cash payment for a benefit group.

(2) Payment issuance: Payments are prorated from the date of authorization or from the 30th day after the day of application, whichever is earlier.

(a) If the case was eligible in a month prior to the month of approval but is not eligible for payment in the month following approval, the benefit group is not eligible for payment in any of these months.

(b) Ongoing monthly issuance: Ongoing cash assistance payments are authorized in the regular monthly issuance process.

(3) Whereabouts unknown: Eligibility shall be terminated if the whereabouts of the benefit

group are unknown to the HCA. A benefit group's whereabouts shall be considered to be unknown if:

(a) mail sent to the last known address is returned to the HCA indicating that the benefit group no longer lives at that address and at least 30 days have passed since the caseworker sent the mail; or

(b) the benefit group does not make any withdrawals from the benefit group's EBT account for 60 days or more.

C. **EBT transactions**: EBT transactions shall not be in any liquor store; any casino, gambling establishment; or any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

[8.106.610.8 NMAC - N, 07/01/2004; A, 02/28/2007, A/E, 01/30/2009; A, 03/31/2009; A, 07/01/2009; A, 12/01/2009; A, 04/01/2014]

8.106.610.9 **CHANGE OF PAYEE: Change of name or payee:** Whenever there is a change in a recipient's name or in the payee's name the caseworker shall immediately make the appropriate changes.

A. **New caretaker of an unrelated dependent child:**

(1) If a new caretaker assumes responsibility for an unrelated dependent child in a case, the case shall be closed and a new application processed.

(2) If the new caretaker is already has an active cash assistance case for other dependent children, the cash assistance case for the children being transferred shall be closed, and the children added to the existing benefit group.

B. **Payee change after benefits are issued:** Cash assistance benefits have been posted to an EBT account, the EBT account can be accessed by another family member through authorization of a new PIN under the old account.

C. **Changes in name or payee are made when:**

(1) a payee legally changes their name and the change has been processed through the social security administration;

(2) a legal guardian is appointed or dismissed;

(3) the parent of an incompetent adult recipient begins to serve as natural guardian; or

(4) there is a change of caretaker for an unrelated dependent child.

[8.106.610.9 NMAC - N, 02/27/2007; 8.106.610.9 NMAC - N, 12/01/2009]

8.106.610.10 [**RESERVED**]

[8.106.610.10 NMAC - Rp, 8.106.610.9 NMAC, 12/01/2009; Repealed, 3/1/2020]

History of 8.106.610 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 620 DESCRIPTION OF PROGRAM BENEFITS - BENEFIT DETERMINATION/GENERAL

8.106.620.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.620.1 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.620.2 SCOPE: The rule applies to the general public.
[8.106.620.2 NMAC - N, 07/01/2004]

8.106.620.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.620.3 NMAC - N, 07/01/2004 ; A, 7/1/2024]

8.106.620.4 DURATION: Permanent.
[8.106.620.4 NMAC - N, 07/01/2004]

8.106.620.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.620.5 NMAC - N, 07/01/2004]

8.106.620.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.

[8.106.620.6 NMAC - N, 07/01/2004]

8.106.620.7 DEFINITIONS: [**RESERVED**]
[8.106.620.7 NMAC - N, 07/01/2004]

8.106.620.8 PAYMENT DETERMINATION:

A. Determining countable benefit group income: The benefit group's net countable income shall be considered in the payment determination. The benefit group's net countable income is subtracted from the standard of need for the size of the benefit group.

B. Determining the payment:

(1) A benefit group whose net countable income equals or exceeds the standard of need for the size of the benefit group shall not be eligible for GA benefits.

(2) For a benefit group whose net countable income does not exceed the standard of need for the size of the benefit group, the benefit amount shall be determined by:

(a) subtracting the benefit group's countable income from the standard of need for the size of the benefit group;

(b) subtracting any sanction amount, if applicable; and

(c) subtracting any recoupment amount, if applicable.

[8.106.620.8 NMAC - N, 07/01/2004]

8.106.620.9 RECOUPMENT: An individual against whom there is an outstanding claim for overpayment of cash assistance shall be required to repay the claims. Recovery of an overpayment may be accomplished by recoupment (see 8.106.640.11 NMAC). Recoupment amounts shall be deducted from the monthly benefit after the sanction amount is deducted, if appropriate.
[8.106.620.9 NMAC - N, 07/01/2004]

8.106.620.10 CHILD SUPPORT PAYMENT SANCTIONS - GA UNRELATED CHILD PROGRAM:

A. General:

(1) Failure by an adult caretaker of an unrelated dependent child to comply with child support cooperation requirements shall result in a payment reduction of twenty-five percent for the first occurrence, fifty percent for the second occurrence and case closure for the third occurrence. Cases closed due to sanctioning are ineligible for a period of six months.

(2) Before imposing the first sanction, the caretaker shall be given the opportunity to meet child support requirements through a conciliation process. If the individual does not agree to cooperate by the end of the conciliation period, a payment sanction shall be imposed. The reduction shall be applied to the benefit group's standard of need.

(3) Child support cooperation requirements shall be applicable to the caretaker adult even if the adult is not included in the benefit group. Payment sanctions shall be applicable to benefit group's standard of need even if the caretaker adult is not included in the benefit group.

B. The conciliation process:

(1) When conciliation is available: Conciliation shall be available to an individual once during an occurrence of assistance. Once a conciliation period has been made available to the benefit group, there must be a period of at least 12 months between occurrences of assistance in order for a conciliation to be available again to the benefit group.

(2) Occurrence of assistance: An occurrence of assistance means a continuous period in which a benefit group receives GA benefits.

(3) Determining that noncompliance has occurred: The determination of noncompliance with child support shall be made by CSSD. The conciliation and sanctioning process for child support noncompliance is initiated by the HCA upon receipt of notice from CSSD that the caretaker has failed to cooperate.

(4) Initiating conciliation: Within ten days of notification by CSSD that the caretaker has not complied, the caseworker shall take action to initiate a conciliation period, if the individual's conciliation has not been used. A conciliation is initiated by the caseworker issuing a conciliation notice.

(5) Conciliation period:

(a) Conciliation is a 30-day period during which the caretaker has the opportunity to correct whatever failure resulted in the noncompliance determination. The conciliation process shall occur only once prior to the imposition of the sanction. The benefit group shall be subject to sanction in the month following the month the notice of adverse action expires.

(b) If CSSD determines that the adult caretaker is not complying with child support requirements, the adult caretaker shall be required to enter into a conciliation process established by HSD to address the noncompliance, or to identify good cause for noncompliance or barriers to compliance, if applicable.

(c) The adult caretaker shall have ten working days from the date a conciliation notice is mailed to contact HSD to initiate the conciliation process. An adult caretaker who fails to initiate the conciliation process shall have a notice of adverse action mailed after the tenth working day following the date on which the conciliation notice is mailed. An adult caretaker who begins, but does not complete, the conciliation process shall be mailed a notice of adverse action 30 days from the date the original conciliation was initiated.

(d) If the adult caretaker has initiated the conciliation process, it is the adult caretaker's responsibility to contact CSSD and to comply with CSSD requirements or to request a waiver. If the caseworker does not receive confirmation from CSSD within 30 days of issuing the conciliation notice that the caretaker is cooperating, has a good cause waiver, or has requested a good cause waiver, the conciliation process shall be considered to have failed and the benefit group shall be subject to a payment sanction.

C. Occurrence of noncooperation:

(1) Each instance in which a caretaker is determined by the HCA to have failed to meet a child support requirement shall be considered a separate occurrence of noncompliance.

(2) When the noncompliance continues for three months without the sanctioned individual reestablishing compliance, progression to the next higher sanction level shall result in the fourth month.

(3) Reestablishing compliance shall allow full payment to resume, or shall appropriately reduce the sanction level for the benefit group in the month following the month in which compliance is established.

D. Cumulative sanctions: Noncompliance sanctions are cumulative as they relate to an individual in the benefit group.

(1) A cumulative sanction shall result when there is more than one failure by an individual in the benefit group to comply with child support enforcement requirements.

(2) A cumulative sanction, whether or not cured, shall remain the property of the individual

benefit group member who caused the sanction. An individual with a cumulative sanction who leaves a benefit group relieves the benefit group of that individual's sanction status.

(3) An individual's compliance shall reverse the sanction level to the benefit group.

(4) An individual's sanction status may be reversed as a result of a hearing decision that renders the sanction invalid.

(5) A third sanction level, which results in a mandatory six-month closure for the benefit group, cannot be reversed.

E. Progressive sanctions: Sanction levels shall be progressive to the benefit group in which the sanctioned individual resides.

(1) When the noncompliance continues for three months without the sanctioned individual reestablishing compliance, progression to the next higher sanction level shall result in the fourth month.

(2) A sanction shall progress until compliance is established by the individual, or there is a waiver of the requirement. Reestablishing compliance shall allow full payment to resume or shall appropriately reduce the sanction level for the benefit group in the month following the month in which compliance is established.

(3) A progressive sanction may be reversed as a result of a hearing decision that renders the sanction level invalid.

(4) An individual's compliance cannot reverse the sanction level attributed to the benefit group. Once a sanction has been imposed, any subsequent sanction is imposed at the next higher level, unless reversed by a hearing decision.

F. Sanctioning:

(1) Within 10 days of determining that the caretaker has failed to meet a child support cooperation requirement, ISD shall issue a notice of adverse action informing the benefit group that its cash assistance payment will be reduced. The payment reduction shall take place with the first payment following expiration of the notice of adverse action.

(2) Notice of adverse action shall apply to all child support noncompliance sanctions and levels, including those relating to the conciliation process.

(3) Failure to comply during the 13-day notice of adverse action time period shall cause the sanction to become effective.

(4) Lifting the sanction: A caretaker who corrects the failure of compliance with child support enforcement requirements during the 13-day notice of adverse action time period shall not have the sanction imposed against the benefit group or payment amount.

(a) The sanction shall not count as a cumulative or progressive sanction, since the reason for the sanction was corrected during the notice of adverse action time period and prior to a benefit reduction being imposed.

(b) A sanction shall be removed effective the month following the month in which the determination is made that the individual has complied with requirements.

(c) A child support enforcement sanction shall be removed after CSSD notifies the caseworker that the individual is in compliance with child support enforcement requirements.

G. Sanction levels:

(1) First-level sanction:

(a) The first failure to comply, or first level sanction for failure to comply, shall result in a reduction of twenty-five percent of the standard of need.

(b) If the first level, or twenty-five percent sanction, lasts for three months, or an individual has a second incident of failure to comply, the sanction shall advance to level two, or fifty percent sanction.

(2) Second-level sanction:

(a) The second level sanction for failure to comply shall result in a reduction of 50percent of the standard of need. The second level is initiated by failure to comply for more than three months or a second instance of noncompliance with a CSSD requirement.

(b) A failure to meet child support enforcement requirements for three months at the second level, or a third incidence of failure to comply with a requirement shall result in the third sanction level.

(3) Third-level sanction:

(a) The third sanction level results in case closure for a period of not less than six months.

(b) Once an individual is sanctioned at the third level, any subsequent incident of failure to comply shall immediately result in the third level sanction, or case ineligibility for six months.

H. Sanctions by other states or other programs: Individuals in sanction status for failure to comply with the requirements of other programs or other states, such as the food stamp employment and training program shall not carry that sanction status into the GA cash assistance program.
[8.106.620.10 NMAC - N, 07/01/2004]

8.106.620.11 NON-REPORTING SANCTIONS:

A. General: The eligibility determination and payment calculation process relies upon applicants and recipients to provide accurate and timely reports of information affecting their eligibility and benefit amount. Payment sanctions for non-reporting shall be established to encourage timely and accurate reporting and to offset benefits resulting from the reporting of inaccurate or misleading information, the untimely reporting of changes, or the failure to report any required information.

B. Length of a sanction: Each non-reporting sanction shall run for a period of four months for the first month in which failure to report occurred. An additional month shall be added for each additional month included in an occurrence of non-reporting until the payment is corrected.

C. Definition of an occurrence of non-reporting: An occurrence of non-reporting exists when an applicant or recipient intentionally fails to report information or reports incorrect information which results in an overpayment of cash assistance benefits.

D. Amount of sanction:

(1) Reporting sanctions shall be calculated at twenty-five percent of standard of need for the size of the benefit group being sanctioned.

(2) Reporting sanctions are not progressive. If there is another occurrence of non-reporting prior to the end of an ongoing non-reporting sanction period, the next sanction and any subsequent non-reporting sanctions shall be consecutive and at the twenty-five percent level.

(3) Reporting sanctions and child support sanctions shall be integrated into a single calculation to determine the final sanction amount.

(4) If a case closes during a reporting sanction period for reasons other than sanctions, the non-reporting sanction shall be suspended and resumed at the same duration the next time the case is reopened.

E. Procedures: The following steps shall be taken in implementing a payment sanction.

(1) The caseworker shall document and establish an overpayment claim using ISD2 overpayment claims procedures. The caseworker shall also determine whether the recipient was at fault.

(2) The county director or a designated unit supervisor shall review the overpayment and determine the accuracy of the overpayment determination and appropriateness of the fault determination. Upon determining that all is in order, the county director, or designated supervisor shall cause a notice of intent to sanction to be issued to the recipient. Failure of the recipient to contact the person issuing the notice within the 10 working days allowed shall constitute waiver of conciliation rights.

(3) If the recipient requests conciliation within the 10 working days after issuance of the notice, the county director or designated supervisor shall schedule a conciliation conference.

(4) The conciliation conference is conducted by the county director or designated supervisor.

(a) The caseworker shall describe the reporting error, how the amount of the overpayment is determined and the reasons for finding the recipient at fault.

(b) The recipient shall have the opportunity to discuss the overpayment determination, the finding of fault and to show good cause why the sanction should not be imposed.

(c) Based upon this conference, the county director or designated supervisor shall determine whether a sanction should be imposed.

(d) The recipient may represent himself or be represented by someone else. If the recipient wishes to be represented by another individual, the recipient must designate that individual on a form ISD-121.

(5) Following the conference, the county director shall issue written notice stating whether or not the sanction is to be imposed, and, if appropriate, the worker shall effect the sanction causing issuance of a notice of adverse action. The payment reduction takes effect in the month following expiration of the notice of adverse action.

(6) Recipients who disagree with the sanction determination shall have fair hearing rights and access to the fair hearing process.
[8.106.620.11 NMAC - N, 07/01/2004]

History of 8.106.620 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 630 DESCRIPTION OF PROGRAM/BENEFITS - CHANGES IN ELIGIBILITY

8.106.630.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.630.1 NMAC - N, 07/01/2004; A, 7/1/2024]

8.106.630.2 SCOPE: The rule applies to the general public.
[8.106.630.2 NMAC - N, 07/01/2004]

8.106.630.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.630.3 NMAC - N, 07/01/2004 ; A, 7/1/2024]

8.106.630.4 DURATION: Permanent.
[8.106.630.4 NMAC - N, 07/01/2004]

8.106.630.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.630.5 NMAC - N, 07/01/2004]

8.106.630.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.
[8.106.630.6 NMAC - N, 07/01/2004]

8.106.630.7 DEFINITIONS: [**RESERVED**]
[8.106.630.7 NMAC - N, 07/01/2004]

8.106.630.8 CHANGE PROCESSING STANDARDS:

A. There is a continuing responsibility on the part of both the recipient and the caseworker to make sure that benefits paid to the benefit group correctly reflect the benefit group's circumstances for the certification period.

B. A change is considered reported on the date the report of change is received by the project area office or, if mailed, the date of the postmark on the benefit group's report, plus three days mailing time.

C. A benefit group will be encouraged to use a change report form to document changes. A change may be reported by mail, by personal visit, by telephone, fax, electronic mail.

D. **HCA action on reported changes:** Reported changes shall be evaluated and changes to eligibility, benefit amount, or both shall be acted on within 10 days of receiving the notice of a change.

(1) The change is made as soon as possible but must be effected no later than the end of the month following the month in which the change is reported.

(2) The caseworker shall take action on any change reported by a benefit group, and on any change that becomes known to the HCA through other sources.
[8.106.630.8 NMAC - N, 07/01/2004; A, 12/01/2009]

8.106.630.9 CHANGE PROCESSING ACTION: If, during a certification period, a change occurs that affects eligibility or benefit amount, the caseworker shall take action to adjust the benefit group's eligibility or benefit amount.

A. **Action on changes:** When a benefit group reports a change, the caseworker must take action to

determine the benefit group's eligibility and benefit amount within 10 days of the date the notice of change is received by the HCA.

B. Reducing the benefit amount: For changes that result in a reduction of cash assistance benefits, the caseworker shall act on the change as follows.

(1) If a signed written report is provided by the benefit group, action shall be taken for the following month without issuing a notice of adverse action. The benefit group shall be provided with adequate notice. If the benefits will be reduced in the same month in which the certification period will expire, no action shall be required to reduce or terminate benefits.

(2) When a benefit group timely reports a change that will reduce benefits, but does not provide a signed written report, the caseworker shall issue an adverse action notice to the benefit group. If the adverse action time limit expires in the following month, there is no overpayment in that month and the benefit group is entitled to the higher benefit amount. The reduction shall be effective in the month following the month in which the adverse action notice expires.

(3) If the change is reported by any other means, within 10 days the caseworker shall take action to issue a notice of adverse action to reduce or terminate benefits effective the month following the month in which the adverse action time limit expires. If the notice of adverse action time limit will expire in the same month that the benefit group's certification period will expire, no action shall be required to reduce or terminate benefits.

C. Increased benefit amount:

(1) If verification of the change is provided at the time the change is reported, the caseworker shall make the change prospective, beginning in the month following the month in which the change was reported.

(2) If verification is not provided at the time the change is reported, the benefit group shall be allowed 13 days from the date a change is reported to provide verification. Benefits shall be increased effective the month following the month in which the verification is provided.

(3) When a benefit group fails to make a timely report of a change that will result in an increased benefit amount, the benefit amount shall increase the month following the month in which the verification is provided. The benefit group is not entitled to an increased benefit amount for any month prior to the month in which the verification is provided.

D. Termination of benefits: When the benefit group reports a change that will result in a termination of benefits, and the change is not reported in writing and signed by a benefit group member, the caseworker shall issue an adverse action notice.

(1) If the adverse action time limit expires in the month following the month the notice is mailed, there is no overpayment to the benefit group in the following month and the benefit group shall be entitled to the higher benefit amount. A claim against the benefit group shall not be established.

(2) If the adverse action time limit will expire in the same month in which the certification period ends, or after the certification period ends, no action shall be taken to terminate benefits and the certification period shall be allowed to expire. The caseworker shall document the change in the case record.

E. No change in benefit amount: When a reported change will not change the benefit amount, the caseworker shall document the change in the case file and notify the benefit group that the report was received and there is no change in benefits.

F. Other changes: All unreported changes of which the caseworker becomes aware must be acted upon. At a minimum, this means documenting changes in the case record. All discrepancies and questionable information shall be resolved to make sure that the correct benefit amount is issued to the benefit group.
[8.106.630.9 NMAC - N, 07/01/2004; A, 12/01/2009]

8.106.630.10 CHANGE NOTICES:

A. Notice of adverse action: Prior to any action to reduce or terminate cash assistance benefits within the certification period, the benefit group shall be provided with a notice of an adverse action, unless the change was reported by the benefit group in writing and was signed by a benefit group member. The adverse action notice shall include at least the following information:

(1) proposed action and reason for the action;

(2) month in which the change takes effect;

(3) adjusted benefit amount;

(4) benefit group's right to request a fair hearing, circumstances under which the benefit group can continue benefits at the greater amount, and deadline dates for requesting a hearing;

(5) benefit group's liability for any benefits overpaid if the result of the fair hearing is that the HCA took the correct action;

(6) general information on whom to contact for additional information, including the right to representation by legal services.

B. Adequate notice: If a change was reported by the benefit group in writing, was signed by a benefit group member, and will result in a reduction or termination in benefits, the benefit group shall be provided with advance written notice of the reduction or termination.

(1) The benefit group shall be notified that its benefits are being reduced or terminated no later than the date the benefit group receives, or would have received, its benefits.

(2) Adequate notice shall be provided when changes reported in writing meet the following conditions:

(a) the benefit group provides a written report of the information that results in the reduction or termination and the report is signed by a member of the benefit group;

(b) the caseworker can determine the benefit group's reduced benefit amount or ineligibility based solely on the information provided by the benefit group in the written report; and

(c) the benefit group retains its right to a fair hearing.

C. Fair hearing rights: The benefit group retains its right to have continued benefits if the fair hearing is requested within the adverse action time limit and the benefit group requests the higher benefit amount pending the hearing decision. The caseworker shall continue the benefit group's previous benefit amount if required, within five working days of the benefit group's request.

D. Other changes: A notice of adverse action shall not be provided when:

(1) there is a mass change in benefits affecting the entire GA program;

(2) the caseworker determines, on the basis of reliable information, that the benefit group has moved out of state;

(3) the caseworker determines on the basis of reliable information that all members of a benefit group have died;

(4) the benefit group has received an increased benefit amount to restore lost benefits, the restoration is complete, and the benefit group has been notified in writing of the date the increased benefit amount will terminate;

(5) the benefit group voluntarily requests in writing, or in the presence of the caseworker, that its participation be terminated; or

(6) the caseworker determines, on the basis of reliable information, that the benefit group has been approved for a concurrent cash assistance program.

[8.106.630.10 NMAC - N, 07/01/2004; A, 12/01/2009]

8.106.630.11 MASS CHANGE NOTICE

A. Change in payment amount: A benefit group's cash assistance payment may be increased or decreased after initial certification.

(1) Increase in payment amount: The HCA shall issue adequate notice to GA recipients regarding an increase in payment amount.

(2) Decrease in payment amount: The HCA shall issue written notice to GA recipients no later than 60 days prior to the change effective date. The notice shall include the citation to the state statute and regulation and fair hearing rights.

B. Application moratorium: Public notice shall be issued 60 days prior to the imposition of a moratorium on applications. Applications received during the moratorium shall be processed in accordance with 8.106.110.16 NMAC.

C. Suspension of program: The GA payment for all benefit groups may be denied for a designated time period based on unavailable state funds. During program suspension disposition of applications shall be made pursuant to 8.106.110.16 NMAC.

(1) Payment of assistance: There shall be no payment to the GA recipient during the designated suspension period and any right to the payment is lost. Retroactive payments for pending applicants shall be authorized for months prior to a designated suspension period.

(2) Notice to recipient and applicant: No later than 60 days prior to the effective change the HCA shall provide GA recipients appropriate notice regarding suspension or restoration of the grant based on the availability of state funds. The notice shall include the citation to the state statute and regulation and fair hearing rights.

D. Public notice: The HCA shall issue a public notice 60 days prior to the changes made based on the availability of state funds in Subsections A - C above. Public notice shall include effective date of change and

right to fair hearing consistent with mass change requirements at 8.100.180.15 NMAC.
[8.106.630.11 NMAC - N, 07/01/2004; 8.106.630.11 NMAC - N, 12/01/2009]

8.106.630.12 LATE REPORTING OF CHANGES

A. If the benefit group failed to timely report a change, the caseworker shall verify the change to determine whether the benefit group received benefits to which it was not entitled (an overpayment).

B. Failure to report changes: Failure to report any change in a timely manner may result in an underpayment or an overpayment to the benefit group.

(1) The caseworker shall establish a claim against the benefit group for any month in which the benefit group was overpaid benefits.

(2) If the establishment of an overpayment is made within the certification period, the benefit group is entitled to a notice of adverse action that its benefits will be reduced due to the overpayment.

(3) No claim shall be established because of a change in circumstances that a benefit group is not required to report.

C. Good cause for failure to report a required change:

(1) If a required change is not reported timely, good cause for not reporting on time is considered to exist if the recipient can show, with appropriate documentation, that the recipient was prevented from reporting by a health problem, including illness, or death of an immediate family member during the time period the individual was required to report.

(2) The health problem or death of an immediate family member must have been of such severity and duration as to effectively prevent the timely reporting by the head of household or unrelated caretaker. The head of household or unrelated caretaker must provide proof of the existence of the health problem and explain exactly how it prevented the recipient from reporting the information to the ISD office.

(3) The determination of good cause shall be made by the caseworker, subject to the review and approval of the county director or the county director's designee.
[8.106.630.12 NMAC - Rn, 8.106.630.11 NMAC, 12/01/2009]

History of 8.106.630 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 631 HEAT AND EAT PROGRAM

8.106.631.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.631.1 NMAC - N, 11/1/2020; A, 7/1/2024]

8.106.631.2 SCOPE: This rule applies to the general public.
[8.106.631.2 NMAC - N, 11/1/2020]

8.106.631.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.631.3 NMAC - N, 11/1/2020 ; A, 7/1/2024]

8.106.631.4 DURATION: Permanent.
[8.106.631.4 NMAC - N, 11/1/2020]

8.106.631.5 EFFECTIVE DATE: November 1, 2020, unless a later date is cited at the end of a section.
[8.106.631.5 NMAC - N, 11/1/2020]

8.106.631.6 OBJECTIVE: The objective of the New Mexico heat and eat program is to provide households with a cash payment to assist with energy expenses to households that do not pay heating or cooling expenses and do not receive LIHEAP but have an identifiable shelter cost. Payments are credited to recipients through a state managed fund. In addition to the energy assistance payment households who received this payment will see an increase in their deduction amount used to determine their SNAP benefit allotment.
[8.106.631.6 NMAC - N, 11/1/2020]

8. 106.631.7 DEFINITIONS: [RESERVED]
[8.106.631.7 NMAC - N, 11/1/2020]

8. 106.631.8 PROGRAM ELIGIBILTY: Benefits shall be processed annually at the beginning of the federal fiscal year dependent on the availability of funding.

A. Limited to current SNAP recipients: No application is needed for an individual or groups of individuals who reside together that do not pay separate heating or cooling costs and do not receive the heating and cooling standard utility allowance (HCSUA).

B. Household: Eligible household include those who:

(1) are receiving SNAP after being determined eligible as outlined in 8.139.110 NMAC;

(2) have gross income less than one hundred sixty-five percent of the poverty level; and

(3) do not pay for any heating or cooling expenses, including the payment of a fee to use an air conditioner; and

(4) are not receiving the maximum SNAP benefit; and

(5) have an identifiable shelter cost.

C. Eligible households: will receive the HCSUA is accordance with 8.139.510.11NMAC.
[8.106.631.8 NMAC - N, 11/1/2020]

8. 106.631.9 BENEFIT DELIVERY:

A. Effective date: At the beginning of every federal fiscal year, October 1, a one-time energy assistance cash payment will be issued to eligible households as defined in Subsection A of 8.106.631.9 NMAC.

B. Benefit issuance: Heat and eat benefits are issued through a direct deposit into a household's EBT account. EBT cards are issued and maintained as defined at 8.139.610 NMAC. A heat and eat participating household has a definite issuance date so that benefits are received on or about the same time annually.

C. Benefit amount: Dependent on the availability of state general fund a cash payment of no less than $20 will be issued.

D. Eligible uses for benefit: This cash benefit is intended to help the household meet their heating or cooling needs. Please refer to 8.106.610.8 NMAC for uses of cash benefit.
[8.106.631.9 NMAC - N, 10/1/2020]

8. 106.631.10 RECOUPMENT: If the benefit is not used by the end of the federal fiscal year that the benefits was issued, September 30, the benefit will be recouped from the participant's EBT card and placed back into the state general fund.
[8.106.631.10 NMAC - N, 11/1/2020]

HISTORY OF 8. 106.631NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 119 REFUGEE RESETTLEMENT PROGRAM
PART 100 RECIPIENT POLICIES-DEFINITIONS AND ACRONYMS

8.119.100.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.119.100.1 NMAC - N, 11/01/2013; A, 7/1/2024]

8.119.100.2 SCOPE: The rule applies to the general public.
[8.119.100.2 NMAC - N, 11/01/2013]

8.119.100.3 STATUTORY AUTHORITY:

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

B. In accordance with authority granted to the health care authority by Subsection J of Section 27-1-3 NMSA 1978, and pursuant to Executive Order No. 80-62, dated 10/01/81, the governor of the state of New Mexico has designated the health care authority (HCA) as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.119.100.3 NMAC - N, 11/01/2013; A, 7/1/2024]

8.119.100.4 DURATION: Permanent
[8.119.100.4 NMAC - N, 11/01/2013]

8.119.100.5 EFFECTIVE DATE: November 1, 2013, unless a later date is cited at the end of a section.
[8.119.100.5 NMAC - N, 11/01/2013]

8.119.100.6 OBJECTIVE: The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance, while supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsor(s) and national voluntary agencies (VOLAGs) work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).
[8.119.100.6 NMAC - N, 11/01/2013]

8.119.100.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) Application: means a written request for assistance, on the appropriate ISD form, signed by or on behalf of an individual or family.

(2) Asylee: means an individual who while in the U.S. is granted permanent residence under Section 208 of the Immigration and Nationality Act (INA) and is unable or unwilling to return to their country of origin because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.

(3) Asylee applicant: means an individual who has applied for, but not yet received, asylum in the U.S. and who is therefore ineligible for the RRP.

(4) Authorized representative: means a person aged 18 years or older who is designated, in writing, by the applicant and is sufficiently knowledgeable about the applicant/benefit group's circumstances to complete the application form correctly and represent the benefit group.

B. Definitions beginning with "B": **Benefit group:** means an individual or group of individuals authorized to receive cash assistance financed by federal or state funds.

C. Definitions beginning with "C":

(1) Case management services: means the determination of appropriate service(s) to refer a refugee, referral to such services(s), and tracking of the refugee's participation in such services(s).

(2) Conditional entrant: means an individual who was admitted to the U.S. under Section 203(a)(7) of the INA.

(3) Cuban/Haitian entrant: means a citizen of Cuba or Haiti who is admitted to the U.S. under section 212(d)(5) of the INA.

D. Definitions beginning with "D":

(1) Date of entry: means the date established by the department of homeland security as the date a refugee or Cuban/Haitian entrant was lawfully admitted to the U.S. for permanent residence. For asylees it means the date on which asylum was granted.

(2) Documentation of immigration status: means documents issued to the individual by DHS or USCIS that identifies the individual's lawful immigration status. The documentation provided by an individual is copied for the case file.

E. Definitions beginning with "E":

(1) Earned income: means cash or payments in-kind that are received as wages from employment or payment in lieu of wages; and earnings from self-employment or earnings acquired from direct provision of services, goods or property, production of goods, management of property or supervision of services.

(2) Economic self-sufficiency: means the ability of a refugee to meet their basic needs without the need for cash assistance.

(3) Employability plan: means an individualized written plan for a refugee, registered for employment services, that sets forth a program of services intended to achieve the earliest possible employment of the refugee.

(4) Employability services: means services designed to enable an individual to attain employment and to improve the work skills of the individual.

F. Definitions beginning with "F": Form I-94: means the white arrival/departure card issued by the department of homeland security to each non-citizen entering the U.S. which identifies the date of entry and the immigration status granted to that person.

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

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

I. Definitions beginning with "I":

(1) Individualized employability plan (IEP): means a written plan, developed by the refugee and the case manager, or the actions to be taken by an employable refugee to achieve employment and economic self-sufficiency.

(2) Institution of higher education: means any educational institution which normally requires a high school diploma or equivalency certificate for enrollment, including but not limited to colleges, universities, and vocational or technical schools at the post-high school level.

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

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

L. Definitions beginning with "L":

(1) Local affiliate: means a not-for-profit agency that is affiliated with a national voluntary agency (VOLAG) and has been approved by the U.S. department of state to conduct a refugee resettlement program.

(2) Local resettlement agency: means a local affiliate of a VOLAG that has entered into a grant, contract, or cooperative agreement with the U.S. department of state to provide initial reception and placement services to refugees.

(3) Local sponsor: means an individual, church, or civic organization that has agreed to assist a refugee to resettle in a specific community.

M. Definitions beginning with "M":

(1) Match grant: means a program sponsored by the office of refugee resettlement (ORR) that provided matching funds to voluntary agencies and local affiliates to provide cash assistance and services to refugees for no more than six months after their lawful arrival in the U.S.

(2) Medicaid: means medical assistance under Title XIX of the Social Security Act, as amended.

(3) Minor unmarried parent: means an unmarried parent, who is under the age of 18

years, or is age 18 and enrolled in high school.

N. Definitions beginning with "N":

(1) National voluntary agency (VOLAG): means one of the national resettlement agencies that has entered into a contract, or cooperative agreement with the U.S. department of state or other federal agency to provide for the resettlement of refugees and to oversee the work of a national network or local affiliates.

(2) New Mexico works: means the federally funded temporary assistance for needy families (TANF) program that carries a 60 month term limit for adults in the state of New Mexico and requires participation in a variety of job search and skill development activities to maintain eligibility.

(3) Non-citizen: means an individual residing in the U.S. who does not hold U.S. citizenship.

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

P. Definitions beginning with "P": Payment: means the amount of the cash assistance benefit.

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

R. Definitions beginning with "R":

(1) Reception and placement grant: means a grant provided by the U.S. department of state or U.S. department of justice that is intended to assist refugees to meet their basic needs during the first 30 to 90 days after admission to the U.S.

(2) Recipient: means a person receiving cash assistance benefits.

(3) Refugee: means any person who is admitted into the U.S. under Section 207 of the INA and is unable or unwilling to return to their country of origin because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.

(4) Resources: means tangible assets and property owned by the applicant with the exception of assets and property in the refugee's country of origin and assets and property given to the refugee as part of the reception and placement program.

(5) Refugee cash assistance (RCA): means a one hundred percent federally funded cash assistance program for non-TANF, non-SSI, eligible needy refugees during their first 12 months in the U.S.

(6) Refugee medical assistance (RMA): means a one hundred percent federally funded medical assistance program for non-Medicaid eligible needy refugees during their first 12 in the U.S.

S. Definitions beginning with "S":

(1) Secondary migrant: means a refugee who was initially resettled in another state but who has relocated their residence to New Mexico.

(2) Spend down: means to deduct incurred medical expenses from countable income, thereby lowering the amount of countable income to a level that may meet the financial eligibility standard.

(3) Standard of deed: means a maximum cash benefit amount that is based on federal regulation for TANF standard of need.

(4) Supplemental security income (SSI): means monthly cash payments to income eligible persons over the age of 65 or who are determined to be disabled under the authority of Title XVI of the Social Security Act.

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

U. Definitions beginning with "U": **Unearned income:** means income from one of these sources: old age, survivors and disability insurance payments (social security); railroad retirement benefits; veteran's administration compensation or pension payments; military retirement and allotments; pensions, annuities and retirement benefits; lodge or fraternal benefits; other public or private disability or retirement benefits or pensions; shared shelter payments; individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income.

V. Definitions beginning with "V": Victim of human trafficking: means an individual who has received certification from ORR as a victim of human trafficking.

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

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

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

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

[8.119.100.7 NMAC - N, 11/01/2013; A, 11/1/2022]

8.119.100.8 ABBREVIATIONS AND ACRONYMS:

A. **AFDC:** aid to families with dependent children
B. **DHS:** (U.S) department of homeland security
C. **DOJ:** (U.S.) department of justice
D. **DOS:** (U.S.) department of state
E. **DWS:** department of workforce solutions
F. **EID:** earned income disregard
G. **HCA:** health care authority
H. **HHS:** (U.S.) department of health and human services
I. **ICE:** (U.S.) immigration and customs enforcement
J. **IEP:** individual employability plan
K. **INA:** Immigration and Nationality Act
L. **IRU:** incapacity review unit
M. **ISD:** income support division
N. **MAD:** medical assistance division
O. **NMDWS:** New Mexico department of workforce solutions
P. **NMW:** New Mexico works
Q. **ORR:** office of refugee resettlement
R. **RCA:** refugee cash assistance
S. **RMA:** refugee medical assistance
T. **RRP:** refugee resettlement program
U. **RSS:** refugee social services
V. **SSI:** supplemental security income
W. **TANF:** temporary assistance for needy families
X. **USCIS:** (U.S.) citizenship and immigration service
Y. **VOLAG:** national voluntary agency

[8.119.100.8 NMAC - N, 11/01/2013]

HISTORY OF 8.119.100 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 410 GENERAL RECIPIENT REQUIREMENTS - NONFINANCIAL ELIGIBILITY CRITERIA

8.139.410.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.410.1 NMAC - Rp, 8.139.410.1 NMAC, 11/1/2023; A, 7/1/2024]

8.139.410.2 SCOPE: General public.
[8.139.410.2 NMAC - Rp, 8.139.410.2 NMAC, 11/1/2023]

8.139.410.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.410.3 NMAC - Rp, 8.139.410.3 NMAC, 11/1/2023; A, 7/1/2024]

8.139.410.4 DURATION: Permanent.
[8.139.410.4 NMAC - Rp, 8.139.410.4 NMAC, 11/1/2023]

8.139.410.5 EFFECTIVE DATE: November 1, 2023, unless a later date is cited at the end of a section.
[8.139.410.5 NMAC - Rp, 8.139.410.5 NMAC, 11/1/2023]

8.139.410.6 OBJECTIVE: Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.
[8.139.410.6 NMAC - Rp, 8.139.410.6 NMAC, 11/1/2023]

8.139.410.7 DEFINITIONS: [RESERVED]

8.139.410.8 ENUMERATION (SOCIAL SECURITY NUMBER):

A. Requirement: The social security number is required for every individual who receives food stamp benefits. Providing the social security number of a household member is voluntary. However, failure to provide the social security number shall result in the denial of food stamp benefits to the household member.

(1) A household participating in the food stamp program (FSP) must provide the social security number of each household member before certification. An actual social security card is not mandatory to fulfill the verification requirement.

(2) If an individual has more than one number, all numbers must be provided.

(3) If an individual does not have a social security number, or if the household does not know if an individual member has a social security number, the household must apply for a social security number for the individual(s) before certification.

(4) A caseworker shall inform the household where to apply and what information is needed and shall advise the household that proof of application from the social security administration (SSA) office for a social security number is required before certification.

(5) The caseworker shall explain to applicants and participants that refusal or failure to comply, without good cause, shall result in disqualification of the individual household member for whom a social security number has not been provided or obtained.

(6) For a newborn, the household must provide a social security number or proof of application for a social security number at the next recertification or within six months, whichever is later.

B. Validation of social security number:

(1) The caseworker shall record, in the case file and the computer file, the social security number of each household member at certification, recertification, or at any contact with the household. The social security number is validated by the SSA on a periodic basis.

(2) Immediate validation of an individual's social security number is not required for participation in the FSP. Household certification or issuance of food stamp benefits shall not be delayed solely to validate the social security number of a household member.

(3) When a social security number has been validated by the SSA, the caseworker shall make a permanent annotation on the client case file to prevent validation of the social security number in the future.

(4) The caseworker shall offer to:

(a) complete, or help the applicant complete, an application for a social security number, form SS-5.

(b) verify identity, age, and citizenship or non-citizen status, as required by SSA;

(c) forward the SS-5 application to the SSA.

C. Disqualification from food stamps: If a caseworker determines that the household has refused or failed to provide or apply for a social security number without good cause, the individual who does not have a social security number shall be ineligible to participate in the FSP.

(1) Refusal to comply: Refusal to provide or apply for a social security number shall result in the disqualification of the individual for whom a social security number is required. Any remaining household members are eligible to participate in the FSP.

(2) Failure to comply: Individuals who fail, without good cause, to meet the enumeration requirement within the required time period are ineligible. The disqualification applies to an individual(s), not to an entire household. An individual becomes eligible to participate, and the disqualification ends, when the social security number is provided.

(3) Determining good cause: If a household can show good cause why an application has not been completed in a timely manner, the household member without a social security number shall be allowed to participate for one month in addition to the application month. To determine good cause, information from the household member, the social security administration, and HCA records shall be considered. Documentary evidence or collateral information (8.139.100.7 NMAC definitions) that the member has applied for a social security number or has made every effort to provide the social security administration with the information needed to complete an application is considered good cause for not complying timely with this requirement. If a household member applying for a social security number is unable to obtain the documents required by the social security administration, the caseworker shall make every effort to help the household get these documents.

(a) If a household can show good cause why an application for a social security number has not been made in a timely manner, the household member concerned shall be allowed to continue to participate each month that good cause exists.

(b) Good cause does not include delays caused by illness, lack of transportation, or temporary absence, since the SSA provides for the application process to be conducted entirely by mail. A personal interview is not required except for persons age 18 or over who must apply for an original social security number at a local SSA office.

(4) Participation pending notification: When an application for a social security number has been filed, as verified by a receipt of application for a social security number from the social security administration (SSA), an individual shall be permitted to participate in the food stamp program, pending notification by the SSA of the household member's social security number.

(5) Subsequent actions: If the social security number is not verified at recertification for a number already provided or has not been computer-verified in the interim, the caseworker shall disqualify the individual for noncompliance with the enumeration requirement. The caseworker shall have offered to help the individual complete an application for a duplicate social security number. Any household member disqualified for noncompliance with the enumeration requirement becomes eligible upon providing verification of a valid social security number.

D. Resources and income: The resources of a disqualified individual count in their entirety. A pro rata share of the disqualified individual's income shall be considered available to the remaining household members.

E. Use of social security number: HCA is authorized to use social security numbers in the administration of the food stamp program. To the extent determined necessary, HCA may access computer information regarding individual applicants and participants who receive benefits or services under Title XVI of the Social Security Act. The social security number shall be used to prevent duplicate participation, to facilitate mass

changes in federal benefits, and to request and exchange information on individuals through the IEVS and SAVE computer match programs, and the department of labor.
[8.139.410.8 NMAC - Rp, 8.139.410.8 NMAC, 11/1/2023]

8.139.410.9 CITIZENSHIP AND IMMIGRATION STATUS FOR ELIGIBILITY: Participation in SNAP is limited to individuals who live in the United States and who are U.S. citizens or are otherwise eligible per the criteria below. The HCA will determine eligibility for non-citizens in accordance with 7 CFR 273.2 and 7 CFR 273.4. No individual is eligible to participate in SNAP unless that individual is otherwise eligible and is:

A. A U.S. citizen;

B. A U.S. non-citizen national;

C. An individual who is:

(1) a member of Hmong or Laotian tribe during the Vietnam era, when the tribe militarily assisted the U.S.; (including a spouse, surviving spouse, or child of tribe member) who are lawfully present in the U.S.;

(2) an American Indian born in Canada who possesses at least fifty percent of blood of the American Indian race to whom the provisions of section 289 of the Immigration and Nationality Act apply; or a member of an Indian tribe as defined at section 4(e) of 25 U.S.C. 450b(e) which is recognized as eligible for the special programs and services provided by the U.S. to Indians because of their status as Indians; or

(3) a victim of human trafficking and their derivative beneficiaries, in accordance with 7 CFR 273.4(a)(5); or

D. A qualified immigrant meeting the criteria in Subsection D, Paragraph (2) below:

(1) A qualified immigrant is a:

(a) lawful permanent resident;

(b) refugee;

(c) asylee;

(d) person granted withholding of deportation or removal;

(e) conditional entrants, (in effect prior to April 1, 1980);

(f) person paroled into the U.S. for at least one year;

(g) Cuban/Haitian entrants;

(h) battered spouses and children with a pending or approved self-petition for an immigrant visa and whose need for benefits has a substantial connection to the battery or cruelty (including qualified parents, spouses, and children of same), or battered spouses and children with an application for cancellation of removal or suspension of deportation, and whose need for benefits has a substantial connection to the battery or cruelty (including qualified parents, spouses, and children of same).

(2) Qualified immigrants are eligible only if they:

(a) were 65 or older and were lawfully residing in the U.S. on August 22, 1996, or

(b) are under age 18, or

(c) have been in "qualified" immigrant status for at least five years, or

(d) are lawful permanent residents who have worked or can be credited with 40 qualifying quarters of employment, or

(e) were granted refugee or asylum status or withholding of deportation/removal; or

(f) are a Cuban/Haitian entrant, or Amerasian immigrant, or

(g) are receiving blindness or disability-related assistance or

(h) are a veteran, active duty military; or the spouse, or the surviving spouse who has not married, or the child.

(i) are in Iraqi or Afghan special immigrant status.

E. Verification of immigrant status is determined in accordance with 7 CFR 273.2(f) and reasonable opportunity is provided pursuant to 7 CFR 273.2(f)(1)(c).

F. Reporting undocumented non-citizens:

(1) HCA shall inform the local DHS office only when an official determination is made that any individual who is applying for or receives benefits is present in the U.S. in violation of the INA. An official determination that an undocumented immigrant is in the U.S. in violation of the INA is only made when:

(a) the undocumented non-citizen's unlawful presence is a finding of fact or conclusion of law that is made by HCA as part of a formal determination about the individual's eligibility; and

(b) HCA's finding is supported by a determination by DHS or the executive office of immigration review (EOIR) that the non-citizen is unlawfully residing in the US, such as a final order of

deportation.

(2) A systematic alien verification for entitlements (SAVE) response showing no service record on an individual or an immigration status making the individual ineligible for a benefit is not a finding of fact or conclusion of law that the individual is not lawfully present.

(3) Undocumented immigrant status is considered reported when ISD enters the information about the non-citizen into the household's computer file.

(4) When a household indicates inability or unwillingness to provide documentation of immigrant status for any household member, HCA must classify that member as an ineligible immigrant. When a person indicates inability or unwillingness to provide documentation of immigrant status, HCA must classify that person as an ineligible immigrant. In such cases HCA must not continue efforts to obtain that documentation.
[8.139.410.9 NMAC - Rp, 8.139.410.9 NMAC, 11/1/2023]

8.139.410.10 RESIDENCE

A. Households may be an active member in only one SNAP household in any month, with the exception of residents of a domestic violence shelter.

B. Domestic violence shelter: Any individual who is a resident of a domestic violence shelter may participate as a member in more than one SNAP household simultaneously, provided that the shelter resident(s) left a household which contained the abusive individual.

C. Residence duration: No residence duration requirement will be imposed on any household.

D. Fixed residence or mailing address: An otherwise eligible household is not required to live in a permanent dwelling or have a fixed mailing address as a condition of eligibility.

E. Intent to reside: An intention to reside permanently in New Mexico is not required as a condition for participation in SNAP. However, a specific temporary purpose, such as vacationing in New Mexico, does not satisfy the residence requirement.

F. Verification of residency: Verification of residence should, whenever possible, be made in conjunction with the verification of other information. This can be done through such documents as rent receipts, mortgage bills, utility expenses, or identification papers which show the name and address of the applicant. Collateral contacts or other documentary evidence can be accepted to verify residence. Any document or collateral contact which reasonably establishes the household's residence must be accepted. No requirement for a specific type of verification may be imposed.

G. Lack of verification in unusual cases: The residence requirement will be verified, except in unusual circumstances, such as homeless households, some migrant farmworker households, where verification of residence cannot reasonably be accomplished.
[8.139.410.10 NMAC - Rp, 8.139.410.10 NMAC, 11/1/2023]

8.139.410.11 NONCONCURRENT RECEIPT OF ASSISTANCE (DUAL PARTICIPATION)

A. In no event may an individual receive food stamp benefits in more than one household in the state of New Mexico in the same month, with the exception of women and children in battered women's shelters (Subsection B of 8.139.410.10 NMAC). In addition, an individual may not receive food stamp benefits in the state of New Mexico and any other state, or the territories of Guam, the Virgin Islands, or Puerto Rico, in the same month. An individual or household participating in a commodity distribution program administered by any Indian tribal organization (ITO) on an Indian reservation is not eligible to receive food stamp benefits in the same month that commodities are received. A household need not be living on the Indian reservation to participate in an Indian tribal commodities program. If an ISS determines that an individual or household has received food stamp benefits to which it was not entitled because of dual participation, a claim will be filed for any month in which there was an over-issuance of food stamp benefits.

B. Disqualification for receipt of multiple benefits: A finding that an individual has received multiple food stamp benefits simultaneously as a result of an administrative disqualification hearing and IPV, or a conviction in federal or state court, will result in a 10 year disqualification period. The income and resources of the disqualified individual will continue to count in their entirety to the household while the individual remains in the home.
[8.139.410.11 NMAC - Rp, 8.139.410.11 NMAC, 11/1/2023]

8.139.410.12 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) GENERAL WORK REQUIREMENTS: Any SNAP recipient may be subject to general work requirements. SNAP recipients who do not meet a federal exemption must meet the general work requirements in accordance with Subsection C of this

section. Federal exemptions from general work requirements are found at 7 Code of Federal Regulation (CFR) 273.7(a)(6) and (b).

A. General Work requirements: ISD will administer the general work requirements in accordance with 7 CFR 273.7. As a condition of eligibility for participation in SNAP, every household member who does not qualify for a federal exemption, must meet general work requirements as outlined in Subsection C of this section.

B. General work requirement exemptions: Federal exemptions from general work requirements are found at 7 CFR 273.7(a)(6) and 273.7(b). Physical and mental unfitness for the federal exemption is defined as an individual who has a mental or physical illness or disability, temporary or permanent, which reduces their ability to financially support themselves. Unfitness can be:

(1) obvious to ISD and documented in the case file; or

(2) not obvious to ISD, but is documented by a physician, physician's assistant, nurse, nurse practitioner, a licensed or certified psychiatrist or a licensed or certified psychologist, or social worker as being unfit to work; the claim of physical or mental unfitness must be substantiated by written documentation identifying the physical or mental condition and certifying that the person is unfit for employment.

C. Compliance with general work requirements: An individual who is not temporarily waived or exempt in accordance with 7 CFR 273.7(a)(6) and (b) must:

(1) register for work at the time of application and every 12 months thereafter; all SNAP participants are considered registered for work with the head of household's signature on an application or recertification form for SNAP participation;

(2) participate in an E&T program to the extent required by law;

(3) participate in a workfare program if assigned by the HCA;

(4) provide ISD or E&T program service provider with information regarding employment status, participation in E&T program status, or availability for work;

(5) report to an employer referred to by ISD or its designee if the potential employment meets the suitability requirements in accordance with 7 CFR 273.7(h);

(6) accept a bona fide offer of suitable employment at a site or plant not subject to a strike or lockout, at a wage equal to the higher of the federal or state minimum wage or eighty percent of the wage that would have governed had the minimum hourly rate of the Fair Labor Standards Act been applicable to the offer of employment; and

(7) not voluntarily and without good cause quit a job of 30 or more hours a week or reduce work effort to less than 30 hours a week within the 30 day period prior to the household's application date, or any time after filing an application, or any time during the household's certification period in accordance with 7 CFR 273.7(a)(vii).

D. Failure to comply with SNAP general work requirements: An individual who is not exempt who refuses or fails without good cause, to comply with the SNAP general work requirements is ineligible to participate in SNAP, and will be considered an ineligible household member, in accordance with 7 CFR 273.1(b)(7). Prior to placing a disqualification for noncompliance with the work requirements, good cause will be determined in accordance with 7 CFR 273.7(i). When determining whether or not good cause applies to voluntary quit, voluntary quit will be evaluated up to the 30 day period prior to applying for SNAP benefits and at any time thereafter. Within 10 calendar days of establishing that the noncompliance was without good cause, ISD must provide the individual with a notice of adverse action, as specified in 7 CFR 273.13. A participant who corrects the failure of compliance during the notice of adverse action 13-day time period shall not have the disqualification imposed against the household member.

(1) Consequences of non-compliance with work requirements will be in accordance with 7 CFR 273.7(f).

(a) For the first occurrence of noncompliance, the individual will be disqualified for three months;

(b) For the second occurrence of noncompliance, the individual will be disqualified for six months; and

(c) For the third or subsequent occurrence of noncompliance, the individual will be disqualified for 12 months.

(2) Treatment of income and resources: All the income and resources of an individual disqualified for non-compliance with general work requirements will be counted to determine the household's income and resource maximum levels and benefit amount in accordance with 8.139.520 NMAC.

(3) Households shall not be considered categorically eligible if any benefit group member is disqualified for failure to comply with general work requirements in accordance with 8.139.420.8 NMAC.

E. **Fair hearings:** Each individual or household has the right to request a fair hearing to appeal a denial, reduction or termination of benefits due to a determination of nonexempt status or a state agency determination of failure to comply with SNAP work requirements, in accordance with 7 CFR 273.7(f)(6).
[8.139.410.12 NMAC - Rp, 8.139.410.12 NMAC, 11/1/2023]

8.139.410.13 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) EMPLOYMENT AND TRAINING PROGRAM (E&T): ISD will administer the E&T program requirements in accordance with 7 CFR 273.7(e). SNAP participants may choose to voluntarily participate in any of the E&T services available. Volunteers can participate to the extent that they wish and will not be subject to any E&T disqualification. Participants who incur expenses that are reasonably necessary and directly related to participation in the E&T program will be reimbursed up to the monthly limit as determined by ISD, in accordance with 7 CFR 273.7(d)(4).
[8.139.410.13 NMAC - Rp, 8.139.410.13 NMAC, 11/1/2023]

8.139.410.14 REQUIREMENTS FOR ABLE BODIED ADULTS: ISD will administer this program in accordance with 7 Code of Federal Regulation (CFR) 273.24. This program is referred to as the time limit rule or the able bodied adults without dependents ("ABAWD") program. The program is mandatory at all times unless there is a federally approved statewide waiver in place in accordance with 7 CFR 273.24(f). A statewide waiver makes the program non-mandatory for all ABAWDs who would otherwise be subject to the three month time limit requirement. When a statewide waiver is not in place, ABAWDs are mandatory for all requirements as detailed below. ISD will inform all potential ABAWD households of the ABAWD time limit prior to the expiration of a statewide waiver. ISD will use a fixed 36 month period for measurement and tracking purposes beginning June 1, 2017 through May 31, 2020, and every subsequent fixed three year period.

A. The age limit standards for individuals who are subject to the ABAWD work requirement.

Age Limit	Date ends
18-49	September 5th 2023
18-50	September 30th 2023
18-52	September 30th 2024
18-54	September 30th 2025

B. **Able bodied adults can comply by:** working 20 hours per week, averaged monthly; for purposes of this provision, 20 hours per week averaged monthly means 80 hours per month; work is defined as:

(1) work in exchange for money;

(2) work in exchange for goods or services ("in kind" work); or

(3) unpaid work, which includes work without compensation that gives a person experience in a job or industry, tests a person's job skills, or involves volunteer time and effort to a not-for-profit organization.

C. **Good cause:** As determined by ISD, if an individual would have worked an average of 20 hours per week but missed some work for good cause, the individual shall be considered to have met the work requirement if the absence from work is temporary. Good cause shall include circumstances beyond the individual's control, such as, but not limited to, illness, illness of another household member requiring the presence of the member, a household emergency, or the unavailability of transportation.

D. **Waived from the time limit requirements:** ISD will waive the three month time limit requirement for the following individuals in accordance with 7 CFR 273.24(f):

(1) any individual residing in or relocating to a county that has an unemployment rate twenty percent above the national average as defined by ISD;

(2) any individual residing in or relocating to pueblos, tribes, and nations, with an estimated employment to population ratio as a measure for insufficient job availability as determined by ISD.

E. Able bodied adults who are determined to be ineligible for SNAP benefits because of non-compliance with the time limit requirements can regain eligibility in accordance with 7 CFR 273.24(d)(i), (d)(ii), (d)(iii), or (d)(v).

F. **Exceptions to the three month time limit**:

(1) Exceptions to the three month time limit required participation are found at 7 CFR 273.24(c).

(2) Physical and mental unfitness for the three month time limit requirements exception is defined as an individual who has a mental or physical illness or disability, temporary or permanent, which reduces their ability to financially support themselves.

(a) unfitness can be obvious to ISD and documented in the case file; or

(b) not obvious, but is documented by a physician, physician's assistant, nurse,

nurse practitioner, a licensed or certified psychiatrist or a licensed or certified psychologist or social worker as being unfit to work; this claim of physical or mental unfitness must be substantiated by written documentation identifying the physical or mental condition and certifying that the person is unfit for employment.

(3) Individuals who are homeless as outlined at Subsection A of 8.139.100.7 NMAC.

(4) Individuals who are Veterans.

(5) Individuals 24 years of age or younger who were in foster care under the responsibility of the state through the maximum age permitted by the state.

G. ISD will administer the eight percent exemptions, as allowed by the food and nutrition service (FNS) and as determined by ISD, in accordance with 7 CFR 273.24(g).

[8.139.410.13 NMAC - Rp, 8.139.410.13 NMAC, 11/1/2023]

HISTORY OF 8.139.410 NMAC:

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

ISD 430.0000, Certification of Eligible Households, 8/8/1980.
ISD-Rule 422.0000, Food Assistance - Residency, 11/4/1982.
ISD-Rule 422.0000, Residency, 2/9/1983.
ISD-Rule 422.0000, Residency, 8/13/1986.
ISD-Rule 423.0000, Food Assistance - Social Security Enumeration, 11/4/1982.
ISD-Rule 423.0000, Social Security Enumeration, 2/4/1983.
ISD-Rule 423.0000, Social Security Enumeration, 4/7/1983.
ISD-Rule 423.0000, Social Security Enumeration, 5/3/1984.
ISD Rule 423.0000, Food Assistance - Social Security Enumeration, 7/22/1987.
ISD-Rule 426.0000, Food Assistance - Citizenship and Alien Status, 11/4/1982.
ISD-Rule 426.0000, Citizenship and Alien Status, 2/11/1983.
ISD-Rule 426.0000, Citizenship and Alien Status, 4/2/1983.
ISD FS 310, Food Stamp Nonfinancial Eligibility Criteria, 2/29/1988.

History of Repealed Material:

8.139.410 NMAC, Food Stamp Program - Food Stamp Program/Income And Resources Excluded By Federal Law filed 6/10/1998 repealed effective 11/1/2023.

Other: 8.139.410 NMAC, Food Stamp Program - Food Stamp Program/Income And Resources Excluded By Federal Law filed 6/10/1998 Replaced 8.139.410 NMAC, Food Stamp Program - Food Stamp Program/Income And Resources Excluded By Federal Law effective 11/1/2023.

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 501 TRANSITIONAL FOOD STAMP BENEFIT ELIGIBILITY

8.139.501.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.501.1 NMAC - N, 09/01/2003; A, 7/1/2024]

8.139.501.2 SCOPE: General public
[8.139.501.2 NMAC - N, 09/01/2003]

8.139.501.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA 1978. Administration of the health care authority (HCA) including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.501.3 NMAC - N, 09/01/2003; A, 7/1/2024]

8.139.501.4 DURATION: Permanent
[8.139.501.4 NMAC - N, 09/01/2003]

8.139.501.5 EFFECTIVE DATE: September 1, 2003, unless a later date is cited at the end of a section.
[8.139.501.5 NMAC - N, 09/01/2003; A, 09/01/2017]

8.139.501.6 OBJECTIVE: The objective of transitional food stamp benefit assistance is to maximize the food purchasing power for and assist in the transition of TANF households that also receive food stamp benefits when the TANF household faces termination of cash assistance benefits. Transitional food stamp benefit assistance is authorized by the Farm Security and Rural Investment Act of 2002, also known as the "Farm Bill, at Title IV, Section 4115.
[8.139.501.6 NMAC - N, 09/01/2003]

8.139.501.7 DEFINITIONS: [RESERVED]
[8.139.501.7 NMAC - N, 09/01/2003]

8.139.501.8 TRANSITIONAL FOOD STAMP BENEFITS:

A. Requirement: Transitional food stamp (TFS) benefits shall be extended to households that receive food stamp benefits and also receiving payments from one of the following cash assistance programs:

(1) TANF; or
(2) New Mexico education works; or
(3) transition bonus program; or
(4) GA dependent child program

B. Conditions: Transitional food stamp benefits shall be extended to a household receiving food stamp benefits under the following conditions:

(1) cash assistance payments for any of the cash assistance programs listed above will be terminated; and

(2) the household received food stamp benefits in the same month the determination is made that the cash assistance payment will be terminated.

C. Extending transitional food stamp benefits: A food stamp household shall be eligible for TFS if the household meets any one of the following conditions:

(1) Gross income exceeds the cash assistance limit: The cash assistance payment is terminated because the benefit group's gross income exceeds the gross income limit for the size of the benefit group.

(2) Net income exceeds the cash assistance limit: The cash assistance payment is terminated because the benefit group's net income exceeds the net income limit for the size of the cash assistance benefit group.

(3) Cash assistance ineligibility at recertification: The cash assistance payment is terminated at recertification, and after the interview, because the benefit group is determined to be ineligible to continue receiving cash assistance or the benefit group chooses not to continue receiving cash assistance for any reason.

(4) Same certification period end date: The food stamp and the cash assistance certification period end dates are in the same month and the benefit group chooses not to continue with the cash assistance recertification process for any reason.

(5) No dependent children: The cash assistance payment is terminated because there are no longer any eligible dependent children in the cash assistance benefit group.

(6) 60-month term limit: The cash assistance payment is terminated because at least one adult in the TANF benefit group has reached the TANF 60-month term limit for receipt of cash assistance, the 18-month time limit for the transition bonus program, or the EWP term limit.

(7) TANF hardship extension ends: The TANF cash assistance payment is terminated because the hardship extension of TANF cash assistance ends.

(8) Term limit appeal status: The cash assistance benefit group has appealed the termination of cash assistance due to the term limit and the benefits are terminated because the hearing decision is in favor of the HCA.

(9) Wage subsidy program participation: The TANF cash assistance payment is terminated because the benefit group has been accepted into the wage subsidy program pursuant to 8.102.460.19 NMAC.

(10) Head of household requests closure of cash assistance case: The head of household requests closure of the cash assistance case in writing, as long as the benefit group continues to reside in New Mexico.

D. Households not eligible for TFS: Certain food stamp households shall not be extended TFS if at the time the TANF cash assistance payment is terminated:

(1) a TANF benefit group is in sanction status at the third sanction level because a TANF benefit group member has failed to comply with work requirements, child support enforcement or reporting requirements;

(2) a TANF benefit group is in sanction status at the first or second sanction level because a TANF benefit group member has failed to comply with work requirements, child support enforcement or reporting requirements;

(3) a TANF benefit group's payment is terminated because the only dependent child in the benefit group is not in compliance with school attendance requirements;

(4) a food stamp household contains an individual who is disqualified due to a failure of the individual to comply with employment and training work requirements.

[8.139.501.8 NMAC - N, 09/01/2003; A/E, 10/15/2008]

8.139.501.9 TRANSITIONAL BENEFIT PERIOD:

A. Determining the transitional benefit period: The transitional benefit period shall be determined prospectively. TFS shall be issued for five months beginning in the month after the final cash assistance payment is received.

B. Continuing the transitional benefit period: The five-month transitional benefit period shall continue even if:

(1) the food stamp household's certification period expires during the transitional benefit period; or

(2) the household's certification period exceeds 12 months.

C. Expiration of the transitional benefit period: The TFS household's new certification period shall expire in the fifth month of the transitional benefit period.

[8.139.501.9 NMAC - N, 09/01/2003; A/E, 10/15/2008]

8.139.501.10 DETERMINING THE TRANSITIONAL FOOD STAMP BENEFIT AMOUNT:

A. Calculating the TFS benefit amount: The TFS benefit amount for the transitional benefit period shall be determined by continuing to count:

(1) all the earned income that was used to calculate the food stamp benefit amount, except that any new income that caused the cash assistance to be terminated shall be excluded; and

(2) all the unearned income that was used to calculate the food stamp benefit amount, except that the TANF cash assistance payment shall be excluded.

B. Changes to the TFS benefit amount: Once the TFS benefit amount has been determined, the amount shall be issued for the five-month transitional benefit period unless:

(1) the TFS household chooses to change the TFS benefit amount or end the transitional benefit period by submitting an application for recertification; or

(2) the TFS amount is adjusted as a result of a change reported by the TFS household subject to Subsection C of 8.139.501.11 NMAC.

[8.139.501.10 NMAC - N, 09/01/2003; A/E, 10/15/2008]

8.139.501.11 REPORTING REQUIREMENTS DURING THE TRANSITIONAL BENEFIT PERIOD:

A. Suspending reporting requirements for TFS households: ISD will suspend all reporting requirements during the TFS household's transitional benefit period.

B. Requirement to provide the TFS household with change reporting information during the transitional benefit period:

(1) A SNAP household that becomes eligible for TFS benefits shall be advised that a change in address should be reported in order to ensure that the household continues to receive notices or other mail from the HCA during the transitional benefit period.

(2) A SNAP household that becomes eligible for TFS benefits shall be advised that the household is not required to report any changes in the household's circumstances during the transitional benefit period.

(3) A TFS household shall be advised that the household may file an application for recertification during the transitional benefit period if a change has occurred that will most likely increase the household's SNAP benefit amount, such as, but not limited to the addition of a new household member with no income of their own or the loss of income for a household member.

C. Action on reported changes: Action shall be taken to adjust the TFS benefit amount during the transitional benefit period without requiring an application for recertification only under the following conditions:

(1) a member of the TFS household files an application for SNAP benefits on their own behalf; or

(2) a newborn child is added to the TFS household.

D. Requirement to file an application for recertification: A TFS household that reports a change, other than an address change or those in Subsection C above, during the transitional benefit period shall be required to file an application for recertification of eligibility.

[8.139.501.11 NMAC - N, 09/01/2003: A/E, 10/15/2008; A, 09/01/2017]

8.139.501.12 CONTINUING SNAP AFTER THE TRANSITIONAL BENEFIT PERIOD:

A. A household receiving TFS shall be recertified using the recertification requirements at 7 CFR 273.14(b) to determine if they can continue receiving a SNAP benefit after the transitional period. The recertification requirements shall inform the TFS household of the expiration of the transitional benefit period and the need to reapply in the fifth month of the transitional benefit period in order to determine the household's eligibility to continue participation in the SNAP program.

B. A TFS household shall be required to file an application for recertification and to complete the recertification process in the fifth month of the transitional benefit period to determine continued eligibility to participate in SNAP.

(1) If otherwise eligible, the SNAP household shall be assigned a new certification period beginning the month following the expiration of the transitional benefit period.

(2) A household that fails to file an application or to complete the application process in the fifth month of the transitional benefit period shall lose eligibility to continue participation in SNAP.

[8.139.501.12 NMAC - N, 09/01/2003; A, 09/01/2017]

8.139.501.13 TERMINATING TRANSITIONAL FOOD STAMP BENEFITS: The TFS benefit shall be terminated if the food stamp household:

A. files an application for recertification at the end of the transitional benefit period and is either approved for a new certification period or denied continued food stamp benefits;

B. files an application for recertification during the transitional benefit period in order to change the food stamp benefit amount;

C. requests closure of the food stamp case in writing;
D. files an application for cash assistance and is approved for a new certification period; or
E. moves out of state.

[8.139.501.13 NMAC - N, 09/01/2003; A/E, 10/15/2008]

HISTORY OF 8.139.501 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 502 STATE FOOD STAMP SUPPLEMENT

8.139.502.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.502.1 NMAC - N, 8/30/2007; A, 7/1/2024]

8.139.502.2 SCOPE: General public.
[8.139.502.2 NMAC - N, 08/30/2007]

8.139.502.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.502.3 NMAC - N, 8/30/2007; A, 7/1/2024]

8.139.502.4 DURATION: Permanent.
[8.139.502.4 NMAC - N, 08/30/2007]

8.139.502.5 EFFECTIVE DATE: August 30, 2007, unless a later date is cited at the end of a section.
[8.139.502.5 NMAC - N, 08/30/2007]

8.139.502.6 OBJECTIVE: The objective of the state food stamp supplement benefit is to reduce hunger and improve nutrition among the elderly or disabled by increasing their ability to purchase food and meet their dietary needs.
[8.139.502.6 NMAC - N, 08/30/2007]

8.139.502.7 DEFINITIONS: [**RESERVED**]

8.139.502.8 STATE SNAP SUPPLEMENT BENEFITS:

A. Purpose: The state SNAP supplement program is aimed at providing the elderly and disabled with increased food purchasing power resulting in better nutrition.

B. Maximum benefit amount: The benefit amount shall be established by the HCA secretary based on available state funds.

C. Eligibility process: The state SNAP supplement shall be determined only for households that meet all eligibility requirements identified in Subsection D of 8.139.502.8 NMAC.

D. Eligibility requirements: The state SNAP supplement benefits shall be subject to all federal SNAP application, eligibility, certification, and reporting requirements. The state SNAP supplement benefits shall be extended only to a household who receives less than the federal minimum benefit allotment. State SNAP supplement benefits shall be provided to a household under the following qualifications and eligibility requirements:

(1) all household members qualify and receive federal SNAP program benefits;

(2) all household members are elderly or disabled as defined in Subsection A of 8.139.100.7 NMAC;

(3) the household does not receive any earned income; and

(4) the household receives a federal SNAP program allotment amount, prior to any claim recoupment, of less than or equal to the federal minimum allotment.

[8.139.502.8 NMAC - N, 08/30/2007; A, 04/15/2009; A, 01/01/2011; A, 03/01/2024]

8.139.502.9 DETERMINING THE BENEFIT:

A. Application: A household shall not be required to submit an application in addition to the application for federal SNAP benefits to qualify or be determined eligible for the state SNAP supplement amount.

B. Eligibility determination: Eligibility shall be determined for a household meeting all eligibility requirements at:

(1) the time of application approval;
(2) the time of recertification;
(3) the month following a reported change which qualifies the household; or
(4) the month following a change that becomes known to the agency in which the change qualifies the household; or
(5) at time of implementation of this program.

C. Calculating the state SNAP supplement amount: A household qualified and eligible for the state SNAP supplement shall receive a state supplement to the federal SNAP allotment amount to an amount that is determined based on the availability of state funds before any recoupments and overpayments have been applied to the benefit amount.

(1) Application month: The state SNAP supplement shall be determined by subtracting the federal FSP benefit amount, after the federal FSP benefit is prorated and prior to any recoupment, from the federal minimum allotment. The state SNAP supplement shall not be prorated.

(2) Ongoing month: The state SNAP supplement shall be determined by subtracting the federal SNAP allotment, prior to any recoupment, from the determined supplement amount.

(3) Eligibility for a prior month:

(a) The state SNAP supplement shall not be provided to a household for a benefit month prior to July, 2007.

(b) A household in which the federal benefit amount is adjusted for a prior month may be eligible for the state SNAP supplement provided the household qualifies and is eligible for the supplement.

(4) Current FSP households: Households which meet the qualifications and eligibility requirements for the state SNAP supplement shall be eligible for the supplement without any action required by the household. The household shall be eligible for a supplement for any month beginning July 2007 and after upon implementation of the program for which the household qualifies.

D. Ineligibility: A household shall become ineligible for the state SNAP supplement if the household does not meet the eligibility requirements specified in 8.139.502.8 NMAC the month following the month the notice of adverse action expires. The household's eligibility for the state SNAP supplement shall be made at the time of:

(1) application approval;
(2) recertification;
(3) a reported change;
(4) a change becomes known to the agency; or
(5) at the time of a mass change.

E. Notice: A household that qualifies and is eligible for SNAP benefits shall be issued notice in accordance with 8.139.110.14 NMAC. A notice of adverse action shall not be considered if the household federal SNAP and state SNAP supplement does not decrease below the federal minimum allotment. A household that qualifies and is eligible for the state SNAP supplement shall be issued a notice for the following circumstances:

(1) Approval: A household shall be issued an approval notice at the time the household is determined eligible for the state SNAP supplement. The approval notice shall identify the amount of the state SNAP supplement.

(2) Benefit change: A household shall be issued a notice at the time the state SNAP supplement is increased or decreased. The amount of benefit is subject to change when the federal SNAP benefit is increased or decreased.

(3) Ineligibility: A household shall be issued a notice when the household no longer qualifies or is eligible for the state SNAP supplement as indicated in Subsection D of 8.139.502.8 NMAC.
[8.139.502.9 NMAC - N, 08/30/2007; A, 04/15/2009; A, 01/01/2011; A, 03/01/2024]

8.139.502.10 BENEFIT ISSUANCE AND DELIVERY:

A. Benefit issuance: The state food stamp supplement benefits are issued at the same time as the federal food stamp benefits, through issuance into a household's electronic benefit transfer (EBT) food stamp account as defined in 8.139.610 NMAC.

B. Expungement: The state food stamp supplement shall be subject to expungement in accordance with 8.139.610.8 NMAC.

C. Issuance and replacement of EBT card: To access and use the state food stamp supplement benefit, the household may use the same EBT card issued for the federal food stamp benefits.

D. Approval notification: Upon approval of the state food stamp supplement benefit, the household

shall be notified of the new food stamp benefit amount and the notice shall be mailed to the applicant as per 8.139.110.14 NMAC.

E. Household use of state food stamp supplement benefits: The household shall only be allowed to use the state food stamp supplement for food purchases in accordance with 8.139.610.11 NMAC.

[8.139.502.10 NMAC - N, 08/30/2007]

8.139.502.11 OVERPAYMENT AND RECOUPMENT:

A. Overpayment: A household that has received the state food stamp supplement benefit and has been determined ineligible or does not qualify for some or all of the state food stamp supplement benefit shall not have a claim established against the household for the state food stamp supplement benefit amount.

B. Recoupment:

(1) The household shall not be required to repay any amount of the state food stamp supplement benefit due to an established claim or overpayment of the federal food stamp benefit.

(2) The household shall remain subject to claim establishment and recoupment for the federal portion of the food stamp benefit in accordance with 8.139.640 NMAC.

(3) The HCA may not recoup any portion of the state food stamp supplement without the household agreeing to the collection.

[8.139.502.11 NMAC - N, 08/30/2007]

HISTORY OF 8.139.502 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 503 NEW MEXICO MODIFIED COMBINED APPLICATION PROJECT

8.139.503.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.503.1 NMAC - N, 06/01/2009; A, 7/1/2024]

8.139.503.2 SCOPE: General public
[8.139.503.2 NMAC - N, 06/01/2009]

8.139.503.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care Authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.503.3 NMAC - N, 06/01/2009 ; A, 7/1/2024]

8.139.503.4 DURATION: Permanent
[8.139.503.4 NMAC - N, 06/01/2009]

8.139.503.5 EFFECTIVE DATE: This pilot program sunsetted effective May 2014.
[8.139.503.5 NMAC - N, 06/01/2009; A, 05/01/2017]
[NMCAP cases that are eligible via the program's parameters remain effective until the end of their three year eligibility. Active NMCAP cases past their three year eligibility via this program will be eligible to apply to receive regular SNAP.]

8.139.503.6 OBJECTIVE: The objective of the New Mexico Modified Combined Application Project (NMCAP) is to increase access to the nutrition benefits offered by the food stamp program among elderly and disabled populations receiving supplemental security income (SSI). The combined application project will increase the ability to purchase food and meet dietary needs. The combined application project for food stamp benefit assistance is authorized by a state demonstration project via a joint partnership with food and nutrition services (FNS) and social security administration (SSA).
[8.139.503.6 NMAC - N, 06/01/2009]

8.139.503.7 DEFINITIONS: [**RESERVED**]

8.139.503.8 PROGRAM ELIGIBILTY: Benefits shall be processed, allotment determined and certification periods assigned based on the waiver guidelines as approved by FNS.
[8.139.503.8 NMAC - N, 06/01/2009]

8.139.503.9 BASIS FOR DEFINING GROUP (HOUSEHOLD COMPOSITION)

A. Household: An applicant can opt to receive NMCAP benefits if the applicant:

(1) receives federal SSI benefits; and

(2) is not institutionalized; and

(3) does not received benefits through the food distribution program on Indian reservations (FDIPR); and

(4) is 22 years of age or older; and

(5) is eligible for separate household status; or

(6) lives with a spouse as defined in Paragraph (31) of Subsection B of 8.139.100.7 NMAC, who also receives SSI benefits; or

(7) is living with others but buys and cooks food separately from others; and

(8) at the time application or recertification for NMCAP the household has no earned income.

B. Verification of information: All information received by the HCA from the SSA data interface will be deemed as true and accurate for purposes of initial verification.
[8.139.503.9 NMAC - N, 06/01/2009; A, 05/01/2012]

8.139.503.10 APPLICATION PROCESS

A. Opt in/out: An applicant can choose to receive benefits through the regular food stamp program if:

(1) combined shelter and utility expenses, as defined at 8.139.520.11 NMAC, are greater than $315; or

(2) out-of-pocket medical expenses, as defined at 8.139.520.11 NMAC, are at least $35 a month.

B. Application requirements: The application at minimum will contain:

(1) the applicant's name, and address;

(2) receipt of income and amount;

(3) amount of applicable deductions, such as shelter and medical; and

(4) must be signed by the applicant or authorized representative.

C. Application filing: Potential NMCAP recipients will receive applications from the HCA based on interface data supplied by SSA. NMCAP applicants also have the right to apply at:

(1) a social security (SSA) office; or

(2) a local ISD county office.

D. Processing standards: Applications are processed by the HCA and notice of disposition is sent to the applicant.

(1) Standard processing: An application shall be processed as soon as possible and the applicant afforded an opportunity to participate no later than 30 days from the date of application.

(2) Expedited processing: In the month of application, NMCAP applicants shall be considered as standard supplemental nutrition assistance program (SNAP) program applicants and may qualify for expedited service.

E. Authorized representatives: The head of the household or the spouse or any other responsible member of the household may designate an individual who is a non-household member to act on its behalf in applying, obtaining or using NMCAP benefits.

(1) The caseworker shall obtain a copy of the household's written authorization for the authorized representative and maintain it in the household's case record. No limit shall be placed on the number of households an authorized representative may represent.

(2) Even if the household member is able to make an application and obtain benefits, the household should be encouraged to name an authorized representative to use the NMCAP benefits in case illness or other circumstances prevent household members from using the benefits themselves.

(3) The authorized representative's identity shall be verified and a copy of the document maintained in the household's case file.
[8.139.503.10 NMAC - N, 06/01/2009; A, 11/01/2013]

8.139.503.11 CASE MANAGEMENT

A. Interviews: NMCAP applicants are not required to see an ISD caseworker or be otherwise subjected to an interview, although additional information or verification may be requested.

B. Certification periods: Eligible households shall be assigned to a 36-month certification period, and with no interim contact.

C. Reporting requirements: All information received by the HCA from the SSA data interface will be deemed as true and accurate for reported changes.

D. Actions on reported changes: NMCAP recipients are subject only to the reporting standards of SSA and all data sent to the HCA monthly. Within 10 days of receipt the HCA shall act on the following changes:

(1) death of a household member;

(2) loss of SSI eligibility;

(3) changes in state residency;

(4) a member of the household's institutional status has changed; or

(5) change in shelter cost.

E. Recertification: NMCAP recipients shall not be subject to an interview to review eligibility at the end of the 36-month certification period. Recipients shall receive notice of expiration and recertification prior to closure. Continued eligibility at recertification will be evaluated based on the submission of a new completed application and information received from SSA. Participants that do not reapply by the end of certification period will be subject to case closure.
[8.139.503.11 NMAC - N, 06/01/2009; A, 05/01/2012; A, 11/01/2013]

8.139.503.12 BENEFIT DELIVERY

A. Effective date: Benefits for the initial month of certification shall be prorated from the date of application according to the standard SNAP program tables at 8.139.500 NMAC.

B. Benefit issuance: NMCAP are issued through a direct deposit into a household's electronic benefit transfer (EBT) account. EBT cards are issued and maintained as defined at 8.139.610 NMAC. An NMCAP participating household has a definite issuance date so that benefits are received on or about the same time each month. The issuance date is based on the last two digits of the social security number of the individual to whom the benefits are issued.

C. Benefit calculation: Benefits are issued based on the household's total monthly shelter costs as defined at Subsection F of 8.139.520.11 NMAC. Benefit amounts shall be subject to review and adjustment in coordination with the regular food stamp program and the cost neutrality study. Monthly NMCAP benefit amounts are based on the following for:

(1) monthly shelter costs equal to or less than $315, the maximum benefit amount is $33; and

(2) monthly shelter costs greater than $315, the maximum benefit amount is $68.
[8.139.503.12 NMAC - N, 06/01/2009; A, 05/01/2012; A/E, 04/01/2013; A, 11/01/2013]

8.139.503.13 OVERPAYMENT AND RECOUPMENT

A. Overpayment: A household that has received NMCAP benefits and has been determined ineligible or does not qualify for some or all of the NMCAP benefit shall have a claim established against the household for the NMCAP benefit amount in accordance with 8.100.640 NMAC.

B. Recoupment:

(1) The household shall be required to repay any amount of the NMCAP benefit due to an established claim or overpayment of the NMCAP benefit.

(2) The household shall remain subject to claim establishment and recoupment for the NMCAP benefit in accordance with 8.100.640 NMAC.
[8.139.503.13 NMAC - N, 05/01/2012; A, 11/01/2013]

HISTORY OF 8.139.503 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 504 NEW MEXICO EXTRA HELP SNAP

8.139.504.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).
[8.139.504.1 NMAC - N, 08/01/2011; A, 7/1/2024]

8.139.504.2 SCOPE: General public
[8.139.504.2 NMAC - N, 08/01/2011]

8.139.504.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.504.3 NMAC - N, 08/01/2011; A, 7/1/2024]

8.139.504.4 DURATION: The New Mexico Extra Help SNAP pilot shall terminate issuance of benefits in conjunction with the cessation of the grant authorized by the United States department of agriculture food and nutrition services (FNS). FNS has authorized the cessation of the program delivery effective April 30, 2013.
[8.139.504.4 NMAC - N, 08/01/2011; A, 04/01/2013]

8.139.504.5 EFFECTIVE DATE: August 1, 2011, unless a later date is cited at the end of a section.
[8.139.504.5 NMAC - N, 08/01/2011]

8.139.504.6 OBJECTIVE: The objective of New Mexico Extra Help SNAP (NM Extra Help SNAP) is to increase access to the nutrition benefits offered by the food stamp program among elderly and disabled populations receiving assistance through the medicare saving program (MSP) through medicaid. The NM Extra Help SNAP will increase the ability to purchase food and meet dietary needs. The NM Extra Help SNAP is authorized by a grant funded by the food and nutrition services (FNS).
[8.139.504.6 NMAC - N, 08/01/2011]

8.139.504.7 DEFINITIONS: [**RESERVED**]

8.139.504.8 PROGRAM ELIGIBILITY

A. An applicant can opt to receive NM Extra Help SNAP benefits if the applicant:
- **(1)** receives benefits through a MSP; and
- **(2)** is 22 years of age or older; and
- **(3)** resides in a NM Extra Help pilot county; and
- **(4)** is eligible for separate household status as defined at Subsection A of 8.139.400.9 NMAC; or
- **(5)** lives with a spouse who also receives MSP benefits; or
- **(6)** is living with others but buys and cooks food separately from others; and
- **(7)** the household has no earned income.

B. Verification of information: All information received by the HCA from the centers for medicaid and medicare (CMS) data interface will be deemed as true and accurate for purposes of initial verification.
[8.139.504.8 NMAC - N, 08/01/2011]

8.139.504.9 APPLICATION PROCESS

A. Opt in/out: An applicant can opt out of NM Extra Help SNAP at any time. To be considered for regular SNAP benefits, the applicant must apply through the regular SNAP application process as defined at 8.139.110 NMAC.

B. Application requirements: The application at minimum will contain:
- **(1)** the applicant's name and address;

(2) receipt of income and amount;
(3) amount of applicable deductions, such as shelter and medical; and
(4) must be signed by the applicant or authorized representative.

C. Application filing: Potential NM Extra Help SNAP recipients will receive applications from the HCA based on interface data supplied by CMS.

D. Processing standards: Applications are processed by the HCA and notice of disposition is sent to the applicant.

(1) Standard processing: An application shall be processed as soon as possible and the applicant afforded an opportunity to participate no later than 30 days from the date of application.

(2) Expedited processing: In the month of application NM Extra Help SNAP applicants shall be considered as standard food stamp program applicants and may qualify for expedited service in accordance with 8.139.110.16 NMAC.

E. Authorized representatives: The head of the household or the spouse may designate an individual who is a non-household member to act on its behalf in applying, obtaining or using food stamp benefits.

(1) The caseworker shall obtain a copy of the household's written authorization for the authorized representative and maintain it in the household's case record. No limit shall be placed on the number of households an authorized representative may represent.

(2) Even if the household member is able to make an application and obtain benefits, the household should be encouraged to name an authorized representative to use the food stamp benefits in case illness or other circumstances prevent household members from using the benefits themselves.

(3) The authorized representative's identity shall be verified and a copy of the document maintained in the household's case file.

[8.139.504.9 NMAC - N, 08/01/2011]

8.139.504.10 CASE MANAGEMENT

A. Interviews: NM Extra Help SNAP applicants are not required to see an ISD caseworker or be otherwise subjected to an interview, although additional information or verification may be requested.

B. Certification periods: Eligible households shall be assigned to a 36-month certification period, and with no interim contact.

C. Reporting requirements: NM Extra Help SNAP recipients are subject only to the reporting standards of MSP and all data sent to the HCA monthly. All information received by the HCA from the CMS data interface will be deemed as true and accurate for reported changes.

D. Actions on reported changes: Within 10 days of receipt the HCA shall act on the following changes:

(1) death of a household member;
(2) loss of MSP eligibility;
(3) changes in state residency;
(4) a member of the household's institutional status has changed; or
(5) receipt of earned income.

E. Recertification: NM Extra Help SNAP recipients shall not be subject to an interview to review eligibility at the end of the 36-month certification period. Recipients shall receive notice of expiration and recertification prior to closure. Continued eligibility will be evaluated based on the submission of a completed application. Participants that do not reapply by the end of certification period will be subject to case closure. Standards for timely submission of the recertification application will be in accordance with at 8.139.120.8 NMAC.

[8.139.504.10 NMAC - N, 08/01/2011]

8.139.504.11 BENEFIT DELIVERY

A. Benefit issuance: NM Extra Help SNAP benefits shall be issued through a direct deposit into a household's electronic benefit transfer (EBT) food stamp account. EBT cards are issued and EBT accounts maintained as defined at 8.139.610 NMAC. A participating household has a definite issuance date so that food stamp benefits are received on or about the same time each month. The issuance date is based on the last two digits of the social security number of the individual to whom the food stamps are issued. Benefits for the month of application shall not be prorated.

B. Eligibility determination: Eligibility is based on adjusted net income (ANI) which equals the countable gross income minus the appropriate standard deduction, minus the total combined shelter cost, and minus

the medical deduction. To be eligible for NM Extra Help SNAP, the applicant household's ANI must be below the appropriate net income level in accordance with 8.139.500 NMAC.

C. Benefit calculation: Benefits are issued based on adjusted income (AI) and the shelter to income ratio (STIR). AI is equal to the gross countable income minus total medical expenses. The STIR is equal to the total shelter costs divided by the AI. Benefit amounts shall be subject to review and adjustment in coordination with the regular food stamp program and cost neutrality and may be adjusted each January.

(1) Benefits for a two person household:

(a) The monthly benefit amount for a two person household with a monthly AI of less than $900.00 is $240.00.

(b) The monthly benefit amount for a two person household with a monthly STIR equal to or greater than 0.9 is $240.00.

(c) The monthly benefit amount for a two person household with a monthly AI equal to or greater than $900.00 but less than $1,500.00 and a STIR equal to or greater than 0.8 and less than 0.9 is $180.00.

(d) The monthly benefit amount for a two person household with a monthly AI equal to or greater than $900.00 but less than $1,500.00 and a STIR equal to or greater than 0.25 but less than 0.8 is $75.00.

(e) The monthly benefit amount for a two person household with a monthly AI equal to or greater than $1,500 but less than $1,800.00 and a STIR equal to or greater than 0.25 is $75.00.

(f) The monthly benefit amount for a two person household with a monthly AI equal to or greater than $900.00 but less than $1,500.00 and a STIR less than 0.25 is $16.00.

(g) The monthly benefit amount for a two person household with a monthly AI equal to or greater than $1,800.00 and a STIR less than 0.25 is $16.00.

(2) Benefits for a one person household:

(a) The monthly benefit amount for a one person household with an AI less than $500.00 is $180.00.

(b) The monthly benefit amount for a one person household with an AI of between $500.00 and $800.00 and a STIR of 0.85 or less is $75.00.

(c) The monthly benefit amount for a one person household with an AI of between $500.00 and $800.00 and a STIR greater than 0.85 is $180.00.

(d) The monthly benefit amount for a one person household with an AI greater than $800.00 and a STIR of 0.65 or more is $75.00.

(e) The monthly benefit amount for a one person household with an AI greater than $800.00 and a STIR less than 0.65 is $16.00.

D. Benefit correction: Benefit corrections shall be determined and adjusted as defined at 8.139.640 NMAC.

[8.139.504.11 NMAC - N, 08/01/2011; A, 07/01/2012; A, 10/01/2012]

8.139.504.12 OVERPAYMENT AND RECOUPMENT

A. Overpayment: A household that has received NM Extra Help SNAP benefits and has been determined ineligible or does not qualify for some or all of the NM Extra Help SNAP benefit shall have a claim established against the household for the NM Extra Help SNAP benefit amount in accordance with 8.139.640 NMAC.

B. Recoupment:

(1) The household shall be required to repay any amount of the NM Extra Help SNAP benefit due to an established claim or overpayment of the NM Extra Help SNAP benefit.

(2) The household shall remain subject to claim establishment and recoupment for the NM Extra Help SNAP benefit in accordance with 8.139.640 NMAC.

[8.139.504.12 NMAC - N, 08/01/2011]

History of 8.139.504 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 520 ELIGIBILITY POLICY / INCOME AND DEDUCTIONS

8.139.520.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.520.1 NMAC - Rp, 8.139.520.1 NMAC, 11/21/2023; A, 7/1/2024]

8.139.520.2 SCOPE: General public.
[8.139.520.2 NMAC - Rp, 8.139.520.2 NMAC, 11/21/2023]

8.139.520.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270/282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.520.3 NMAC - Rp, 8.139.520.3 NMAC, 11/21/2023 A, 7/1/2024]

8.139.520.4 DURATION: Permanent.
[8.139.520.4 NMAC - Rp, 8.139.520.4 NMAC, 11/21/2023]

8.139.520.5 EFFECTIVE DATE: November 21, 2023, unless a later date is cited at the end of a section.
[8.139.520.5 NMAC - Rp, 8.139.520.5 NMAC, 11/21/2023]

8.139.520.6 OBJECTIVE: Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.
[8.139.520.6 NMAC - Rp, 8.139.520.6 NMAC, 11/21/2023]

8.139.520.7 DEFINITIONS: [**RESERVED**]

8.139.520.8 INCOME: The national income eligibility standards are based on the federal income poverty levels established in Section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)). The net income standard is the federal income poverty guideline for the 48 contiguous states and the District of Columbia. The gross income standard is one hundred and thirty percent of that amount. The income standards are adjusted annually each October 1st. Activities described in this section relate to the calculation of a household's income to determine eligibility and food stamp benefit amount.

A. Elderly/disabled households: Households which contain an elderly or disabled member, as defined in 8.139.100 NMAC, definitions, must meet the net income eligibility standards listed in Subsection E of 8.139.500.8 NMAC.

B. Other households: Households which do not contain an elderly or disabled member, as defined, must meet the gross income eligibility standards for the food stamp program (FSP) (Subsection E of 8.139.500.8 NMAC). If a household is determined eligible based on gross income standards, deductions shall be allowed in calculating net monthly income to arrive at a final eligibility determination based on net income standards.

C. Categorically eligible: Households that are entitled to broad/based categorically eligibility must meet gross and net income eligibility. Households that are categorically eligible, due to receipt of financial assistance do not need to meet the gross or net income eligibility standard. The food stamp benefit amount for all CE households shall be based on net income limits. All categorically eligible one/ and two/person households are entitled to the minimum food stamp benefit amount, except in an initial month if the prorated benefit is less than ten dollars.

D. Income of ineligible or disqualified household members:

(1) The earned or unearned income of an individual disqualified for intentional program violation (IPV) or for noncompliance with the employment and training (E&T) work requirements shall be attributed in its entirety to the remaining members.

(2) The earned or unearned income of an individual disqualified for failing to provide or apply for a social security number or because the individual is an ineligible non-citizen shall continue to be counted as income, minus a pro rata share for the disqualified or ineligible member(s).

E. Income of non/household members: The earned or unearned income of an individual listed below shall not be considered available to the household with which the individual lives:

(1) roomers;

(2) boarders;

(3) foster children, if the household chooses not to include them;

(4) live/in attendants; and

(5) ineligible students.

[8.139.520.8 NMAC - Rp, 8.139.520.8 NMAC, 11/21/2023]

8.139.520.9 INCOME STANDARDS

A. Earned income: Earned income includes the following:

(1) Wages and salaries: All wages and salaries paid to an employee.

(2) Sick pay: Sick pay is counted as earned income if the person receiving sick pay will be returning to work after recovery and is still considered an employee by the employer.

(3) Military personnel: A household consisting of one or more military personnel receiving a basic allowance for quarters or basic allowance for subsistence instead of free housing or food shall have such funds counted as earned income.

(4) Self/employment: The gross income from a self/employment enterprise, including the total gain from the sale of any capital goods or equipment related to the business, minus the costs of doing business, is considered earned income. This is the gross income of the self/employed individual.

(5) Rental property: Income from rental property is considered earned only if a household member is actively engaged in the management of the property an average of at least 20 hours per week. The owner is allowed the cost of doing business.

(6) Roomer or boarder: Payments from a roomer or boarder are considered self/employment income. The 20 hours per week provision applied to rental property does not apply to roomer or boarder situations.

(7) Training allowances: A training allowance from a vocational and rehabilitative program recognized by federal, state or local governments, such as DVR, is considered earned income, to the extent the training allowance is not a reimbursement.

(8) VISTA payments: Payments under Title I (VISTA, university year for action, etc.) of the Domestic Volunteer Service Act of 1973 (Pub. L. 93/113 Stat., as amended) are considered earned income to applicant households not receiving food stamp benefits at the time the household member joined VISTA.

(9) Workforce Investment Act: Earnings of an individual participating in an on/the/job training program under Section 204 (b) (1) (C) or Section 254 (c) (1) (A) of the Workforce Investment Act (WIA). This provision does not apply to household members under 19 years of age who are under the parental control of an adult member, regardless of school attendance or enrollment. Earnings include monies paid under the WIA and monies paid by the employer. This section includes adult and youth programs and summer youth employment and training programs, but does not include job corps, E&T programs for Native Americans, migrant and seasonal farm workers, and veterans employment programs.

B. Unearned income: Unearned income includes, but is not limited to, the following:

(1) Federal assistance programs: Assistance payments from federal or federally aided cash assistance programs, such as supplemental security income (SSI), Title IV/A (temporary assistance to needy families), general assistance (GA), or other assistance programs based on need. Assistance payments from programs which require, as a condition of eligibility, the actual performance of work without compensation other than the assistance payments themselves, shall be considered unearned income.

(2) Other benefits: Annuities, pensions, retirement, veteran's or disability benefits, workman's compensation, unemployment compensation benefits (UCB), OASDI, and strike benefits are unearned income.

(3) Foster care payments: Foster care payments for children or adults shall be counted in their entirety unless the household providing the foster care chooses to exclude the foster child household member.

(4) Support or alimony: Support or alimony payments made directly to the household from non/household members.

(5) Educational funds: Scholarships, educational grants, fellowships, deferred payment loans for education, and veteran's educational benefits, are counted, after allowable deductions, unless the educational assistance is excluded in its entirety in Subsection E of 8.139.520.9 NMAC. Gifts or money a student may receive from parents or other private source on a periodic basis shall be counted as unearned income, including the portion used to pay for tuition and mandatory fees.

(6) Government/sponsored programs: Payments to individuals from individual Indian monies and grants from the bureau of Indian affairs.

(7) Gain or benefit: Dividends, interest, royalties, and all other direct money payments from any source which can be construed to be a gain or a benefit to the household. Interest income includes payments on a bank account that are simply posted in a bank book and not paid directly to a household.

(8) Trust funds: Money withdrawn or dividends that are or could be received by a household from a trust fund considered an excludable resource. Such trust withdrawals shall be considered income in the month received, unless excluded in Subsection D of 8.139.520.9 NMAC. Dividends which the household has the option of either receiving as income or reinvesting in the trust shall be considered income in the month they become available to the household, unless excluded per Subsection D of 8.139.520.9 NMAC.

(9) Rental property: Income from rental property shall be considered unearned when a household member engages in the management of the property less than 20 hours per week. The gross income minus the cost of doing business is counted as household income.

(10) Sponsored non-citizen income: The amount of monthly income of a non-citizen's sponsor and the sponsor's spouse (if living with the sponsor) that is deemed to be that of the non-citizen (Subsection G of 8.139.420.9 NMAC).

(11) Termination pay: Severance pay (e.g., two weeks pay instead of notice) and supplementary unemployment benefits (a series of payments similar to UCB, but paid by the employer) received after termination shall be considered unearned income.

(12) Vacation or sick pay: Unused vacation or sick pay paid in installments over a period of at least two months is considered unearned income in the months received. If paid as a lump sum at termination of employment, the income is considered a resource in the month received.

(13) Cash awards, gifts, prizes: Cash awards, gifts, prizes and winnings shall be considered unearned income in the month received, subject to the $30 per quarter exclusion, even if paid on a one/time basis.

(14) One/time income: The distinction between one/time income and a one/time lump sum resource is that a lump sum is money owed the household from a past period and paid retroactively.

C. Other countable income:

(1) Legal entitlement: Any payment that a household is legally entitled to receive, but is diverted by the provider of the payment to a third party for an expense incurred or owed by the household shall be counted as income. The distinction is whether the individual or organization making a payment on behalf of a household is using funds that otherwise must be paid to the household, such as wages, cash assistance grant, or child support or alimony payments. In these cases, a household is legally entitled to the money. If an employer, agency, or former spouse who owes such funds to a household diverts the money to a third party to pay for a household expense, the money is still counted as income, unless a court orders the money diverted.

(2) Garnished wages: Wages earned by a household member that are garnished or diverted by an employer and paid to a third party for a household expense shall be counted as income.

(3) Public assistance: All or part of a public assistance grant that is normally provided by a money payment to a household, but is diverted to a third party or to a protective payee for purposes of managing expenses, shall be counted as income.

(4) Third party energy assistance payments: Any payment made to a household under a state law to provide energy assistance shall be considered money payable directly to the household, unless under the law the payment cannot be provided in cash.

D. Excluded income: The following income shall be excluded in determining FS benefits:

(1) Federal laws: Income excluded by federal laws. The comprehensive list is found in 8.139.527 NMAC.

(2) In/kind benefits: Any gain or benefit which is not in the form of money paid directly to the household, including non/monetary or in/kind benefits such as meals, clothing, public housing, gifts for special occasions, or produce from a garden.

(3) Vendor payments: Money payments that a household is not legally entitled to receive,

and which are paid directly to a third party for a household expense are considered a vendor payment. A money payment made on behalf of a household is considered a vendor payment whenever an individual or organization outside the household uses its own funds to make a direct payment to a household's creditors, or to a person or organization providing a service to a household. Vendor payments include but are not limited to:

(a) rent paid directly to the landlord by a friend or relative, who is not a household member;

(b) rent or mortgage payments made to landlords or the mortgagee by the department of housing and urban development (HUD) or by a state or local housing authority;

(c) payments by a government agency to a child care institution to provide day care for a household member;

(d) insurance company payments made directly to titleholders or loan companies when a household member becomes disabled or dies and is covered by credit life and disability insurance;

(e) housing assistance payments made to a third party on behalf of a household residing in transitional housing for the homeless;

(f) a rent payment by an employer made directly to the landlord, in addition to paying the household its regular wages, is considered a vendor payment and is excluded as income.

(4) Energy assistance: Any payment or allowance made for the purpose of providing energy assistance under any federal law, except for a payment or allowance provided under Title IV/A of the Social Security Act; any federal or state one/time assistance for weatherization or emergency repair or replacement of heating or cooling devices.

(5) State or local general assistance: Any general assistance provided to a household which cannot, under state law, be provided in cash directly to a household.

(6) Child care food program: Payments made to a household from the child care food program for child care, or any amount received as payment for care or reimbursement for costs incurred is excluded income.

(7) Plan for achieving self/support (PASS) program: Income of an SSI recipient necessary for the fulfillment of a plan for achieving self/support which has been approved under Sections 1612 (b)(4) (A)(iii) or 1612(b)(4)(B)(iv) of the Social Security Act. The income may be spent in accordance with an approved PASS or deposited into a PASS savings account for future use.

(8) Infrequent/irregular income: Any income received in the certification period which is received too infrequently or irregularly to be reasonably anticipated. The income received cannot exceed $30.00 in a quarter.

(9) Lump/sum payment: Money received in the form of a nonrecurring lump sum payment, including but not limited to income tax refunds; rebates or credits; retroactive lump sum social security or SSI; cash assistance; railroad retirement; or other similar payments. Lump sum insurance settlements and refunds of security deposits on rental property or utilities are counted as resources in the month received, unless specifically excluded from consideration as a resource by federal law.

(10) TANF diversion: A TANF payment made to divert a family from becoming dependent on cash assistance shall be considered as a nonrecurring lump/sum payment if the payment is not defined as ongoing monthly assistance.

(11) Loans: All loans, including loans from private individuals as well as commercial institutions, other than educational loans on which repayment is deferred.

(12) Charitable donations: Charitable cash donations based on need from one or more private, nonprofit charitable organizations, not to exceed $300 in a federal fiscal quarter (January through March, April through June, July through September, and October through December).

(13) Earned income tax credit (EITC): EITC payments received either as a lump sum, or advance payments of earned income tax credits received as part of a paycheck or as a reduction in taxes that otherwise would have been paid at the end of the year.

(14) Diverted retirement income: The portion of a civil service retirement annuity or military retirement payment that is diverted to a former spouse by court order in a divorce decree is excluded from the income of the retiree.

(15) Annual clothing allowance: The clothing allowance provided each year to an TANF household whose children are entering or returning to school.

(16) Utility reimbursements: Any amount paid by the department of housing and urban development (HUD) or farmers home administration (FmHA) to a household as a utility reimbursement, or to a utility provider on behalf of a household, is excluded income.

E. Educational expenses:

(1) Title IV/BIA: Cash assistance received under Title IV of the higher education amendments of 1992, including federal college work study authorized under Title IV, or cash assistance received from bureau of Indian affairs student assistance programs shall be excluded in determining eligibility and food stamp benefit amounts effective for award years beginning on or after July 3, 1993.

(2) Title XIII: Financial assistance received under Title XIII of the Tribal Development Student Assistance Act shall be excluded in determining eligibility and food stamp benefit amounts effective October 1, 1992.

(3) Earmarked funds: All educational assistance, including, but not limited to, educational loans on which payment is deferred, grants, scholarships, fellowships, veteran's educational benefits, and the like, provided for a student to participate in or attend a recognized institution of post/secondary education, school for the handicapped, vocational education program, or program that provides for the completion of a secondary (i.e., high school) diploma or equivalency (GED), shall be excluded to the extent that the assistance is either used or made available for:

(a) tuition;

(b) mandatory fees, including rental or purchase of any equipment, materials, and supplies required to pursue the course of study involved;

(c) books and supplies;

(d) transportation expenses;

(e) origination fees and insurance premiums on student loans; and

(f) miscellaneous personal expenses (other than living expenses) incidental to a student's attendance at a school, institution, or program.

(4) Restrictions:

(a) Educational assistance provided for normal living expenses (room, board, and dependent care) shall not be excluded as income.

(b) Educational expenses in excess of the educational assistance provided may not be deducted from other income.

(c) A student household eligible for a deduction for dependent care expenses may claim only the amount which exceeds the amount of educational assistance made available for dependent care.

(5) Deferred payment educational loans: Any amount of state, local, or private deferred payment educational loans shall be excluded to the extent that the lender specifically earmarks or budgets part of or all of the loan for educational expenses. If the institution, school, program, or other lender does not earmark or budget amounts from the loan for educational expenses, students receive an exclusion for amounts verified as an educational expense.

F. Reimbursements:

(1) Past or future expenses: Reimbursements for past or future expenses, to the extent they do not exceed actual expenses, and do not represent a gain or benefit to the household, shall be excluded.

(2) Identified expense: Reimbursements made for an identified expense, other than normal living expenses, and used for the purpose intended, shall be excluded.

(3) Normal living expenses: Reimbursements for normal living expenses, such as rent or mortgage, clothing, or food eaten at home, shall be considered a gain or benefit to a household and are not excluded.

(4) Multiple expenses: If a reimbursement, including a flat allowance, covers multiple expenses, each expense does not need to be identified separately, as long as none of the reimbursement covers normal living expenses. The amount by which a reimbursement exceeds the actual incurred expense shall be counted as income.

(5) Excludable reimbursements:

(a) Job/training related: Reimbursements or flat allowances for job or training/related expenses, such as travel, per diem, uniforms, and transportation to and from the job or training site. Reimbursements provided over and above the basic wages for such expenses are excluded. However, these expenses, if not reimbursed, are not otherwise deductible from income.

(b) Migrant worker expenses: Reimbursements for travel expenses incurred by migrant workers.

(c) Volunteers: Reimbursements for out/of/pocket expenses incurred by volunteers in the course of their work.

(d) Medical or dependent care: Medical or dependent care reimbursements.

(e) Nonfederal educational expense: Nonfederal reimbursements or allowances

for students for specific educational expenses, such as travel or books, but not allowances for normal living expenses such as food, rent, or clothing shall be excluded. Portions of a general grant or scholarship must be specifically earmarked by the grantor as an educational expense rather than for living expenses to be excludable as a reimbursement.

(f) Title XX services: Reimbursements received by households to pay for services provided by Title XX of the Social Security Act.

(g) E&T program: Reimbursements for expenses necessary for participation in an education component to fulfill E&T work requirements in a work program.

(6) Nonexcludable reimbursements:

(a) Title IV/A grant: No portion of an title IV/A grant shall be excluded as a reimbursement if the grant is increased to adjust for work/related or child care expenses.

(b) Educational funds: No portion of any federal or nonfederal (state, local, private) educational loan, grant, scholarship, fellowship, veteran's educational benefit and the like shall be excluded as a reimbursement, to the extent that it provides income assistance for normal living expenses.

G. Payments for third party beneficiary: Payments received and used for the care and maintenance of a third/party beneficiary who is not a household member shall be excluded as income. If the intended beneficiaries of a single payment include both household and non/household members, any identifiable portion of the payment intended and used for the care and maintenance of a nonmember is excluded. If the nonmember's share cannot be readily identified, the payment is divided equally among intended beneficiaries. The exclusion is applied to the nonmember's pro rata share, or the amount actually used for the nonmember's care and maintenance, whichever is less.

H. Earned income of a student: The earned income of an elementary or secondary school student living in the same food stamp household with a natural, adoptive or step/parent, or under the parental control of another member of the same food stamp household other than a parent, shall be excluded if the student is:

(1) under age 18, and is

(2) attending classes, including GED classes, at least half/time.

(3) Temporary interruptions: The exclusion shall continue to apply during temporary interruptions in school attendance for semester or vacation breaks, provided that the child's enrollment will resume following the break.

(4) Child's/other members income: If a child's earnings or amount of work performed cannot be differentiated from that of other household members, the total earnings shall be divided equally among the working members and the child's pro rata share shall be excluded.

(5) Child turns 18 years old: The earnings of students shall be counted beginning the month following the month the student turns 18.

I. Money owed to other sources:

(1) Money withheld to repay previous overpayments: Money withheld to repay prior overpayments (recoupments) or money voluntarily or involuntarily returned from an assistance payment, earned income, or other income source shall be excluded from income, provided that:

(a) repayment is made from the same income source, and

(b) the income is from a countable income source.

(c) this exclusion applies only to recoupment or repayment situations.

(2) Other withholding: Money withheld for any other purpose is considered income. Money withheld for other purposes include: Medicare premiums; processing fees for child support payments collected by CSSD; and deductions (taxes, insurance, etc.) from unearned income, such as civil service, PERA, and military retirement benefits.

(3) Failure to comply with another assistance program's requirements or fraud: A household's food stamp benefit amount shall not increase when benefits received from another program have been decreased (reduced, suspended or terminated) because of a determination by the other program of intentional failure to comply with a requirement of the other program or an act of fraud. This provision applies in cases where the other program is a means/tested, federal, state or local welfare or public assistance program, which is governed by welfare or public assistance laws or regulations and which distributes public funds.

(a) Conditions:

(i) If the HCA is not able to obtain necessary cooperation from another federal, state or local means/tested welfare or public assistance program to enable it to comply with the requirements of this provision, the HCA is not held responsible as long as a good faith effort to obtain the information has been made.

(ii) A household's current food stamp benefit amount shall not be reduced, suspended or terminated when the benefits under another assistance program have been decreased.

(iii) Food stamp benefits shall be adjusted when eligible members are added to the food stamp household regardless of whether or not the household is prohibited from receiving benefits for the additional member under another federal, state, or local welfare or public assistance means/tested program.

(iv) Changes in household circumstances which are not related to a penalty imposed by another federal, state or local welfare or public means/tested assistance program shall not be affected by this provision.

(b) This provision does not apply to individuals or households subject to disqualification for noncompliance with E & T work requirements which are comparable to Title IV or UCB work requirements in Subsection H of 8.139.410.12 NMAC. In such cases, an individual or household disqualification occurs and food stamp benefits are reduced.

(c) There is no time restriction on the application of this provision. The prohibition against increasing food stamp benefits shall apply for the duration of the penalty imposed by the welfare or public assistance program.

(d) **Recoupments:** Food stamp benefits shall not increase in cases where the household is subject to either a reduction in benefits or recoupment due to intentional failure to comply with the other program's requirements. Food stamp benefits shall not increase as long as a reduction or recoupment is in effect.

(e) This provision does not result in a reduction, termination, or suspension of a household's current food stamp benefit amount; therefore, a caseworker need not send an adverse action notice. A caseworker may send adequate notice to a household affected by this provision.

(4) **Child support payments transferred under title IV/D:** A child support payment received by a cash assistance household that must be transferred to or retained by the child support services division (title IV/D) to maintain cash assistance eligibility, shall be excluded as income.

J. **Guaranteed Based Income:** Guaranteed basic income provides an individual or household a one time or recuring cash payment or transfer funded from a public or private source intended to support the basic needs of individuals or households by reducing poverty, promoting economic mobility, or increasing the financial stability.

(1) **Exempt:** Any payments that is funded solely with private funds or a mixture of private and public funds will be excluded as income.

(2) **Counted:** Any payment that is funded solely with public funds will be counted as income.

K. **Universal Basic Income:** Universal basic income is a government-guaranteed program that provides a modest cash income at regular intervals (e.g., each month or year) to every individual or household to meet basic needs.

(1) **Exempt:** Any payments that is funded solely with private funds or a mixture of private and public funds will be excluded as income.

(2) **Counted:** Any payment that is funded solely with public funds will be counted as income.

[8.139.520.9 NMAC - Rp, 8.139.520.9 NMAC, 11/21/2023]

8.139.520.10 COUNTING INCOME:

A. **Income averaging:**

(1) **Optional income averaging:** Income received by a household may be averaged at the household's option (See 8.139.500.10 NMAC) except as specified below.

(2) **Mandatory income averaging:** Averaging is mandatory for income received under the following circumstances:

(a) contract or self/employment income;

(b) educational monies.

B. **Rounding off:** Calculations shall be rounded to the nearest dollar. Figures between one cent and forty/nine cents are rounded down; figures between 50 cents and 99 cents are rounded up. When adding gross amounts received weekly, biweekly or semi/monthly to arrive at the monthly income, cents are retained until the total monthly amount is determined; the total monthly amount is rounded as the final step. Cents resulting from the computation of the twenty percent earned income deduction are rounded before being subtracted from earned income. Cents are retained in the computation of shelter and medical expenses until the final step.

C. **Ineligible or disqualified household members:** An ineligible or disqualified household member

shall not be included when:

(1) determining the maximum food stamp benefit amount for the household's size;

(2) comparing the household's monthly income with the income eligibility standards; or

(3) comparing the household's resources with the resource eligibility limits.

(4) Intentional program violation (IPV) or work disqualified:

(a) The income and resources of individuals disqualified for IPV or noncompliance with E&T work requirements shall be counted in their entirety.

(b) A household's allowable deductions for earned income, medical expenses, dependent care expenses, excess shelter expenses, and the standard deduction continue to apply to the remaining household members.

(c) HCA shall make sure that a household's food stamp benefit amount is not increased as a result of the disqualification of one or more members.

(5) Ineligible non-citizen or SSN disqualified:

(a) Resources: Resources of ineligible non-citizens, or individuals disqualified for failure or refusal to apply for or provide a social security number, shall be counted in their entirety.

(b) Income and deductions of ineligible non-citizens:

(i) Income belonging to the ineligible non-citizen shall be counted on a pro rata basis to remaining eligible household members. The prorated share is calculated by first subtracting any allowable exclusions from the ineligible non-citizen's income, then dividing the income evenly by all household members, including the excluded member(s). The result is multiplied by the number of eligible household members to determine countable income.

(ii) The twenty percent earned income deduction is applied to the countable income attributed to the remaining eligible household members.

(iii) The allowable expense(s) either billed to or paid by the ineligible non-citizen shall be allowed in its entirety as a household expense.

(c) Income and deductions for ABAWD or SSN disqualified individuals:

(i) Income belonging to an individual disqualified because of ABAWD status or failure or refusal to provide a social security number shall be counted on a pro rata basis to remaining eligible household members. The prorated share is calculated by first subtracting any allowable exclusions from the disqualified member's income, then dividing the income evenly by all household members, including the excluded member(s). The result is multiplied by the number of eligible household members to determine countable income.

(ii) The twenty percent earned income deduction is applied to the countable income attributed to the remaining household members.

(iii) The portion an allowable expense either paid by or billed to a disqualified individual(s) is divided evenly among all household members, including the disqualified individual(s). All but the disqualified individual's share is counted as a deductible expense for the remaining household members.

(6) Reduction/termination during certification period: When an individual is excluded or disqualified during the certification period, the caseworker shall determine the eligibility of the remaining household members based on information already in the case record.

(7) Excluded for IPV disqualification: If a household's benefits are reduced or terminated during the certification period because one of its members was disqualified for an IPV, the caseworker shall notify the remaining household members of changes in eligibility and food stamp benefit amount at the same time the excluded member is notified of the disqualification. The household is not entitled to an adverse action notice but may request a fair hearing to contest the reduction or termination of benefits, unless it has already had a fair hearing on the amount of the claim as a result of consolidation of the administrative disqualification hearing with the fair hearing.

(8) Excluded for other causes: If a household's benefits are reduced or terminated during the certification period because one or more of its members is an ineligible non-citizen, is disqualified for failure to comply with E&T work requirements, disqualified for failing or refusing to apply for or provide a social security number, the caseworker shall issue an adverse action notice informing the household of the individual's ineligibility, the reason for the ineligibility, the eligibility and benefit amount of the remaining member(s), and the actions the household must take to end the disqualification.

D. Non-household members:

(1) Income and resources: The income and resources of non-household members, such as certain students, roomers, and boarders, are not considered available. Cash payments from a non-household member to the household shall be counted as income (Subsection E of 8.139.520.8 NMAC). Vendor payments (Subsection

D of 8.139.520.9 NMAC) shall be excluded as income.

(2) Deductible expenses: If a household shares deductible expenses with a non-household member, only the amount actually paid or contributed by the household is deductible as an expense. If the payments or contributions cannot be differentiated, the expenses shall be divided evenly among individuals actually paying or contributing to the expense; only the household's pro rata share is deducted.

(3) Combined income of household/non-household members: When the earned income of one or more household members and the earned income of a non-household member are combined as one wage, the income for the household shall be determined as follows.

(a) If the household's share can be identified, it is counted as earned income.

(b) If the household's share cannot be identified, the caseworker shall divide the earned income among all those whom it was intended to cover and count a prorated share to the household.

E. Self/employed household: The following guidelines shall be used to determine eligibility and food stamp benefit amount for self/employed households, including those households that own or operate commercial boarding houses.

(1) Averaging self/employment income:

(a) Annualizing:

(i) Households which by contract or self/employment derive their annual income in a period of time shorter than one year shall have income averaged over a 12 month period, provided that the income from the contract is not received on an hourly or piecework basis.

(ii) Annualizing shall not apply to seasonal or migrant farm workers.

(iii) Self/employment income representing a household's annual income shall be averaged over a 12 month period, even if the income is received within only a short period of time.

(iv) The self/employment income shall be annualized even if the household receives income from other sources in addition to self/employment.

(v) Self/employed households include, but are not limited to, school employees, sharecroppers, and farmers. Tenured teachers who may not actually have a signed contract shall have their income considered on this basis.

(vi) For self/employed households that receive their annual income in a short period of time, an initial certification period is assigned to bring the household into the annual cycle.

(vii) Households which receive their annual income from self/employment and have no other source of income may be certified for up to 12 months.

(b) Anticipated income:

(i) If the average annualized amount or self/employment income received on a monthly basis does not accurately reflect a household's actual circumstances because it has experienced a substantial increase or decrease in business, self/employment income shall be calculated on anticipated earnings.

(ii) Income shall not be calculated based on previous income (e.g., income tax returns) if a self/employed household has experienced a substantial increase or decrease in business.

(c) Projected income: If a household's self/employment enterprise has been in existence for less than one year, the income from self/employment shall be averaged over the period of time the business has been in operation. The resulting monthly amount shall be projected for the coming year. If the business has been in operation for such a short time that there is insufficient information to make a reasonable projection, the household shall be certified for short periods of time until the business has been in operation long enough to make a longer projection.

(d) Seasonal income: Self/employment income which is intended to meet the household's needs for only part of the year shall be averaged over the period of time the income is intended to cover.

(2) Determining monthly self/employment income:

(a) For the period of time over which self/employment income is averaged, the caseworker shall add all self/employment income, including capital gains, exclude the cost of producing the self/employment income, and divide the self/employment income by the number of months over which the income shall be averaged.

(b) A capital gain is defined as proceeds from the sale of capital goods or equipment. Capital gains are counted in full as income to determine self/employment income.

(c) For households with self/employment income calculated on an anticipated basis, the caseworker shall add any capital gains the household anticipates receiving in the next 12 months, beginning with the date the application is filed. The resulting amount is counted in successive certification periods during the 12 months, except that a new average monthly amount is calculated if the anticipated amount of capital gains changes.

(3) Determining net self/employment income:

(a) A household's total self/employment income, minus the allowable costs of producing the income, shall be counted as gross income to the household. The gross self/employment income shall be added to any other earned income.

(b) The total monthly gross earned income, after allowing the twenty percent earned income deduction, is added to all monthly unearned income to determine income eligibility.

(c) For households anticipating income, the cost of producing income is calculated by anticipating allowable costs of producing the self/employment income.

(d) Expenses exceeding self/employment income shall not be deducted from other income.

(e) If a self/employment enterprise is a farming or ranching operation, expenses exceeding self/employment income may be offset against any other countable household income, provided that the farming or ranching operation grosses or is anticipated to gross at least $1,000 annually.

(4) Allowable costs: Allowable costs of producing self/employment income include, but are not limited to:

(a) identifiable costs of labor, stock, raw material, seed and fertilizer.

(b) payments on the principal of the purchase price of income/producing real estate and capital assets, equipment, machinery, and other durable goods;

(c) interest paid to purchase income/producing property;

(d) insurance premiums, and taxes paid on income/producing property;

(e) transportation costs necessary to produce self employment income, such as farmers carrying grain to elevators, or trips to obtain needed supplies, are allowable costs of doing business; costs are allowed at twenty-five cents per mile;

(f) payment of gross receipts taxes.

(5) Costs not allowed: In determining net self/employment income, the following shall not be allowed as a cost of doing business:

(a) net losses from previous periods;

(b) federal, state, and local personal income taxes, money set aside for retirement purposes, and other work/related personal expenses (such as transportation to and from work), since these expenses are accounted for by the twenty percent earned income deduction (Paragraph (3) of Subsection E of 8.139.520.10 NMAC);

(c) charitable contributions and entertainment; and

(d) depreciation.

F. Boarders:

(1) Individuals paying a reasonable amount for room and board shall be excluded from a household when determining the household's eligibility and food stamp benefit amount.

(2) Payments from a boarder shall be counted as self/employment income.

(3) Household income eligibility is determined as follows.

(a) Income from a boarder includes all direct payments to the household for room and meals, including contributions for shelter expenses.

(b) Shelter expenses paid by a boarder directly to someone outside the household shall not be counted as income. Such payments are considered vendor payments and are not used to determine reasonable compensation (Paragraph (4) of Subsection C of 8.139.400.11 NMAC), or as a shelter expense for the household.

(4) After determining the income received from a boarder, the caseworker shall exclude the portion of the boarder payment which is a cost of doing business. The cost of doing business is equal to either of the following, provided that the amount allowed as a cost of doing business does not exceed the payment the household receives from the boarder for lodging and meals:

(a) the amount of the maximum food stamp allotment for a household size that is equal to the number of boarders (Subsection E of 8.139.500.8 NMAC); or

(b) the actual documented cost of providing room and meals if the actual cost exceeds the appropriate maximum food stamp allotment; if actual costs are used, only separate and identifiable costs of providing room and meals to boarders are excluded.

[8.139.520.10 NMAC - Rp, 8.139.520.10 NMAC, 11/21/2023]

8.139.520.11 GENERAL DEDUCTIONS:

A. Use of deductions: A household must qualify for deductions by first meeting a gross income test. A household is not eligible if gross income is more than the standard listed in Subsection E of 8.139.500.8 NMAC for a household size. If income falls below the gross income limit, a household shall be allowed deductions, where applicable, to make a final eligibility and benefit amount determination. Households that include elderly or disabled members, as defined, automatically qualify for deductions; eligibility is determined based on net rather than gross income.

B. Standard deduction: All households are allowed a standard deduction from income. The standard deduction is listed in Paragraph (3) of Subsection F of 8.139.500.8 NMAC, tables, and is adjusted effective every October 1st.

C. Earned income deduction: Twenty percent of gross earned income shall be deducted. Excluded income is not used for purposes of computing the earned income deduction.

(1) Computing an over issuance: The earned income deduction (EID) shall not be allowed when calculating the income to be used in determining an over issuance which is due to the failure of a household to report earned income in a timely manner.

(2) Work supplementation programs: The EID shall not be allowed for any amount of income which is earned under a work supplementation or support program and is attributable to public assistance.

D. Medical deductions: Allowable medical deductions include:

(1) Elderly/disabled: Medical expenses in excess of $35 per month, excluding special diets, incurred by any household member who is elderly or disabled.

(2) Emergency SSI: Individuals receiving emergency SSI benefits based on presumptive eligibility shall be eligible for the medical deduction.

(3) Death: A medical expense incurred by a household member who dies shall be allowed as a deduction if the member was eligible for the deduction at the time of death and if the remaining household members are legally responsible for payment.

(4) Hospital/outpatient/nursing home: Medical expenses, such as hospitalization or outpatient treatment, nursing care and nursing home care, including payments by a household for an individual who was an eligible household member immediately before entering a hospital or nursing home facility recognized by the state, are allowable deductions.

(5) Not eligible: Spouses, children or other individuals in the household who are not elderly or disabled, shall not be entitled to claim the medical deduction.

(6) Allowing medical expenses:

(a) One/time only expense:

(i) A household may choose to have a one/time only expense, reported at certification, deducted in a lump sum or averaged over the certification period.

(ii) If a household incurs a one/time medical expense and has made arrangements with the provider to make monthly installments (beyond the current certification period), the expense may be allowed each month as arranged.

(iii) A household reporting a one/time only medical expense during its certification period may choose to have a one/time deduction or to have the expense averaged over the remaining months of the certification period.

(b) Households certified for 24 months: A household certified for 24 months cannot have a one/time medical expense averaged over the 24/month certification period.

(i) A one/time medical expense may be deducted in the first month of the 24/month certification period; or the one/time medical expense may be deducted and averaged over the first 12 months of the 24/month certification period.

(ii) One/time medical expenses reported after the first 12 months of the certification period shall be averaged over the remaining months.

(c) Expense in last month of certification: If a household is billed for and reports an expense during the last month of its certification period, the deduction shall not be allowed. If the expense will be paid in installments during the following certification period, the deduction shall be allowed during the appropriate number of months in the subsequent certification period.

(d) Fluctuating expenses: Fluctuating medical expenses shall be allowed as deductions if regularly recurring, reasonably anticipated, and verified. Once determined, the household is not required to report changes of $25 or less or reverify expenses each month.

(e) Anticipated changes in expenses: At certification and recertification the household must report and verify all medical expenses. The household's monthly medical deduction for the

certification period shall be based on:

(i) anticipated changes in the household's medical expenses that can reasonably be expected to occur during the certification period based on available information about the recipient's medical condition, public or private insurance coverage, and current verified medical expenses; and

(ii) expenses that occurred during the certification period that will continue in the new certification period; and

(iii) consideration of unpaid and past due medical expenses that will continue in the certification period.

(f) If a household reports an allowable medical expense at the time of certification but cannot provide verification at that time, and if the amount of the expense cannot be reasonably anticipated based upon available information about the recipients' medical condition and public or private medical insurance coverage, the household shall have the non-reimbursable portion of the medical expense considered at the time the amount of the expense or reimbursement is reported and verified.

(g) A household shall not be required to file reports about its medical expenses during the certification period. If a household voluntarily reports a change in its medical expenses, the caseworker shall act on the change in accordance with regulations in Subparagraph (c) of Paragraph (1) of Subsection B of 8.139.120.10 NMAC.

(7) **Past due and unpaid medical expenses:** The medical expense deduction shall not be determined by averaging past due or unpaid monthly medical expenses. Such expenses shall be used only as an indicator of what can reasonably be anticipated. Medical expenses which the household might reasonably anticipate receiving include but are not limited to costs of medical services and treatment received regularly, but less often than monthly, and prescription drugs.

(8) **Medical and dental care:** Medical and dental care, psychotherapy, and rehabilitation services, provided by licensed practitioners authorized by state law, or other qualified health professional, shall be allowed as medical expense deductions. State licenses in New Mexico are authorized by occupational licensing boards. A state/licensed practitioner has such a license. Native American practitioners (medicine men) are not licensed, but are recognized as health practitioners for this purpose.

(9) **Prescription drugs and medical supplies:** Prescription drugs, when prescribed by a licensed practitioner authorized under state law, and over/the/counter medications (including insulin) when approved by a licensed practitioner or other qualified health professional, shall be allowed as deductions. In addition, costs for medical supplies, sick/room equipment (including rental), or other prescribed equipment are deductible.

(10) **Health and hospitalization/medicare premiums:** Health and hospitalization insurance premiums, and medicare premiums, as well as any cost sharing or spend/down expenses incurred by medicaid recipients, are allowable deductions. If a medical insurance policy includes benefits for household members not eligible for a deduction, only that portion of the premium assigned to the eligible member(s) may be considered a deduction. In the absence of specific information about how much of the premium is for the eligible member(s), a pro rata amount may be used. This system may be used even if the policy holder does not qualify for the deduction but the policy includes a person(s) who does qualify. The cost of life or health and accident policies, such as those payable in lump sum settlements for death or dismemberment, or income maintenance policies that continue mortgage or loan payments while the beneficiary is disabled, are not deductible.

(11) **Transportation and lodging costs:** Reasonable costs of transportation and lodging to obtain medical treatment or services are deductible. The allowance for mileage in privately owned vehicles is the same as the amount allowed state employees. Lodging costs may not exceed the daily expense amount allowed (per diem) for state employees.

(12) **Maintaining an attendant:** Costs of maintaining an attendant, homemaker or home health aide, child care services, or housekeeper that are necessary because of age, infirmity, or illness are deductible medical expenses. In addition, an amount equal to the food stamp benefit amount for one person is deductible if the household furnishes the majority of the attendant's meals. The food stamp benefit amount for the meal/related deduction is the one in effect at the time of initial certification. The caseworker shall update the food stamp benefit amount for meals at the next scheduled recertification. If a household incurs attendant care expenses that could qualify under both the medical deduction and the dependent care deduction, the caseworker shall treat the expense as a medical expense.

(13) **Other expenses:** Other deductible expenses include but are not limited to:

(a) dentures, hearing aids, prosthetics;

(b) securing and maintaining a seeing/eye or hearing dog, or other service animal, including the cost of dog food and veterinary bills; and

(c) eyeglasses or contact lenses prescribed by an ophthalmologist or an optometrist.

(14) Prescription drug card expense:

(a) An individual participating in the food stamp program who has enrolled for the medicare/approved drug discount card shall have $23 credited to the monthly medical expense allowed for that individual.

(b) An individual participating in the food stamp program who receives a $600 transitional assistance credit on the medicare/approved drug discount card for the calendar years 2004 and 2005 shall have $50 credited to the monthly medical expense allowed for that individual for each month after September 2004, through December 2005, and not beyond that month.

E. Dependent care expenses:

(1) Deductible amounts: Payments may be deducted for the actual cost of the care of children or other dependents when necessary for a household member to accept or continue employment, comply with E&T work requirements, or an equivalent effort by those not required to comply with E&T work requirements, or attend training or pursue education which is preparatory to employment or leads to a degree. Allowable costs include:

(a) the costs of care given by an individual care provider or care;

(b) transportation costs to and from the care facility; and

(c) activity or other fees associated with the care provided to the dependent that are necessary for the household to participate in the care.

(2) Household member provides care: If a household member provides dependent care, the payment is neither income to the payee nor a deduction for the payor (see Subsection A of 8.139.500.11 NMAC).

F. Household expenses:

(1) Shelter expenses:

(a) Definition: Continuing charges for the shelter occupied by a household include rent, mortgage payment, or other continuing charges leading to the ownership of the shelter, such as loan repayments for the purchase of a mobile home and interest on such payments. If payments are made on more than one mortgage on the home, each payment is counted for the period the payment is intended to cover. Security deposits on rental property and downpayments for the purchase of a home are not allowed as shelter expense deductions. Closing costs shall not be allowed as a shelter expense, unless the closing costs can be itemized to identify costs that are allowable deductions, such as insurance and property taxes.

(b) Excess shelter expense deduction: Monthly shelter expenses in excess of fifty percent of a household's income, after all other deductions have been allowed may be deducted, subject to the following restrictions:

(i) The shelter deduction may not exceed the maximum amount indicated in Paragraph (3) Subsection F of 8.139.500.8 NMAC, unless the household contains a member who is elderly or disabled, as defined.

(ii) Households may not claim shelter expenses if the expense shall be paid as a vendor payment by an individual or organization outside the household.

(iii) The household must be responsible for payment of the shelter expense; however, the household need not have paid the expense to claim the deduction. A current billing statement is used to establish the expense. The expense may not be allowed more than once.

(2) Taxes and insurance: Property taxes, state and local assessments, and insurance on the structure itself, but not separate costs for insuring furniture or personal belongings, are deductible expenses.

(3) Natural disasters: Expenses for the repair of a home that has been substantially damaged or destroyed by a natural disaster such as fire or flood may be deducted. Expenses shall not be allowed if the household has been or will be reimbursed by public or private relief agencies, insurance companies, or any other source. Expense deductions are limited to the repair of the home and not its furnishings.

(4) Costs of temporarily unoccupied home:

(a) If the home is temporarily unoccupied by a household because of employment or training away from home, illness, or abandonment caused by a natural disaster or casualty loss, the shelter costs for the home may be deducted. However, a household may claim only one SUA.

(b) For costs of a home vacated by the household to be included in its shelter costs:

(i) the household must intend to return to the home;

(ii) the current occupants of the home, if any, cannot be claiming shelter expenses for food stamp purposes;

(iii) the home cannot be leased or rented during the household's absence.

(c) Verification is required of households claiming this deduction if the cost is questionable or would result in a deduction.

(5) Maximum deduction limit adjustment: The maximum deduction limit for excess shelter expenses will be revised as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as follows: effective January 1, 1997 through September 30, 1998, the deduction will be $250; from October 1, 1998 through September 30, 2000 the deduction will be $275; and effective from October 1, 2000 the deduction will be $300; and will remain so indefinitely.

(6) Homeless shelter standard: A household in which all household members are defined as homeless, within the definition at Paragraph (40) of Subsection A of 8.139.100.7 NMAC, shall be allowed the homeless shelter standard if the household incurs any shelter expenses at any time during the month.

(a) The homeless household may claim actual shelter expenses if the expenses exceed the homeless shelter standard and the expenses are verified. Verification standards at Subsection A of 8.100.130.15 NMAC and 8.100.130.9 NMAC shall be used to verify shelter expenses, as well as other reasonable documentation determined to establish the homeless household's actual expenses.

(b) The caseworker shall assist the homeless household in determining whether claiming the homeless shelter standard or actual expenses would be most beneficial to the household.

(c) The homeless shelter standard shall be deducted from the household's countable net income.

(7) Utility expenses:

(a) Allowable expenses for the mandatory utility standards: Allowable expenses that may be used to determine the mandatory utility standards include the cost of home heating or cooling; cooking fuel; electricity; water and sewerage; garbage and trash collection fees; the service fee for one telephone, including but not limited to, basic service fees, wire maintenance fees, subscriber line charges, relay center surcharges, 911 fees, taxes; and fees charged by the utility provider for initial installation of the utility.

(i) A one/time deposit is not allowed as a utility expense.

(ii) Expenses billed to a landlord or housing unit, but separately identifiable from the rent as an expense to the household, are allowable expenses.

(iii) A household shall not be allowed actual utility expenses, even if the expenses exceed the amount of the mandatory utility standard for which the household is eligible.

(iv) A household that is determined eligible for a mandatory utility standard deduction shall receive only one standard deduction during the household's food stamp certification period.

(b) Mandatory heating or cooling standard: A food stamp household shall be allowed the heating/cooling standard utility allowance (HCSUA) during the household's certification period. The HCSUA includes all utility expenses for heating or cooling the household's home. The household's heating or cooling expense must be billed separately from other shelter expenses. The HCSUA shall be allowed if the household:

(i) incurs a heating or cooling expense separate from other shelter expenses; or

(ii) receives or received a direct payment or a payment is made on behalf of the household under the Low Income Home Energy Assistance Act of 1981; or

(iii) receives or received a payment or a payment is made on behalf of the household under any other similar energy assistance program as long as the household still incurs out/of/pocket heating or cooling expenses in excess of the energy assistance provided; or

(iv) lives in a public housing unit that has central utility meters, incurs a heating or cooling expense, and the household is charged only for excess heating or cooling usage.

(c) Mandatory limited utility standard: A food stamp household shall be allowed a limited utility allowance (LUA) if the household does not incur a heating or cooling expense but does incur two or more of the following expenses:

(i) electricity or fuel, for purposes other than heating or cooling;

(ii) water;

(iii) sewerage;

(iv) well and septic tank installation or maintenance;

(v) garbage or trash collection; and

(vi) one telephone.

(d) Mandatory telephone standard: A food stamp household shall be allowed the

telephone standard if the household incurs an expense only for the telephone used by the household. The telephone standard shall be allowed for only one telephone charge for the residence.

G. Child support deduction: A deduction shall be allowed for child support payments paid by a household member to or for a non/household member, provided that the household member has a legal obligation to pay child support and such payments are being made.

(1) Legal obligation and verification: The household's legal obligation to pay child support, the amount of the obligation, and the monthly amount of child support the household actually pays shall be verified. Any document that verifies the household's legal obligation to pay child support, such as a court or administrative order, or legally enforceable separation agreement shall be acceptable verification. Documents that are accepted as verification of the household's legal obligation to pay child support shall not be accepted as verification of the household's actual monthly child support payments. Actual payment of child support shall be verified by documentation including, but not limited to, cancelled checks, wage withholding statements, verification of withholding from unemployment compensation, and statements from the custodial parent regarding direct payments or third party payments the non/custodial parent pays or expects to pay on behalf of the custodial parent. The HCA shall be responsible for obtaining verification of the household's child support payments if the payments are made to the child support services division.

(2) Determining the deduction amount:

(a) Household with at least three months of payment history: Average the last three month period, taking into account any anticipated changes in the legal obligation. This average is the child support deduction amount. In the event that the client has at least a three month payment history and the payment includes arrearages, the amount paid toward arrearages shall be used in the average.

(b) Household with less than three months of payment history: The HCA shall estimate the anticipated payments according to the obligation and discussion with the client. This anticipation shall not include payments toward arrearages.

H. Non-deductable expenses:

(1) Excluded reimbursement/vendor payments:

(a) That portion of any allowable expense that is reimbursed to the household or that is paid through a vendor payment to a third party is not allowable as a deduction.

(b) Actual utility expense deductions or the SUA, as appropriate, shall be allowed for households receiving payments from LIHEAP, or receiving energy assistance payments under a program other than LIHEAP, as long as the household continues to incur out/of/pocket expenses for home heating or cooling.

(c) A reimbursement paid by HUD or FHA to a household, or indirectly to a utility provider, is not allowed as a deductible expense.

(d) A household receiving HUD or FHA utility reimbursements shall be entitled to the SUA if it incurs heating or cooling costs exceeding the amount of excluded utility reimbursements.

(2) Household member provides service:

(a) When one household member pays another household member to provide a product or service, the money that is exchanged is neither an expense for one nor income for the other household member. Expenses are deductible only when a product or service is provided by someone outside the household and the household makes a money payment for the product or service.

(b) Similarly, income is not counted for one household member who is paid by another household member to obtain wood for home heating. The actual cost of the wood is allowed as a utility expense if an outside money payment is made. Money exchanged between household members is not considered income to the individual receiving the money and is not an expense to the member paying it.

(3) Past due shelter expenses: Payment on delinquent rent, mortgage, property taxes or utilities are not allowed as deductible expenses even if not previously billed.

[8.139.520.11 NMAC - Rp, 8.139.520.11 NMAC, 11/21/2023]

8.139.520.12 CALCULATING INCOME: To determine a household's income eligibility, the following guidelines will be followed:

A. The gross monthly income of all members, minus any income exclusions, is a household's gross income. Households which do not include elderly or disabled members must meet the gross income standard before other calculations are made.

B. Twenty percent of gross earned income is subtracted to determine net monthly earned income. or multiply the gross earned income by eight percent.

C. Total monthly earned income of all household members, minus income exclusions, if any, is

added to net monthly unearned income.

D. The standard deduction is subtracted.

E. If a household member(s) is entitled to an excess medical deduction, the amount of medical expenses that exceeds $35 is deducted.

F. Allowable monthly dependent care expenses, if any, are subtracted, up to the maximum amount allowed per dependent.

G. Subtract allowable monthly child support payment.

H. Add allowable shelter expenses to determine total shelter costs.

I. Subtract from total shelter costs fifty percent of the household's monthly income after all of the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost.

(1) The excess shelter cost, up to the maximum amount allowed, is subtracted from monthly income determined after G above.

(2) Households with elderly or disabled members have the full shelter cost amount exceeding Fifty Percent of net income subtracted.

(3) The household's net monthly income has been determined.

J. The household's net monthly income is compared to the net income standard Subsection E of 8.139.500.8 NMAC to determine eligibility.

[8.139.520.12 NMAC - Rp, 8.139.520.12 NMAC, 11/21/2023]

HISTORY OF 8.139.520 NMAC:

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

ISD 460.0000, Action on Households with Special Circumstances, 8/15/1980.
ISD 450.0000, Determining Household Eligibility and Benefit Levels, 8/15/1980.
ISD/Rule 429.0000, Food Assistance / Income, 11/4/1982.
ISD/Rule 429.0000, Food Assistance / Income, 2/17/1983.
ISD/Rule 429.0000, Food Assistance / Income, 9/8/1983.
ISD/Rule 429.0000, Food Assistance / Income, 1/20/1984.
ISD/Rule 429.0000, Food Assistance / Income, 5/1/1986.
ISD FS 430, Food Stamp Deductions, 3/1/1988.
ISD FS 440, Food Stamp Financial Determinations, 3/1/1988.
ISD/Rule 431.0000, Food Assistance / Determining Household Eligibility/Benefit Levels and Related Activities, 11/4/1982.
ISD/Rule 430.0000, Determining Household Eligibility/Benefit Levels and Related Activities, 2/9/1983.
ISD/Rule 430.0000, Determining Household Eligibility/Benefit Levels and Related Activities, 10/13/1983.
ISD/Rule 430.0000, Determining Household Eligibility/Benefit Levels and Related Activities, 4/24/1984.
ISD/Rule 430.0000, Determining Household Eligibility/Benefit Levels and Related Activities, 8/27/1984.
ISD/Rule 432.0000, Food Assistance / Determining Resources, 11/4/1982.
ISD/Rule 433.0000, Food Assistance / Determining Income, 11/4/1982.
ISD/Rule 433.0000, Determining Income, 2/9/1983.
ISD/Rule 433.0000, Determining Income Prospectively, 10/13/1983.
ISD/Rule 433.0000, Determining Income Prospectively, 4/24/1984.
ISD/Rule 434.0000, Food Assistance / Determining Deductible Expenses, 11/4/1982.
ISD/Rule 434.0000, Determining Deductible Expenses, 10/13/1983.
ISD/Rule 434.0000, Determining Deductible Expenses, 4/24/1984.
ISD/Rule 434.0000, Determining Deductible Expenses, 5/11/1984.
ISD/Rule 434.0000, Determining Deductible Expenses, 8/3/1984.
ISD/Rule 435.0000, Food Assistance / Calculating Income and Benefit Levels, 11/4/1982.
ISD/Rule 435.0000, Calculating Income and Benefit Levels, 2/11/1983.
ISD/Rule 435.0000, Calculating Income and Benefit Levels, 10/13/1983.
ISD/Rule 453.0000, Food Assistance / Self/employed Households, 11/5/1982.
ISD/Rule 453.0000, Food Assistance / Self/employed Households, 4/24/1986.
ISD/Rule 454.0000, Food Assistance / Boarders, 11/5/1982.
ISD/Rule 455.0000, Food Assistance / Treatment of Income/Resources and Deductions of Disqualified Members and Ineligible Aliens, 11/5/1982.
ISD/Rule 455.0000, Treatment of Income and Resources and Deductions of Excluded Members, 5/31/1983.

ISD/Rule 455.0000, Treatment of Income, Resources and Eligibility/Benefit Level of Excluded Members, 8/23/1983.
ISD FS 420, Food Stamp Income Eligibility, 3/1/1988.
ISD FS 430, Food Stamp Deductions, 3/1/1988.
ISD FS 440, Food Stamp Financial Determinations, 3/1/1988.

History of Repealed Material: 8.139.520 NMAC, Eligibility Policy / Income and Deductions (filed on 4/26/2001) Repealed effective 11/21/2023.

Other: 8.139.520 NMAC, Eligibility Policy / Income and Deductions (filed on 4/26/2001) replaced by 8.139.520 NMAC, Eligibility Policy / Income and Deductions effective 11/21/2023.

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 527 FOOD STAMP PROGRAM / INCOME AND RESOURCES EXCLUDED BY FEDERAL LAW

8.139.527.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.527.1 NMAC - Rp, 8.139.527.1 NMAC 11/01/2023; A, 7/1/2024]

8.139.527.2 SCOPE: General public.
[8.139.527.2 NMAC - Rp, 8.139.527.2 NMAC 11/01/2023]

8.139.527.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270/282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.527.3 NMAC - Rp, 8.139.527.3 NMAC 11/01/2023; A, 7/1/2024]

8.139.527.4 DURATION: Permanent.
[8.139.527.4 NMAC - Rp, 8.139.527.4 NMAC 11/01/2023]

8.139.527.5 EFFECTIVE DATE: November 1, 2023, unless a later date is cited at the end of the section.
[8.139.527.5 NMAC - Rp, 8.139.527.5 NMAC 11/01/2023]

8.139.527.6 OBJECTIVE: Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the HCA.
[8.139.527.6 NMAC - Rp, 8.139.527.6 NMAC 11/01/2023]

8.139.527.7 DEFINITIONS [**RESERVED**]

8.139.527.8 INCOME AND RESOURCES EXCLUDED BY FEDERAL LAWS: Certain income and resources are specifically excluded by federal law from consideration in determining eligibility for the food stamp program.
[8.139.527.8 NMAC - Rp, 8.139.527.8 NMAC 11/01/2023]

8.139.527.9 GENERAL:

A. The value of assistance to children under P.L. 79/396, Section 12(e) of the National School Lunch Act, as amended by Section 9(d) of P.L. 94/105. This law authorizes the school lunch program, the summer food service program for children, the commodity distribution program, and the child and adult care food program. The exclusion applies to assistance provided to children rather than that paid to providers.

B. The value of assistance to children under P.L. 89/642, Section 11(b) of the Child Nutrition Act of 1966 is not considered income or resources for any purpose. This law authorizes the special milk program, the school breakfast program, and the special supplemental food program for women, infants, and children (WIC).

C. Under WIC demonstration projects, coupons that may be exchanged for food at farmers' markets by P.L. 100/435, Section 501, 9/19/88, which amended Section 17(m)(7) of the Child Nutrition Act of 1966.

D. Reimbursements received under the Uniform Relocation Assistance and Real Property Acquisition Policy Act of 1970, P.L. 91/646, Section 216.

E. Any payment under Titles I and II of the Domestic Volunteer Services Act of 1973, P.L. 93/113.

(1) Payments under Title I of the Act, including payments from VISTA, university year for

action and the urban crime prevention program, made to volunteers will be excluded for an individual receiving FS benefits or public assistance at the time the individual joined the Title I program, except that households which were receiving an income exclusion for a VISTA or other Title I subsistence allowance at the time of conversion to the Food Stamp Act of 1977 continue to receive an income exclusion for VISTA for the length of their volunteer contract in effect at the time of conversion.

(2) Temporary interruptions in food stamp participation do not alter the exclusion after an initial determination has been made.

(3) New applicants who were not receiving food stamps at the time they joined VISTA will have their volunteer payments counted as earned income.

(4) Payments to volunteers under Title II, including RSVP, foster grandparents program and senior companion program, are excluded as income.

F. Payments precipitated by an emergency or major disaster as defined in the Disaster Relief Act of 1974, P.L. 93/288, Section 312(d), as amended by the Disaster Relief and Emergency Assistance Amendments of 1988, P.L. 100/707, Section 105(i). This exclusion applies to federal assistance, including Federal Emergency Management Assistance (FEMA) funds, provided to directly affected individuals and to comparable disaster assistance provided by states, local governments, and disaster assistance organizations. Most, but not all FEMA funds are excluded. For example, some payments made to homeless people to pay for rent, mortgage, food, and utility assistance when there is no major disaster or emergency are not excluded under this provision. A major disaster is any natural catastrophe such as a hurricane, drought, or, regardless of cause, any fire, flood, or explosion, which the president determines causes damage of enough severity and magnitude to warrant major disaster assistance to supplement the efforts and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby. An emergency is any occasion or instance for which the president determines that federal assistance is needed to supplant state and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe.

G. The amount of any home energy assistance payments or allowances provided directly to, or on behalf of, a household under the Low Income Home Energy Assistance Act, P.L. 99/425, Section (e), 9/30/86. In determining any excess shelter expense deduction, the full amount of such payments or allowances is deemed to be expended by such household for heating or cooling expenses.

H. Amounts made available for tuition and fees, and, for students attending an institution at least half time, for books, supplies, transportation and miscellaneous personal expenses (other than room, board, and dependent care) provided under Title IV of the Higher Education Act Amendments of 1986, P.L. 99/498, Section 479B, as amended by P.L. 100/50, June 3, 1987, and by the bureau of Indian affairs.

(1) The Higher Education Amendments of 1992, P.L. 102/325, 7/23/92, contain two separate provisions affecting the treatment of payments made under the Higher Education Act. In regard to Title IV, Student Assistance, Part F, Section 479B provides that: Notwithstanding any other provision of law, student financial assistance received under Title IV or under bureau of Indian affairs student assistance programs, will not be counted in determining the need or eligibility of any person for benefits or assistance, or the amount of such benefits or assistance, under any federal, state, or local program financed in whole or in part with federal funds. Educational assistance authorized under Title IV will be excluded with respect to determinations beginning on or after July 1, 1993.

(2) Excluded educational assistance authorized under Title IV includes the following:

(a) basic educational opportunity grants (BEOG or PELL);

(b) presidential access scholarships (super PELL grants);

(c) supplemental educational opportunity grants (SEOG);

(d) state student incentives grants (SSIG);

(e) federal direct student loan programs (FDSLP) (formerly GSL and FFELP):

(i) federal direct supplemental loan program (provides loans to students);

(ii) federal direct PLUS program (provides loans to parents);

(iii) federal direct Stafford loan program;

(iv) federal consolidated loan program;

(f) direct loans to students in institutions of higher education (Perkins loans, formerly NDSL);

(g) federal work study funds (not all federal work study funds come under Title IV of the Higher Education Act);

(h) TRIO grants (to organizations or institutions for students from disadvantaged

backgrounds):

(i) upward bound (some stipends go to students);

(i) student support services;

(ii) Robert E. McNair post/baccalaureate achievement;

(iii) Robert C. Byrd honors scholarship program.

(j) college assistance migrant program (CAMP) for students whose families are engaged in migrant and seasonal farm work;

(k) high school equivalency program (HEP);

(l) national early intervention scholarship and partnership program.

(3) There is only one BIA student assistance program per se. It is the higher education grant program, which is sometimes called the scholarship grant program. Education or training assistance received under any BIA program must be excluded. There is an adult education program providing money to adults to get a GED, attend technical schools, and to receive job training. There is also an employment assistance program. In addition, education and training may be made available under separate programs like the Indian child and family programs. Each tribe has a BIA agency that may be contacted for more information about education and training assistance.

(4) Section 480(b) of Title IV provides that the changes made in part F of Title IV of the Act by the amendment made by this section shall apply with respect to determinations of need under such part F for award years beginning on or after July 1, 1993.

(5) Under Title XIII, Indian Higher Education Programs, Part E//Tribal Development Student Assistance Revolving Loan Program, under the Tribal Development Student Assistance Act, Section 1343(c) provides that for purposes of determining eligibility, loans provided under this program may not be considered in needs analysis under any other federal law, and may not penalize students in determining eligibility for other funds. The Part E exclusion was effective October 1, 1992.

(6) Payments received under the Carl D. Perkins Vocational Education Act, Section 507, P.L. 98/524, as amended by P.L. 101/392, 9/25/90, Section 501 and 701 of the Carl D. Perkins Vocational and Applied Technology Education Act Amendments of 1990, are excluded.

(7) Amounts made available for tuition and fees, and for students attending an institution at least half time, books, supplies, transportation, dependent care, and miscellaneous personal expenses (other than room and board) are excluded. This provision was effective July 1, 1991. The programs under the Carl D. Perkins Act include the following:

(a) Indian vocational education program;

(b) native Hawaiian vocational education program;

(c) state vocational and applied technology education program, which contains the:

(i) state program and state leadership activities;

(ii) program for single parents, displaced homemakers, and single pregnant women;

(iii) sex equity program;

(iv) programs for criminal offenders;

(v) secondary school vocational education program;

(vi) postsecondary and adult vocational education program;

(vii) state assistance for vocational education support programs by community based organizations;

(viii) consumer and homemaking education program;

(ix) comprehensive career guidance and counseling program;

(x) business/labor/education partnership for training program.

(d) national tech/prep education program;

(e) state/administered tech/prep education program;

(f) supplementary state grants for facilities and equipment and other program improvement activities;

(g) community education employment centers program;

(h) vocational education lighthouse schools program;

(i) tribally controlled postsecondary vocational Institutions program;

(j) vocational education research program;

(k) national network for curriculum coordination in vocational and technical education;

(l) national center or centers for research in vocational education;

(m) materials development in telecommunications program;
(n) demonstration centers for the training of dislocated workers program;
(o) vocational education training and study grants program;
(p) vocational education leadership development awards program;
(q) vocational educator training fellowships program;
(r) internships for gifted and talented vocational education students program;
(s) business and education standards program;
(t) blue ribbon vocational education program;
(u) educational programs for federal correctional institutions;
(v) model programs of regional training for skilled trades;
(w) demonstration projects for the integration of vocational and academic learning program;
(x) cooperative demonstration programs;
(y) bilingual vocational training program;
(z) bilingual vocational instructor training program;
(aa) bilingual materials, methods, and techniques program;

(8) Federal Perkins Loans authorized under Part E of Title IV of the Higher Education Act must be handled in accordance with other Title IV income.

(9) Section 5(d)(3) of the Food Stamp Act, as amended by P.L. 101/624, Food Agriculture, Conservation and Trade Act of 1990, Title XVIII, Mickey Leland Memorial Domestic Hunger Relief Act, 11/28/90, and P.L. 102/237, Food, Agriculture, Conservation, and Trade Act Amendments of 1991, Section 903, provide that educational monies are excluded from income:

(a) when they are awarded to a person enrolled at a recognized institution of post/secondary education, at a school for the handicapped, in a vocational education program, or in a program that provides for completion of a secondary school diploma or obtaining the equivalent of (GED);

(b) to the extent that they do not exceed the amount used for or made available as an allowance determined by the school, institution, program, or other grantor, for tuition, mandatory fees, including the rental or purchase of any equipment, materials, and supplies related to the pursuit of the course of study involved, books, supplies, transportation, and other miscellaneous personal expenses (other than living expenses) of the student incidental to attending such school, institution, or program; and

(c) to the extent loans include any origination fees and insurance premiums.

I. Payments, allowances, and earnings to individuals participating in programs under the Job Training Partnership Act (JTPA) of 1982, P.L. 97/300 except for on/the/job training payments provided under section 204(5) of Title II of the JTPA to dependents 19 years of age or older.

J. Payments, allowances, and earnings of individuals participating in projects conducted under Title I of the National and Community Services Act of 1990. Such projects were considered to be conducted under the JTPA, per P.L. 101/610, Section 117(d), 11/16/90, which clarified Section 142(b) of the JTPA. There are about 47 different NCSA programs, and they vary by state.

K. Funds received by individuals 55 and older under the Senior Community Service Employment Program under Title V of the Older Americans Act, P.L. 100/175, Section 166, 11/29/87. Each state and eight organizations receive Title V funds. The eight organizations that receive Title V funds are:

(1) green thumb;
(2) national council on aging;
(3) national council of senior citizens;
(4) American association of retired persons;
(5) U.S. forest service;
(6) national association for Spanish speaking elderly;
(7) national urban league;
(8) national council on black aging.

L. Any amount by which the basic pay of an individual is reduced under P.L. 99/576, Veteran's Benefits Improvement and Health Care Authorization Act of 1986, Section 303(a)(1), 8/7/86, which amended Section 1411(b) and 1412(c) of the Veterans Educational Act of 1984 (GI Bill), which will revert to the treasury. Title 38 of the USC, Chapter 30, Section 1411 refers to basic educational assistance entitlement for service on active duty, and Section 1412 refers to basic educational assistance entitlement for service in the selected reserve. Section 216 of P.L. 99/576 authorized stipends for participation in study of Vietnam/era veterans' psychological problems. These payments are not excluded by law.

M. P.L. 100/242, Section 126(c)(5)(A), 11/6/87, the Housing and Community Development Act of 1987, excludes most increases in earned income of a family residing in certain housing while participating in HUD demonstration projects authorized by Section 126. Demonstration projects are authorized by this law for Charlotte, NC, and 10 additional locations. The affected regional offices are contacted individually regarding these projects.

N. P.L. 101/625, Section 522(i)(4), 11/28/90, Cranston/Gonzales National Affordable Housing Act, excludes most increases in the earned income of a family residing in certain housing while participating in HUD demonstration projects authorized by this public law. Demonstration projects are authorized by this law for Chicago, IL, and three other locations. The affected regional offices are contacted individually regarding these projects.

O. The value of any payment made under the Family Support Act, P.L. 100/485, Section 301, which amended Section 402 (g) (1)(E) of the Social Security Act, including payments made under Title IV/A of the Social Security Act, and including transitional payments (entitlement payments).

P. "At risk" block grant payments are excluded by P.L. 101/508, Section 5801, which amended Section 402(i) of the Social Security Act (11/5/1990). No deduction may be allowed for any expense covered by such payments.

Q. The value of any provided or arranged, or any amount received as payment for such care or reimbursement for costs incurred for such care is excluded by P.L. 102/586, Section 8, signed 11/4/1992, which amended the Child Care and Development Block Grant Act Amendments of 1992 by adding section 658S. The value or amount of is excluded from income for purposes of any federal or federally/assisted program that bases eligibility or amount of benefits on need. These payments are made under the Social Security Act, as amended.

R. A payment made to a participant for costs that are necessary and directly related to participation in a work program. Such costs include, but are not limited to, dependent care costs, transportation, expenses related to work, training or education, such as uniforms, personal safety items, other necessary equipment, and books or training manuals. Such costs may not include the cost of meals away from home. In addition, the value of dependent care services provided for or arranged for are excluded.

S. The full amount of any public assistance (PA) or general assistance (GA) housing assistance payment made to a third party on behalf of a household residing in transitional housing for the homeless by P.L. 103/66, the Mickey Leland Childhood Hunger Relief Act, 1993, which revised Section 5(k)(2)(F) of the Food Stamp Act. The exclusion is effective 9/1/1994.

T. Payments made under the Radiation Exposure Compensation Act, P.L. 101/426, Section 6 (h)(2), 10/15/1990.

U. All payments from the agent orange settlement fund or any other fund established pursuant to the settlement in the agent orange product liability litigation retroactive to January 1, 1989, in accordance with the Agent Orange Compensation Exclusion Act, P.L.101/201, 12/6/1989. An agent orange disabled veteran receives yearly payments. Survivors of deceased disabled veterans receive a lump/sum payment. These payments are disbursed by the AETNA insurance company.

(1) P.L. 101/239, signed 12/19/1989, the Omnibus Budget Reconciliation Act of 1989, Section 10405, also excluded payments made from the agent orange settlement fund or any other fund established pursuant to the settlement in the **In re: agent orange product liability litigation**, M.D.L. No. 381 (E.D.N.Y.) from income and resources in determining eligibility for the amount of benefits under the food stamp program.

(2) P.L. 102/4, Agent Orange Act of 1991, 2/6/1991, authorized veterans' benefits to some veterans with service/connected disabilities resulting from exposure to agent orange. Such VA payments are not excluded by law.

V. Any earned income tax credit is excluded from is not taken into account in determining resources for the month of receipt and the following month, under P.L. 101/508, 11/5/1990, the Omnibus Budget Reconciliation Act of 1990, Title XI Revenue Provisions, Section 11111, Modifications of Earned Income Tax Credit, subsection (b). This provision is effective for taxable years beginning after December 31, 1990. Subsequently, the September 1988 amendments to the Food Stamp Act require the exclusion from income of any payment made to a household under Section 3507 of the Internal Revenue Code of 1986 (relating to advance payment of earned income credit). The August 1993 amendments to the Food Stamp Act require the exclusion from resources of any earned income tax credits received by any member of the household for a period of 12 months from receipt if such member was participating in the food stamp program at the time the credits were received and participated in the program continuously during the 12 month period. The 1993 amendments are to be implemented September 1, 1994.

W. Payments made to individuals because of their status as victims of Nazi persecution per P.L. 103/286, August 1, 1994. The exclusion is effective for eligibility and benefit determinations made on or after

August 1, 1994, and excludes payments made before, on or after August 1.

X. Combat related military pay if the pay is the result of deployment to or service in a combat zone and was not received immediately prior to serving in combat zone.

Y. Guaranteed Basic Income is a program where individuals receive direct cash payments on a regular basis if they meet the eligibility criteria for that program. Income from this program is exempt when any funding comes from a private source.

Z. Universal Basic Income is any payments that is funded solely with private funds or mixture of private and public funds will be excluded income.

[8.139.527.9 NMAC - Rp, 8.139.527.9 NMAC 11/01/2023]

8.139.527.10 AMERICAN INDIAN OR ALASKA NATIVE:

A. Payments to the Turtle Mountain Band of Chippewas, Arizona (P.L. 97/403).

B. Payments to the Blackfeet, Gros Ventre, and Assiniboine tribes (Montana) and the Papago, Arizona tribe per P.L. 97/408.

C. Per capita and interest payments made to the Assiniboine Tribe of the Fort Belknap Indian Community, Montana, and to the Assiniboine Tribe of the Fort Peck Indian Reservation, Montana under P.L. 98/124, Section 5. Funds were awarded in docket 10/81L.

D. Funds awarded in docket number 15/72 of the United States Court of Claims and distributed to members of the Red Lake Band of Chippewas in accordance with P.L. 98/123, Section 3, 10/13/1983.

E. Payments to the Saginaw Chippewa Indian Tribe of Michigan under P.L. 99/346, Section 6 (b)(2).

F. Per capita payments distributed to, or held in trust for, the Chippewas of the Mississippi in accordance with P.L. 99/377, Section 4(b), 8/8/1986. The judgments were awarded in Docket Number 18/S. The funds are divided by reservation affiliation for the Mille Lac, White Earth, and Leech Lake Reservations, all of Minnesota.

G. All compensation, including cash, stock partnership interest, land, interest in land, and other benefits received under the Alaska Native Claims Settlement Act, P.L. 92/203, Section 29, dated 1/2/1976 and the Alaska Native Claims Settlement Act Amendments of 1987, P.L. 100/241, Section 15, 2/3/1988.

H. In accordance with 25 USCS 1407, Judgment Funds, as amended by P.L. 93/134 and P.L. 97/458, funds appropriated in satisfaction of judgments of the Indian claims commission or claims court in favor of any Indian tribe, band, etc. which:

(1) are distributed per capita or held in trust pursuant to a plan approved under the provisions of this Act (25 USCS Subsections 1401 et seq), or

(2) on the date of enactment of this act (January 12, 1983), are to be distributed per capita, or are held in trust pursuant to a plan approved by congress prior to the date of enactment of this act (January 12, 1983), or

(3) were distributed pursuant to a plan approved by congress after December 31, 1981, but prior to the date of enactment of this act (January 12, 1983), and any purchases made with such funds, including all interest and investment income accrued thereon while such funds are so held in trust, except for per capita payments in excess of $2,000. The $2,000 amount applies to each payment made to each person. Initial purchases made with exempt payments distributed between January 1, 1982, and January 12, 1983, are excluded from resources to the extent that excluded funds were used.

I. Per capita payments from funds which are held in trust by the secretary of the interior (trust fund distributions) for an Indian tribe per P.L. 98/64, 8/2/83, which applied the exclusion in 25 USC 1407. Per capita payments may be authorized for specific tribes under other public laws.

J. Relocation assistance payments to members of the Navajo and Hopi tribes under P.L. 93/531, section 22.

K. Income derived from certain submarginal land held in trust for certain Indian tribes under P.L. 94/114, section 6, 10/17/1975. The tribes that may benefit are the:

(1) Bad River band of the Lake Superior tribe of Chippewa Indians of Wisconsin;

(2) Blackfeet tribe;

(3) Cherokee nation of Oklahoma;

(4) Cheyenne River Sioux tribe;

(5) Crow Creek Sioux tribe;

(6) lower Brule Sioux tribe;

(7) Devils Lake Sioux tribe;

(8) Fort Belknap Indian community;

(9) Assiniboine and Sioux tribes;
(10) Lac Courte Oreilles band of Lake Superior Chippewa Indians;
(11) Keweenaw bay Indian community;
(12) Minnesota Chippewa tribe;
(13) Navajo tribe;
(14) Oglala Sioux tribe;
(15) Rosebud Sioux tribe;
(16) Shoshone/Bannock tribes;
(17) Standing Rock Sioux tribe.

L. Payments from the disposition of funds to the Grand River Band of Ottawa Indians, per P.L. 94/540.

M. Indian claims commission payments made to the confederated tribes and bands of the Yakima Indian Nation and the Apache tribe of the Mescalero reservation under P.L. 95/433, Section 2.

N. Payments made to the Passamaquoddy tribe, the Penobscot nation, and the Houlton Band of Maliseet under the Maine Indian Claims Settlement Act of 1980, P.L. 96/420, Section 9(c), 10/10/1980.

O. Funds made to heirs of deceased Indians under the Old Age Assistance Claims Settlement Act, under P.L. 98/500, Section 8, 10/17/1984, except for per capita shares in excess of $2,000.

P. Funds distributed per capita to the Sac and Fox Indians or held in trust per P.L. 94/189, Section 6, 12/31/1975. The funds are divided between members of the Sac and Fox tribe of Oklahoma and the Sac and Fox tribe of the Mississippi in Iowa. The judgments were awarded in Indian claims commission dockets numbered 219, 153, 135, 158, 231, 83, and 95.

Q. Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior in accordance with P.L. 99/146, Section 6(b), 11/11/1985. Judgments were awarded in dockets numbered 18/S, 18/U, 18/C, and 18/T. Dockets 18/S and 18/U are divided among the following reservations:

(1) **Wisconsin:** Bad River reservation, Lac du Flambeau reservation, Sokaogon Chippewa community, Red Cliff reservation, St. Croix reservation.

(2) **Michigan:** Keweenaw Bay Indian community, (l'Anse, Lac Vieux Desert, and Ontonagon Bands).

(3) **Minnesota:** Fond du Lac reservation, Grand Portage reservation, Nett Lake reservation (including Vermillion Lake and Deek creek), White Earth reservation.

(4) Under Dockets 18/C and 18/T, funds are given to the Lac Courte Oreilles Band of the Lake Superior Bands of Chippewa Indians of the Lac Courte Oreilles reservation of Wisconsin, the Bad River Band of the Lake Superior tribe of Chippewa Indians of the Bad River reservation, the Sokaogon Chippewa community of the Mole Lake Band of Chippewa Indians, and the St. Croix Chippewa Indians of Wisconsin.

R. Monies paid to the White Earth Band of Chippewa Indians in Minnesota, under the White Earth Reservation Land Settlement Act of 1985, per P.L. 99/264, Section 16, 3/24/1986.

S. Funds, assets, or income from the trust fund established and paid to the Puyallup tribe in the state of Washington will not affect the eligibility or benefit amount of its members for any federal program, per P.L. 101/41, 6/21/1989, Section 10(b), of the Puyallup tribe of Indians Settlement Act of 1989. Section 10(c) provides that none of the funds, assets, or income from the trust fund established in Section 6(b) shall at any time be used a basis for denying or reducing funds to the tribe or its members under any federal, state or local program.

T. Funds appropriated in satisfaction of judgments awarded to the Seminole Indians in Dockets 73, 151, and 73/A of the Indian claims commission, except for per capita payments in excess of $2,000 under P.L. 101/277, 4/30/1990. Payments were allocated to the Seminole nation of Oklahoma, the Seminole tribe of Florida, the Miccosukee tribe of Indians of Florida, and the independent Seminole Indians of Florida.

U. Payments, funds, or distributions authorized, established, or directed by the Seneca Nation Settlement Act of 1990 in accordance with P.L. 101/503, Section 8(b), dated November 3, 1990.

V. Interests of individual Indians in trust or restricted lands, and up to $2,000 per year of income received by individual Indians that is derived from such interests under 25 USCS 1408, as amended by P.L. 93/134, Section 8, 10/19/73, P.L. 97/458 and P.L. 103/66, Section 13736, 10/7/93. Interests include an Indian's right to or legal share of the trust or restricted lands and any income accrued from the funds in trust or the restricted lands. The exclusion applies to each individual Indian with an interest. The income exclusion applies for both eligibility and benefit amount purposes in the food stamp program. The income exclusion applies to calendar years and is effective beginning January 1, 1994.

W. Grant programs for child and family services on or near reservations in preparation for and implementation of child welfare codes under 25 USC 1931 Indian Child Welfare, P.L. 95/608, 11/8/1978),

subparagraph (a). Such programs may include, but are not limited to, family assistance, including homemaker and home counselors, day care, after school care, and employment, recreational activities, and respite care; home improvement; the employment of professional and other trained personnel to assist the tribal court in the disposition of domestic relations and child welfare matters; and education and training of Indians, including tribal court judges and staff, in skills relating to child and family assistance and service programs. Subparagraph (b) provides that assistance under 25 USCS 1901 et seq. shall not be a basis for the denial or reduction of any assistance otherwise authorized under any federally assisted programs.
[8.139.527.10 NMAC - Rp, 8.139.527.10 NMAC 11/01/2023]

HISTORY OF 8.139.527 NMAC:
Pre/NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 440.0000, Eligibility Criteria / Financial, 8/15/1980.
ISD 440.0000, Eligibility Criteria / Financial, 10/24/1980.
ISD/Rule 428.0000, Food Assistance / Resources, 11/4/1982.
ISD/Rule 428.0000, Food Assistance / Resources, 2/14/1983.
ISD/Rule 428.0000, Food Assistance / Resources, 1/12/1984.
ISD/Rule 428.0000, Food Assistance / Resources, 5/1/1986.
ISD FS 410, Food Stamp Resources, 3/1/1988.

History of Repealed Material: [**RESERVED**]

History of Repealed Material:
8.139.527 NMAC, Food Stamp Program - Food Stamp Program/Income And Resources Excluded By Federal Law filed 4/26/2001 repealed effective 11/1/2023.

Other: 8.139.527 NMAC, Food Stamp Program - Food Stamp Program/Income And Resources Excluded By Federal Law filed 4/26/2001 - was Replaced by 8.139.527 NMAC, Food Stamp Program - Food Stamp Program/Income And Resources Excluded By Federal Law, effective 11/1/2023.

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT RULES
PART 410 GENERAL RECIPIENT REQUIREMENTS

8.200.410.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.200.410.1 NMAC - Rp, 8.200.410.1 NMAC, 10/1/2017; A, 7/1/2024]

8.200.410.2 SCOPE: The rule applies to the general public.
[8.200.410.2 NMAC - Rp, 8.200.410.2 NMAC, 10/1/2017]

8.200.410.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.200.410.3 NMAC - Rp, 8.200.410.3 NMAC, 10/1/2017; A, 7/1/2024]

8.200.410.4 DURATION: Permanent.
[8.200.410.4 NMAC - Rp, 8.200.410.4 NMAC, 10/1/2017]

8.200.410.5 EFFECTIVE DATE: October 1, 2017, unless a later date is cited at the end of a section.
[8.200.410.5 NMAC - Rp, 8.200.410.5 NMAC, 10/1/2017]

8.200.410.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.200.410.6 NMAC - Rp, 8.200.410.6 NMAC, 10/1/2017]

8.200.410.7 DEFINITIONS: [**RESERVED**]

8.200.410.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.200.410.8 NMAC - A, 1/1/2022]

8.200.410.9 GENERAL RECIPIENT REQUIREMENTS: To be eligible or continue eligibility for medicaid or other medical assistance programs, an applicant or eligible recipient must meet specific non-financial requirements. In addition to the rules in this chapter, refer to 8.100.130 NMAC regarding the following requirements:

A. citizenship or non-citizen status;
B. enumeration;
C. residence;
D. non-concurrent receipt of assistance;
E. applications for other benefits; and
F. assignment of medical support rights.

[8.200.410.9 NMAC - Rp, 8.200.410.9 NMAC, 10/1/2017]

8.200.410.10 USE OF SOCIAL SECURITY NUMBER (42 CFR 435.910): Federal law requires, as a condition of eligibility, that each individual (including children) seeking medicaid furnish each of their social security numbers (SSN).

A. HCA will advise the applicant of:
(1) the statute or other authority under which the agency is requesting the applicant's SSN; and

(2) the uses HCA will make of each SSN, including its use for verifying income, eligibility, and amount of medical assistance payments per 42 CFR 435.940 through 435.960.

B. If an applicant cannot recall their SSN or SSNs or has not been issued a SSN HCA will:

(1) assist the applicant in completing an application for an SSN;

(2) obtain evidence required under the social security administration (SSA) regulations to establish the age, the citizenship or non-citizen status, and the true identity of the applicant; and

(3) either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

C. HCA cannot deny or delay services to an otherwise eligible individual pending issuance or verification of the individual's SSN by SSA or if the individual meets one of the exceptions in Paragraph (5) of Subsection A of 8.200.410.10 NMAC.

D. HCA will verify the SSN furnished by an applicant or beneficiary with SSA to ensure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

E. Exception:

(1) The requirement of Paragraph (3) of Subsection A of 8.200.410.10 NMAC does not apply and HCA may give a medicaid identification number to an individual who:

(a) is not eligible to receive an SSN;

(b) does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104; or

(c) refuses to obtain an SSN because of well-established religious objections.

(2) The identification number may be either an SSN obtained by HCA on the applicant's behalf or another unique identifier.

(3) The term well established religious objections means that the applicant;

(a) is a member of a recognized religious sect or division of the sect; and

(b) adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

(4) HCA may use the medicaid identification number established by HCA to the same extent as an SSN is used for purposes described in Subparagraph (b) of Paragraph (1) of Subsection A of 8.200.410.NMAC.

[8.200.410.10 NMAC - Rp, 8.200.410.10 NMAC, 10/1/2017]

8.200.410.11 CITIZENSHIP: To be eligible for medicaid, an individual must be a citizen of the United States; United States national or a non-citizen who meets the requirements set forth in either Subsection A or B of 8.200.410.11 NMAC.

A. Non-citizens who entered the United States prior to August 22, 1996: Non-citizens who entered the United States prior to August 22, 1996, will not be subject to the five-year bar for purposes of medicaid eligibility. These classes of non-citizens are as follows.

(1) Qualified non-citizens who entered the United States prior to August 22, 1996, and obtained their qualified non-citizen status prior to that date, are eligible for medicaid without the five year waiting period.

(2) Non-citizens who entered the United States prior to August 22, 1996, and remained continuously present in the United States until the date they obtained qualified non-citizen status on or after August 22, 1996; any single absence from the United States of more than 30 days, or a total aggregate of absences of more than 90 days, is considered to interrupt "continuous presence".

(3) Lawful Permanent Residents (LPRs) are qualified non-citizens per 8 USC 1641.

(4) A non-qualified non-citizen who was permanently residing in the United States under color of law (PRUCOL) on or before August 22, 1996, does not lose medicaid eligibility provided all other factors of eligibility continue to be met. These non-citizens are "grandfathered". For these individuals, non-citizen eligibility may continue to be based on the PRUCOL standard. An individual eligible under the PRUCOL standard retains their grandfathering rights even if benefits terminate.

B. Qualified non-citizens who entered the United States on or after August 22, 1996:

(1) Qualified non-citizens who entered the United States on or after August 22, 1996, are barred from medicaid eligibility for a period of five years, other than emergency services (under Category 085), unless meeting an exception below. LPRs who adjust from a status exempt from the five-year bar are not subject to the five-year bar. The five-year bar begins on the date the non-citizen obtained qualified status. The following classes of qualified non-citizens are exempt from the five-year bar:

(a) a non-citizen admitted to the United States as a refugee under Section 207 of the Immigration and Nationality Act;

(b) a non-citizen granted asylum under Section 208 of the Immigration and Nationality Act;

(c) a non-citizen whose deportation is withheld under Section 243(h) of the Immigration and Nationality Act;

(d) a non-citizen who is lawfully residing in the state and who is a veteran with an honorable discharge not on account of non-citizen status; is on active duty other than on active duty for training, in the armed forces of the United States; or the spouse or unmarried dependent child under the age of 18 of such veteran or active duty non-citizen;

(e) a non-citizen who was granted status as a Cuban and Haitian entrant, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980;

(f) a non-citizen granted Amerasian immigrant status as defined under Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act, 1988;

(g) victims of a severe form of trafficking, in accordance with Paragraph (1) of Subsection B of Section 107 of the Trafficking Victims Protection Act of 2000, P.L. 106-386;

(h) members of a federally recognized Indian tribe, as defined in 25 U.S.C. 450b(e);

(i) American Indians born in Canada to whom Section 289 of the Immigration and Nationality Act applies;

(j) Afghan and Iraqi special immigrants under Section 8120 of Pub. L. 111-118 of the Department of Defense Appropriations Act, 2010;

(k) non-citizens receiving SSI; and

(l) battered non-citizens who meet the conditions set forth in Section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) as added by Section 501 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, P.L. 104-208 (IIRIRA), and amended by Section 5571 of the Balanced Budget Act of 1997, P.L. 105-33 (BBA), and Section 1508 of the Violence Against Women Act of 200, P.L. 106-386; Section 431(c) of PRWORA, as amended, is codified at 8 USC 1641(c). HCA covers battered non-citizens with state general funds until the five-year bar is met.

(m) effective December 27, 2020, per section 208 of the Consolidated Appropriations Act, 2021 individuals who are considered compact of free association migrants (COFA) are also referred to as compact citizens. COFA is an agreement between the United States and the three Pacific Island sovereign states of Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau known as Freely Associated States.

(2) Qualified non-citizen: A "qualified non-citizen", for purposes of this regulation, is a non-citizen, who at the time the non-citizen applies for, receives, or attempts to receive a federal public benefit, is:

(a) a non-citizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act;

(b) a non-citizen who is granted asylum under Section 208 of such act; or

(c) a refugee who is admitted to the United States under Section 207 of the act; or

(d) an Amerasian who is admitted to the United States under Section 207 of the act; or

(e) a non-citizen who is paroled into the United States under Section 212(d)(5) of such act for a period of at least one year; or

(f) a non-citizen whose deportation is being withheld under Section 243(h) of such act or under Section 241(b)(3); or

(g) a non-citizen who is granted conditional entry pursuant to 203(a)(7) or such act as in effect prior to April 1, 1980; or

(h) a non-citizen who is a Cuban or Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980); or

(i) certain battered women and non-citizen children of battered parents (only those who have begun the process of becoming a lawful permanent resident under the Violence Against Women Act); or

(j) victims of a severe form of trafficking and their spouses, children, siblings, or parents; or

(k) members of a federally recognized Indian tribe, as defined in 25 U.S.C. 450b(e); or

(l) American Indians born in Canada to whom Section 289 of the Immigration and Nationality Act applies; or

(m) Afghan and Iraqi special immigrants under Section 8120 of Pub. L. 111-118 of the Department of Defense Appropriations Act, 2010.

(3) Children under age 21 and pregnant women exempt from the five year bar: As authorized by CHIPRA 2009 legislation, New Mexico medicaid allows lawfully residing children under age 21 and pregnant women, if otherwise eligible including meeting state residency and income requirements, to obtain medicaid coverage. Lawfully residing children under age 21 and pregnant women must meet the residency requirement as set forth in 8.200.410.12 NMAC. A child or pregnant woman is considered lawfully present if he or she is:

(a) a qualified non-citizen as defined in Section 431 of PRWORA (8 USC Section 1641);

(b) a non-citizen in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission as defined under 8 USC 1101(a)(15);

(c) a non-citizen who has been paroled into the United States pursuant to Section 212(d)(5) of the Immigration and Nationality Act (8 U.S.C. Section 1182(d)(5)) for less than one year, except for a non-citizen paroled for prosecution, for deferred inspection or pending removal proceedings;

(d) a non-citizen who belongs to one of the following classes:

(i) non-citizens currently in temporary resident status pursuant to Section 210 or 245A of the Immigration and Nationality Act (8 U.S.C. Section1160 or 1255a, respectively);

(ii) non-citizens currently under temporary protected status (TPS) pursuant to Section 244 of the Immigration and Nationality Act (8 U.S.C. Section 1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) non-citizens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) family unity beneficiaries pursuant to Section 301 of Pub. L. 101-649, as amended;

(v) non-citizens currently under deferred enforced departure (DED) pursuant to a decision made by the president;

(vi) non-citizens currently in deferred action status except those with deferred action under "Defined Action for Childhood Arrivals" who are not considered lawfully present.

(vii) non-citizens whose visa petitions have been approved and who have a pending application for adjustment of status;

(e) a non-citizen with pending applicants for asylum under Section 208(a) of the INA (8 U.S.C. Section 1158) or for withholding of removal under Section 241(b)(3) of the INA (8 U.S.C. Section 1231) or under the convention against torture who has been granted employment authorization, or is an applicant under the age of 14 and has had an application pending for at least 180 days;

(f) non-citizens whose applications for withholding of removal under the convention against torture have been granted;

(g) children who have pending applications for special immigrant juvenile status as described in Section 101(a)(27)(J) of the Immigration and Nationality Act (8 U.S.C. Section1101(a)(27)(J));

(h) non-citizens who are lawfully present in American Samoa under the immigration laws of American Samoa; or

(i) victims of trafficking.

(4) Non-citizen sponsors (where an affidavit of sponsorship was executed pursuant to Section 213 of the Immigration and Nationality Act subsequent to August 22, 1996): The income and resources of a non-citizen sponsor, of any individual applying for medicaid, are deemed available to the applicant, when an affidavit of support is executed pursuant to Section 213 of the Immigration and Nationality Act, on or after August 22, 1996. This counting of non-citizen sponsor income and resources is effective until the sponsored non-citizen achieves citizenship.

(5) The state assures that it provides limited medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the social security act and 8.285.400 NMAC and implemented at 42 CFR 440.255, to the following individuals who meet all medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status or present an SSN.

(a) qualified non-citizens subject to the five-year waiting period described in 8 USC 1613; or

(b) non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 42 CFR 435.406(b).

[8.200.410.11 NMAC - Rp, 8.200.410.11 NMAC, 10/1/2017; A/E, 1/18/2018; A, 8/1/2018; A, 1/1/2022]

8.200.410.12 TYPES OF ACCEPTABLE DOCUMENTARY EVIDENCE OF CITIZENSHIP (42 CFR 435.407):

A. Stand-alone evidence of citizenship: The following must be accepted as sufficient documentary evidence of citizenship:

(1) A U.S. passport, including a U.S. passport card issued by the department of state, without regard to any expiration date as long as such passport or card was issued without limitation.

(2) A certificate of naturalization.

(3) A certificate of U.S. citizenship.

(4) A valid state-issued driver's license if the state issuing the license requires proof of U.S. citizenship, or obtains and verifies a SSN from the applicant who is a citizen before issuing such license.

(a) A real ID issued on or after November 14, 2016 is sufficient documentary evidence of citizenship.

(b) A driver authorization card (DAC) is not sufficient documentary evidence of citizenship.

(5) Documentary evidence issued by a federally recognized Indian tribe identified in the federal register by the bureau of Indian affairs within the U.S. department of the interior, and including tribes located in a state that has an international border, which;

(a) Identifies the federally recognized Indian tribe that issued the document;

(b) Identifies the individual by name; and

(c) Confirms the individual's membership, enrollment, or affiliation with the tribe.

(d) Documents described in Paragraph (5) of Subsection A of 8.200.410.12 NMAC include, but are not limited to:

(i) A tribal enrollment card;

(ii) A certificate of degree of Indian blood;

(iii) A tribal census document;

(iv) Documents on tribal letterhead, issued under the signature of the appropriate tribal official, that meet the requirements of Paragraph (5) of Subsection A of 8.200.410.12 NMAC.

(6) A data match with the SSA.

B. Evidence of citizenship: If an applicant does not provide documentary evidence from the list in Subsection A of 8.200.410.12 NMAC, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in Subsection C of 8.200.410.12 NMAC:

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Guam, American Samoa, Swain's Island, Puerto Rico (if born on or after January 13, 1941), the Virgin Islands of the U.S. or the Commonwealth of the Northern Mariana Islands (CNMI) (if born after November 4, 1986, (CNMI local time)). The birth record document may be issued by a state, commonwealth, territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico or the Northern Mariana Islands before the applicable date referenced in Paragraph (1) of Subsection B of 8.200.410.12 NMAC, the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:

(a) Puerto Rico: Evidence of birth in Puerto Rico and the applicant's statement that he or she was residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941;

(b) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI));

(i) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986, (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);

(ii) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975, and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);

(iii) Evidence of continuous domicile in the NMI since before January 1, 1974, and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) A certification of report of birth, issued to U.S. citizens who were born outside the U.S.

(3) A report of birth abroad of a U.S. citizen.

(4) A certification of birth in the U.S.

(5) A U.S. citizen identification card.

(6) A Northern Marianas identification card issued by the U.S. department of homeland security (or predecessor agency).

(7) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth.

(8) Evidence of U.S. civil service employment before June 1, 1976.

(9) U.S. military record showing a U.S. place of birth.

(10) A data match with the Systematic Alien Verification for Entitlements (SAVE) Program or any other process established by the department of homeland security (DHS) to verify that an individual is a citizen.

(11) Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000 as amended (8 U.S.C. 1431).

(12) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.

(13) Life, health, or other insurance record that indicates a U.S. place of birth.

(14) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.

(15) School records, including pre-school, head start and daycare, showing the child's name and U.S. place of birth.

(16) Federal or state census record showing U.S. citizenship or a U.S. place of birth.

(17) If the applicant does not have one of the documents listed in Subsection A or Paragraph (1) through (17) of Subsection B of 8.200.410.12 NMAC, he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

C. Evidence of identity:

(1) HCA will accept the following as proof of identity, provided such document has a photograph or other identifying information sufficient to establish identity, including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

(a) Identity documents listed at 8 CFR 274a.2 (b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority.

(b) Driver's license issued by a state or territory.

(c) School identification card.

(d) U.S. military card or draft record.

(e) Identification card issued by the federal, state, or local government.

(f) Military dependent's identification card.

(g) U.S. coast guard merchant mariner card.

(h) For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.

(i) Two other documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards; high school, high school equivalency and college diplomas; marriage certificates; divorce decrees; and property deeds or titles.

(2) Finding of identity from a federal or state governmental agency. The agency may accept as proof of identity a finding of identity from a federal agency or another state agency including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

(3) If the applicant does not have any document specified in Paragraph (1) of Subsection C of 8.200.410.12 NMAC and identity is not verified under Paragraph (2) of Subsection C of 8.200.410.12 NMAC, the agency must accept an affidavit signed, under penalty of perjury, by a person other than the applicant who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying

information establishing identity, as described in Paragraph (1) of Subsection C of 8.200.410.12 NMAC. The affidavit does not have to be notarized.

D. Verification of citizenship by a federal agency or another state: HCA may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a federal agency or another state agency, if such verification was done on or after July 1, 2006.

E. Assistance with obtaining documentation: HCA will provide assistance to individuals who need assistance in securing satisfactory documentary evidence of citizenship in a timely manner.

F. Documentary evidence: A photocopy, facsimile, scanned or other copy of a document must be accepted to the same extent as an original document under this section, unless information on the copy submitted is inconsistent with other information available to HCA or HCA otherwise has reason to question the validity of, or the information in, the document.

[8.200.410.12 NMAC - N, 10/1/2017; A, 1/1/2022]

8.200.410.13 REASONABLE OPPORTUNITY PERIOD (42 CFR 435.956(b)):

A. HCA provides a reasonable opportunity period to individuals who have made a declaration of citizenship or satisfactory immigration status in accordance with 42 CFR 435.406, and for whom the HCA is unable to verify citizenship or satisfactory immigration status. During the reasonable opportunity period, the HCA continues efforts to complete verification of the individual's citizenship or satisfactory immigration status, or request documentation if necessary. The HCA provides notice of such opportunity that is accessible to persons who have limited English proficiency and individuals with disabilities, consistent with 42 CFR 435.905(b). During such reasonable opportunity period, the HCA must, if relevant to verification of the individual's citizenship or satisfactory immigration status:

(1) in the case of individuals declaring citizenship who do not have an SSN at the time of such declaration, assist the individual in obtaining an SSN in accordance with 42 CFR 435.910 and Paragraph (2) of Subsection A of 8.200.410.10 NMAC, and attempt to verify the individual's citizenship once an SSN has been obtained and verified;

(2) provide the individual with information on how to contact the electronic data source so that he or she can attempt to resolve any inconsistencies defeating electronic verification directly with such source, and pursue verification of the individual's citizenship or satisfactory immigration status if the individual or source informs the HCA that the inconsistencies have been resolved; and

(3) provide the individual with an opportunity to provide other documentation of citizenship or satisfactory immigration status, in accordance with section 1137(d) of the Act and 42 CFR 435.406 or 435.407 and 8.200.410.12 NMAC.

B. The reasonable opportunity period:

(1) begins on the date on which the notice is received by the individual. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual shows that he or she did not receive the notice within the five-day period; and

(2) ends on the earlier of the date the HCA verifies the individual's citizenship or satisfactory immigration status or determines that the individual did not verify their citizenship or satisfactory immigration status or 90 days except that;

(3) HCA extends the reasonable opportunity period beyond 90 days, allowing for up to three 10 day extensions, for individuals declaring to be in a satisfactory immigration status if the HCA determines that the individual is making a good faith effort to obtain any necessary documentation or the agency needs more time to verify the individual's status through other available electronic data sources or to assist the individual in obtaining documents needed to verify their status.

(4) if, by the end of the reasonable opportunity period, the individual's citizenship or satisfactory immigration status has not been verified the HCA will take action within 30 days to terminate eligibility.

[8.200.410.13 NMAC - N, 10/1/2017]

8.200.410.14 RESIDENCE: To be eligible for medicaid, an applicant or eligible recipient must be living in New Mexico on the date of application and final determination of eligibility and have demonstrated an intention to remain in the state.

A. Establishing residence: Residence is established by living in the state and carrying out the types of activities associated with day-to-day living, such as occupying a home, enrolling a child in school or getting a state driver's license. An applicant or recipient who is homeless is considered to have met the residence requirements if he or she intends to remain in the state.

B. Recipients receiving benefits out-of-state: An applicant or an eligible recipient who receives financial or medical assistance in another state which makes residence in that state a condition of eligibility are considered residents of that state until the ISD office receives verification from the other state agency indicating that it has been notified by an applicant or eligible recipient of the abandonment of residence in that state.

C. Individuals court ordered into full or partial responsibility of the state children youth and families department (CYFD): When CYFD places a child in a new state of residence, the new state of residence is responsible for the provision of medicaid; however, the state must provide limited medicaid coverage for medicaid services that are part of the state medicaid benefit package and not available in the new state of residence.

D. Abandonment: Residence is not abandoned by temporary absences. Temporary absences occur when an eligible recipient leaves the state for specific purposes with time-limited goals. Residence is considered abandoned when the applicant or the eligible recipient leaves the state for any of the following reasons:

(1) intends to establish residence in another state;

(2) for no specific purpose with no clear intention of returning;

(3) applies for financial, food or medical assistance in another state which makes residence in that state a condition of eligibility; or

(4) for more than 30 consecutive calendar days, without notifying HCA of their departure or intention of returning.

E. Evidence of immigration status may not be used to determine that an individual is not a state resident per 42 CFR 435.956 (c)(2).

[8.200.410.14 NMAC - Rp, 8.200.410.12, 10/1/2017]

8.200.410.15 NON-CONCURRENT RECEIPT OF ASSISTANCE:

A. An applicant or an eligible recipient receiving medicaid in another state is not medical assistance program eligible in New Mexico except when:

(1) institutional care medicaid begins on a specific date within the month rather than automatically reverting to the first day of the month, if an applicant for institutional care medicaid (Category 081, 083 or 084) moves to New Mexico from another state and it can be verified that the other state will terminate the individual's medicaid eligibility under that state program prior to the initial eligibility date in New Mexico, the application may be approved even though the individual receives medicaid from the other state for part of the month; coverage in New Mexico begins after the end date of services from the other state;

(2) an individual is court ordered into full or partial responsibility CYFD; when CYFD places a child in a new state of residence, the new state of residence is responsible for the provision of medicaid; however, New Mexico must provide limited medicaid coverage for medicaid services that are part of New Mexico's medicaid benefit package and not available in the new state of residence.

B. An individual who is eligible for a full-coverage medicaid program may also be eligible for one of the medicare cost sharing medical assistance program categories. See 8.200.400 NMAC.

C. When a supplemental security income (SSI) recipient enters into a nursing home or hospital (institutionalized), SSA will re-evaluate SSI and related medicaid eligibility.

(1) When SSA determines that the individual remains eligible for SSI while institutionalized, the SSI benefit is adjusted as follows:

(a) if institutionalized for more than 90 calendar days - the SSI benefit is limited to $30 a month; or

(b) if institutionalized for 90 calendar days or less - the SSI benefit continues at the regular amount.

(2) When SSA determines that the individual is not eligible for SSI, the individual or their authorized representative should file an application at HCA for institutional care medicaid. If the individual meets all factors of eligibility, approval of the institutional care medicaid application should be coordinated with the SSI closure date. If eligible, there will not be a break in eligibility and the individual shall not receive both SSI and institutional care medicaid in the same month pursuant to 8.281.400.10 NMAC.

[8.200.410.15 NMAC - Rp, 8.200.410.13, 10/1/2017]

8.200.410.16 APPLICATIONS FOR OTHER BENEFITS: As a condition of eligibility, a medicaid applicant or an eligible recipient must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, within 30 calendar days from the date HCA furnishes notice of the potential benefit, unless they can show good cause for not doing so.

A. **Benefit types:** Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, old age survivors and disability insurance (OASDI) benefits, railroad retirement benefits, and unemployment compensation.

B. **Exceptions to general requirement/good cause:** An individual may request a good cause waiver to this requirement by presenting ISD with corroborating evidence that:

(1) applying for other benefits is against the best interest of the individual, child or others, including physical or emotional harm to a child, parent or caregiver relative, adoption proceedings, and potential for emotional impairment; or

(2) exceptions applicable to institutional care medicaid, the SSI-related categories and the home and community based waivers are pursuant to Subsection B of 8.215.500.9 NMAC, Subsection B of 8.281.500.9 NMAC, and Subsection B of 8.290.500.9 NMAC.

C. **Failure to apply for and take steps to determine eligibility for other benefits:** When the parent(s) or where applicable the specified relative fails or refuses to apply for and take steps to determine eligibility within 30 calendar days from the date HCA furnishes notice of the potential benefit, the parent(s) or specified relative is not eligible for medicaid. An eligible recipient under the age of 18 years shall not lose their medicaid eligibility under this provision.

[8.200.410.16 NMAC - Rp, 8.200.410.14, 10/1/2017]

8.200.410.17 INMATE IN A PUBLIC INSTITUTION:

A. A public institution is a:

(1) state and private correctional facility;

(2) county and privately operated jail;

(3) department of health behavioral health facility forensic unit;

(4) detention facility operated under the authority of CYFD; or

(5) facility that is operated under the authority of CYFD that provides for the care and rehabilitation of an individual who is under 18 years of age and who has committed an act that would be designated as a crime under the law if committed by an individual who is 18 years of age or older.

B. An inmate is a person incarcerated in a public institution listed in Subsection A of 8.200.410.15 NMAC for 30 or more days.

C. An inmate who is incarcerated in a public institution is not eligible for MAP services. The only exception are those services provided to an inmate while he or she is an inpatient in a medical facility outside the public institution for 24 hours or longer.

D. Incarceration in a public institution is not a basis for denying or terminating a MAP category of eligibility. During the time of incarceration an inmate may apply or recertify for a MAP category of eligibility.

[8.200.410.17 NMAC - Rp, 8.200.410.15, 10/1/2017]

8.200.410.18 AUTOMATIC ENROLLMENT INTO MEDICARE PART B COVERAGE:

A. Beginning August 1, 2019, HCA automatically enrolls into medicare part B individuals:

(1) who are active on a full medicaid or medicare savings program category of eligibility with the exception of the following categories:

(a) other adults (COE 100);

(b) newborn (COE 031);

(c) children, youth and families department medicaid categories (COEs 017, 037, 046, 047, 066, and 086);

(d) family planning (COE 029);

(e) pregnancy services (COE 301);

(f) refugee (COE 049 and 059);

(g) qualified disabled working individuals (COE 050);

(h) breast and cervical cancer (COE 052); and

(2) who are enrolled in medicare part A and eligible for and not enrolled in medicare part B.

B. HCA informs applicants and recipients in writing who may be eligible for automatic enrollment into medicare part B. HCA will automatically enroll eligible individuals into medicare part B regardless of whether general or open enrollment of medicare part B is allowed under federal law at the time an individual is approved for medicaid.

[8.200.410.18 NMAC - N, 8/1/2019]

HISTORY OF 8.200.410 NMAC:

History of Repealed Material:
8.200.410 NMAC, General Recipient Requirements, filed 6/11/2003 - Repealed effective 1/1/2014.
8.200.410 NMAC, General Recipient Requirements, filed 12/2/2013 - Repealed effective 10/1/2017.

NMAC History:
8.200.410 NMAC, General Recipient Requirements, filed 12/2/2013 was replaced by 8.200.410 NMAC, General Recipient Requirements effective 10/1/2017.

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT RULES
PART 420 SPECIAL RECIPIENT REQUIREMENTS

8.200.420.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.200.420.1 NMAC - Rp, 8.200.420.1 NMAC, 1/1/2014 ; A,7/1/2024]

8.200.420.2 SCOPE: The rule applies to the general public.
[8.200.420.2 NMAC - Rp, 8.200.420.2 NMAC, 1/1/2014]

8.200.420.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.200.420.3 NMAC - Rp, 8.200.420.3 NMAC, 1/1/2014; A, 7/1/2024]

8.200.420.4 DURATION: Permanent.
[8.200.420.4 NMAC - Rp, 8.200.420.4 NMAC, 1/1/2014]

8.200.420.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.200.420.5 NMAC - Rp, 8.200.420.5 NMAC, 1/1/2014]

8.200.420.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.200.420.6 NMAC - Rp, 8.200.420.6 NMAC, 1/1/2014]

8.200.420.7 DEFINITIONS: [**RESERVED**]

8.200.420.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.200.420.8 NMAC - Rp, 8.200.420.8 NMAC, 1/1/2014]

8.200.420.9 AGE: For certain medicaid categories, an individual must meet specified age requirements. See specific NMAC eligibility chapters for each medicaid category for age requirements.
[8.200.420.9 NMAC - Rp, 8.200.420.9 NMAC, 1/1/2014]

8.200.420.10 SCHOOL ATTENDANCE: School attendance is a factor in determining JUL medicaid eligibility for 18 year-old applicants or re-determining recipients. School attendance is not a factor in determining JUL medicaid for children under the age of 18 years.
[8.200.420.10 NMAC - Rp, 8.200.420.10 NMAC, 1/1/2014]

8.200.420.11 DISABILITY: For an individual applying for a specific medical assistance division (MAD) category of eligibility, disability is a condition of eligibility. The determination of disability is made by the disability determination services unit. The social security administration's (SSA) definition of disability is used for that determination.
[8.200.420.11 NMAC - Rp, 8.200.420.11 NMAC 1/1/2014]

8.200.420.12 THIRD PARTY LIABILITY: Refer to 8.200.430.13 NMAC.
[8.200.420.12 NMAC - Rp, 8.200.420.12 NMAC, 1/1/2014]

8.200.420.13 MEDICAID ESTATE RECOVERY: Refer to 8.200.430.20 NMAC.

[8.200.420.13 NMAC - Rp, 8.200.420.13 NMAC, 1/1/2014]

HISTORY 8.200.420 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 304.1000, Provider Reimbursement Responsibility, filed 1/17/1980.
ISD 304.1000, Provider Reimbursement Responsibility, filed 9/8/1981.
ISD 304.2000, Recipient Reimbursement Responsibility, filed 1/9/1980.
ISD 304.3000, Reimbursement Limitations, filed 1/17/1980.
ISD 304.3000, Reimbursement Limitations, filed 9/8/1981.
ISD Rule 304.3000, Reimbursement Limitations, filed 12/17/1985.
ISD 304.4000, Billing Limitations, filed 1/17/1980.
ISD 304.4000, Billing Limitations, filed 9/8/1981.
ISD 304.7000, Reimbursement To Out-Of-State Providers, filed 1/17/1980.
ISD 304.7000, Reimbursement To Out-Of-State Providers, filed 9/8/1981.
ISD 304.8000, Third Party Liability, filed 1/17/1980.
ISD 304.8000, Third Party Liability, filed 9/8/1981.
ISD 304.9000, Usual And Customary, filed 1/17/1980.
ISD 304.9000, Reasonable Charge Pricing, filed 9/8/1981.
ISD Rule 304.9000, Reasonable Charge Pricing, filed 2/17/1984.
ISD Rule 304.9000, Reasonable Charge Pricing, filed 3/30/1984.
MAD Rule 304.9, Reimbursement, filed 12/15/1987.
MAD Rule 304.9, Reimbursement, filed 8/11/1988.
MAD Rule 304, Billing And Reimbursement, filed 11/8/1989.
MAD Rule 304, Billing And Reimbursement, filed 4/21/1992.

History of Repealed Material:
8.200.420 NMAC, Special Recipient Requirements, filed 6/13/2001 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 201 MEDICAID ELIGIBILITY - MEDICAID EXTENSION (CATEGORY 001, 003 and 004)
PART 400 RECIPIENT POLICIES

8.201.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.201.400.1 NMAC - Rp, 8.201.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.201.400.2 SCOPE: The rule applies to the general public.
[8.201.400.2 NMAC - Rp, 8.201.400.2 NMAC, 1/1/2019]

8.201.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Sections 27-2-12 et seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.201.400.3 NMAC - Rp, 8.201.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.201.400.4 DURATION: Permanent.
[8.201.400.4 NMAC - Rp, 8.201.400.4 NMAC, 1/1/2019]

8.201.400.5 EFFECTIVE DATE: January 1, 2019, unless a later date is cited at the end of the section.
[8.201.400.5 NMAC - Rp, 8.201.400.5 NMAC, 1/1/2019]

8.201.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.201.400.6 NMAC - Rp, 8.201.400.6 NMAC, 1/1/2019]

8.201.400.7 DEFINITIONS: [**RESERVED**]

8.201.400.8 [**RESERVED**]

8.201.400.9 MEDICAID EXTENSION - CATEGORIES 001, 003 AND 004: Medicaid extension (categories 001, 003 and 004) provides coverage for certain groups of individuals who have lost eligibility for supplemental security income (SSI) for specified reasons.
[8.201.400.9 NMAC - Rp, 8.201.400.9 NMAC, 1/1/2019]

8.201.400.10 BASIS FOR DEFINING THE GROUP: Medicaid provides coverage for the following groups of applicants/recipients who have received supplemental security income (SSI) benefits and who have lost their SSI benefits for specified reasons.

A. Pickle and 503 lead cases:

(1) Individuals who were entitled to SSI benefits and who subsequently lose eligibility for SSI solely due to the cost-of-living increase (COLA) in Title II benefits are automatically extended medicaid effective the month after the termination of SSI. These cases are referred to as 503 leads. See Public Law 94-566, Section 503 (also known as the "Pickle Amendment").

(2) Individuals who lose SSI eligibility for any reason other than the COLA increases (Pickle cases) may be entitled to medicaid if the following conditions exist:

(a) the reason for loss of SSI no longer exists; and

(b) the adjusted income after applying the applicable income disregards is below the current SSI income ceiling federal benefit rate (FBR).

(3) Individuals who received both Title II and SSI benefits after April 1977 and who lost SSI eligibility but would still be eligible for SSI if the Title II COLAs were deducted from countable income are eligible for medicaid extension. See Lynch V. Rank, 747 F.2d. 528 (9th Cir. 1984). These individuals must meet the requirements for SSI eligibility after the Title II COLAs are deducted.

(a) To determine the countable Title II income, deduct the Title II COLAs received after the last SSI eligibility period using the FBR table compared with the current SSI income ceiling. See 8.200.520 NMAC, Income Standards.

(b) The social security administration (SSA) office identifies applicants/recipients as "Pickle" or "503 lead" cases and the HCA disseminates this information to the appropriate income support division (ISD) office. The income support division (ISD) worker approves the case effective the month after the SSI termination.

(c) After identification as a 503 lead or a Pickle case, the SSA office generates a notice to individuals advising them of their right to apply for medicaid.

B. Early widow(er)s:

(1) Widow(er)s between 60 and 64 years of age, who meet the following requirements are eligible for medicaid extension, (Public Law 100-203, which amended Section 1634D of the Social Security Act):

(a) current Title II recipients who were entitled to and received SSI benefits;

(b) subsequently lost eligibility for SSI due to initial receipt of, or increase in, early widow's or widower's benefits; and

(c) are not entitled to medicare part A, hospital insurance.

(2) Medicaid coverage is extended until an applicant/recipient either becomes eligible for the hospital insurance under medicare part A or reaches 65 years of age, whichever is earlier.

(3) The ISD worker disregards a Title II widow(er)'s benefit for the purpose of determining eligibility.

C. Child insurance benefits:

(1) Individuals who lose SSI eligibility after July 1, 1987, as a result of entitlement to or receipt of an increase in Title II benefits for disabled adult children (DACs) are eligible for medicaid extension. [Public Law 99-643, Section 6].

(2) The SSA office identifies DACs systematically and HCA alerts the appropriate ISD office to approve the case effective the month after the SSI termination.

(a) Title II DAC benefit is disregarded in determining eligibility.

(b) Title II benefits are awarded from the account(s) of the individual's parent(s) and, in most instances, can be identified by a claim suffix of "C" following the claim number;

D. Disabled widow(er)s and disabled surviving divorced spouses:

(1) Disabled widow(er)s and disabled surviving divorced spouses who lost SSI on or after January 1, 1991 due to receipt of Title II benefits resulting from the liberalization of the definition of disability. See Section 503 of OBRA 1990. To qualify for medicaid, these applicant/recipients must meet all of the following conditions:

(a) received SSI for the month prior to the month in which they began receiving the Title II benefits;

(b) would continue to be eligible for SSI if the amount of the Title II benefit were not counted as income; and

(c) are not entitled to medicare part A.

(2) These applicants/recipients lose eligibility for medicaid extension when they become entitled to medicare part A.

E. Nonpayment SSI status (E01): Non-institutionalized SSI recipients who lose SSI eligibility due to initial receipt of Title II benefits in an amount exactly equal to the current income ceiling of the SSI program are eligible for medicaid extension ("E01" pay status); medicaid can cover non-institutionalized individuals with a nonpayment SSI status. The ISD worker must verify that the following standards are met:

(1) individual does not reside in an institution. Individuals who appear on the computer system (SDX) in payment status "E01" with living arrangement (LA) code "D" are not eligible for medicaid extension. These individuals lost SSI eligibility because they became institutionalized and their remaining income exceeds the $30 SSI FBR for institutionalized individuals. The ISD worker must evaluate eligibility under institutional care medicaid categories 081, 083 or 084;

(2) individual appears on the system with payment status code "E01" status;

(3) individual has unearned income equal to the current SSI income ceiling; and

(4) individual's income comes from Title II benefits (source code "A" on the SDX).

F. Revolving SSI payment status "ping-pongs": Individuals whose payment status "ping-pongs" back and forth between E01 and C01 status are eligible for medicaid extension.

(1) Revolving SSI eligibility due to payment of medicare Part B premiums by medicaid: The SSI recipient starts to receive Title II benefits and is entitled to medicare. The recipient is then entitled to medicaid payment of the part B medicare premium. This results in a recalculation of the Title II benefits. The recalculated Title II benefit equals the exact amount of the SSI income ceiling (SSI FBR). SSI payment status changes to E01 and medicaid stops paying the Part B premium. Without medicaid payment of the Part B premium, the Title II and (SSI) benefits are recomputed and the individual is eligible for SSI payments (C01). The scenario repeats, resulting in the ping-pong effect. Individuals initially eligible for medicaid extension under E01 status lose eligibility when their income exceeds the SSI income ceiling.

(2) Avoidance of revolving eligibility status: To avoid this situation, at the applicant/recipient's request, he or she can be eligible for medicaid as a medicaid extension case though eligibility can ping-pong back and forth between SSI payment status (C01) and SSI nonpayment status (E01).

(3) Referral process: The SSA refers these individuals to HCA using the "E01-C01 medicaid extension referral form." The ISD worker enters these applicants/recipients on the eligibility computer system as medicaid extension eligibles. SSA has already established that these individuals meet all SSI criteria except that their Title II benefit equals the exact amount of the SSI income ceiling.

G. Recipients ineligible for SSI cash benefits:

(1) Certain recipients of SSI who become ineligible for cash benefits are automatically extended medicaid benefits for an additional two months following the month in which the SSI case was closed. If the state is paying the recipient's medicare premiums (buy-in), this benefit is also continued during the period of extended benefits.

(2) Applicants/recipients automatically eligible for two months extended medicaid and buy-in as former SSI recipients are limited to those who lost SSI cash benefit for the following reasons:

(a) E01-Eligible for benefits, but no payment is due based on the payment computation;

(b) N01-Non-pay recipient's countable income exceeds Title XVI limitations;

(c) N04-Non-pay non-excludable resources exceed Title XVI limitations;

(d) N05-Non-pay recipient's gross income from self-employment exceeds Title XVI limitations;

(e) N07-Non-pay recipient's disability ceased;

(f) N08-Non-pay recipient's blindness ceased;

(g) N12-Non-pay recipient voluntarily withdrew from the program;

(h) N14-Non-pay aged claim denied for age;

(i) N16-Non-pay disability claim denied. Applicant not disabled;

(j) N19-Non-pay recipient has voluntarily terminated participation in the SSI program;

(k) N27-Non-pay disability terminated due to substantial gainful activity (SGA);

(l) N30-Non-pay slight impairment-medical consideration alone, no visual impairment;

(m) N31-Non-pay capacity for SGA-customary past work, no visual impairment;

(n) N32-Non-pay capacity for SGA-other work, no visual impairment;

(o) N33-Non-pay engaging in SGA despite impairment, no visual impairment;

(p) N34-Non-pay impairment is no longer severe at time of adjudication and did not last 12 months, no visual impairment;

(q) N35-Non-pay impairment is severe at time of adjudication but not expected to last 12 months, no visual impairment;

(r) N41-Non-pay slight impairment-medical condition alone, visual impairment;

(s) N42-Non-pay capacity for SGA-customary work visual impairment;

(t) N43-Non-pay capacity for SGA-other work, visual impairment, or impairment disabling for a period of less than 12 months;

(u) N44-Non-pay engaging in SGA despite impairment, visual impairment.

(v) N45-Non-pay impairment no longer severe at the time of adjudication and did not last 12 months, visual impairment;

(w) N46-Non-pay impairment is severe at the time of adjudication but not expected to last 12 months, visual impairment;

(x) N51-Non-pay impairment does not meet or equal listing (disabled child under 18 only);

(y) S07-Suspended-returned check for other than death, address, payee change, or death of representative payee;

(z) S08-Suspended-representative payee development pending;

(aa) S10-Suspended-adjudicative suspense (system generated);

(bb) S21-Suspended-the recipient is presumptively disabled or blind and has received three months payments;

(cc) T30-Terminated-received payments, but must be re-established to correct SSR;

(dd) T31-Terminated-system generated termination (payment previously made). Recipient met denial or non-pay terminated criteria;

(ee) T33-Terminated-manual termination (previous payment made).

(3) **Ex-Parte Review:** Individuals who lose SSI eligibility, who are automatically extended for two months, per one of the reasons in Subsection G of 8.201.400.10 NMAC, are automatically evaluated for another medicaid category of eligibility before their extension period expires. If determined eligible the new medicaid category begins the month following the two month extension period.
[8.201.400.10 NMAC - Rp, 8.201.400.10 NMAC, 1/1/2019]

8.201.400.11 GENERAL RECIPIENT REQUIREMENTS:
[8.201.400.11 NMAC - Rp, 8.201.400.11 NMAC, 1/1/2019]

8.201.400.12 ENUMERATION: An applicant/recipient must furnish their social security number in accordance with 8.200.410.10 NMAC.
[8.201.400.12 NMAC - Rp, 8.201.400.12 NMAC, 1/1/2019]

8.201.400.13 CITIZENSHIP: Refer to Medical Assistance Program Manual Section 8.200.410.11 NMAC.
[8.201.400.13 NMAC - Rp, 8.201.400.13 NMAC, 1/1/2019]

8.201.400.14 RESIDENCE: Applicants/recipients must be physically present in New Mexico and have demonstrated intent to remain in the state. If an applicant/recipient does not have the present mental capacity to declare intent, a parent, guardian, or adult child may assume responsibility for the declaration of intent. If an applicant/recipient does not have the present mental capacity to declare intent and there is no guardian or relative to assume responsibility for a declaration of intent, the state where the applicant/recipient is living is recognized as the state of residence. Temporary absence from the state does not prevent eligibility. A temporary absence exists when an applicant/recipient leaves the state for a specific purpose with a time-limited purpose and intends to return to New Mexico when that purpose has been accomplished. Applicants/recipients who are eligible for New Mexico medicaid are terminated if they move out of state.
[8.201.400.14 NMAC - Rp, 8.201.400.14 NMAC, 1/1/2019]

8.201.400.15 NONCONCURRENT RECEIPT OF ASSISTANCE: To be eligible for medicaid extension under the 503 leads and Pickle group, an applicant/recipient must have been eligible for, and have received, both Title II and SSI benefits concurrently in any month that they are currently receiving Title II benefits.
[8.201.400.15 NMAC - Rp, 8.201.400.15 NMAC, 1/1/2019]

8.201.400.16 SPECIAL RECIPIENT REQUIREMENTS: To be eligible for medicaid extension, an applicant/recipient must be aged, blind, or disabled as defined by the social security administration (SSA). This determination is made by SSA prior to applicable for medicaid extension.
[8.201.400.16 NMAC - Rp, 8.201.400.16 NMAC, 1/1/2019]

8.201.400.17 AGE: Applicants/recipients for medicaid extension must meet the age requirements as specified in 8.201.400.10 NMAC, Basis for Defining the Group.
[8.201.400.17 NMAC - Rp, 8.201.400.17 NMAC, 1/1/2019]

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

[8.201.400.18 NMAC - Rp, 8.201.400.18 NMAC, 1/1/2019]

8.201.400.19 ASSIGNMENT OF MEDICAL SUPPORT: Refer to Medical Assistance Program Manual Subsection F of 8.200.420.12 NMAC.
[8.201.400.19 NMAC - Rp, 8.201.400.19 NMAC, 1/1/2019]

8.201.400.20 REPORTING REQUIREMENTS: Medicaid applicant/recipients must report any change in circumstances which may affect eligibility to the local income support division (ISD) office within 10 days of the change.
[8.201.400.20 NMAC - Rp, 8.201.400.20 NMAC, 1/1/2019]

HISTORY OF 8.201.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 5/26/1980.
ISD 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 1/26/1982.
MAD Rule 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 12/1/1987.
MAD Rule 870, Retroactive Medicaid Coverage, filed 1/31/1990.
MAD Rule 870, Retroactive Medicaid Coverage, filed 3/11/1992.
MAD Rule 870, Retroactive Medicaid Coverage, filed 11/16/1994.
MAD Rule 372.0000, Medicaid Extension, 12/1/1987.
MAD Rule 872, Medicaid Extension, filed 1/31/1990.
MAD Rule 872, Medicaid Extension, filed 3/11/1992.
MAD Rule 872, Medicaid Extension, filed 8/20/1992.
MAD Rule 872, Medicaid Extension, filed 9/26/1994.

History of Repealed Material:
MAD Rule 872, Medicaid Extension, filed 9/26/1994 - Repealed effective 2/1/1995.
8.201.400 NMAC - Recipent Policies, filed 6/11/2203 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 201 MEDICAID ELIGIBILITY - MEDICAID EXTENSION (CATEGORY 001, 003 and 004)
PART 600 BENEFIT DESCRIPTION

8.201.600.1 ISSUING AGENCY: Health Care Authority.
[8.201.600.1 NMAC - Rp, 8.201.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.201.600.2 SCOPE: The rule applies to the general public.
[8.201.600.2 NMAC - Rp, 8.201.600.2 NMAC, 1/1/2019]

8.201.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.201.600.3 NMAC - Rp, 8.201.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.201.600.4 DURATION: Permanent.
[8.201.600.4 NMAC - Rp, 8.201.600.4 NMAC, 1/1/2019]

8.201.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.201.600.5 NMAC - Rp, 8.201.600.5 NMAC, 1/1/2019]

8.201.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.201.600.6 NMAC - Rp, 8.201.600.6 NMAC, 1/1/2019]

8.201.600.7 DEFINITIONS: [**RESERVED**]

8.201.600.8 [**RESERVED**]

8.201.600.9 BENEFIT DESCRIPTION: Applicants/recipients of medicaid extension receive the full range of medicaid-covered services.
[8.201.600.9 NMAC - Rp, 8.201.600.9 NMAC, 1/1/2019]

8.201.600.10 BENEFIT DETERMINATION: Application for the medicaid extension is made on the assistance application form. Applications must be acted on and notice sent to the applicant of the action taken within 45 days after the date of application. 503 lead cases, disabled adult child (DACs), and ping-pongs nonpayment SSI status (E01), SSI child cases, and SSI extension cases do not require a separate application for initial processing.
[8.201.600.10 NMAC - Rp, 8.201.600.10 NMAC, 1/1/2019]

8.201.600.11 INITIAL BENEFITS: When an eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, this notice includes the reason for the denial and an explanation of rights to an administrative hearing.
[8.201.600.11 NMAC - Rp, 8.201.600.11 NMAC, 1/1/2019]

8.201.600.12 ONGOING BENEFITS: A periodic review is completed at least every 12 months.
[8.201.600.12 NMAC - Rp, 8.201.600.12 NMAC, 1/1/2019]

8.201.600.13 SSI EXTENSION RETROACTIVE BENEFIT COVERAGE: Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.201.600.13 NMAC - Rp, 8.201.600.13 NMAC, 1/1/2019]

8.201.600.14 CHANGES IN ELIGIBILITY: If a recipient becomes ineligible, advance notice of the closure is sent by the ISD worker. If a recipient dies, the case is closed effective the following month.
[8.201.600.14 NMAC - Rp, 8.201.600.14 NMAC, 1/1/2019]

HISTORY OF 8.201.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 5/26/1980.
ISD 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 1/26/1982.
MAD Rule 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 12/1/1987.
MAD Rule 870, Retroactive Medicaid Coverage, filed 1/31/1990.
MAD Rule 870, Retroactive Medicaid Coverage, filed 3/11/1992.
MAD Rule 870, Retroactive Medicaid Coverage, filed 11/16/1994.
MAD Rule 372.0000, Medicaid Extension, 12/1/1987.
MAD Rule 872, Medicaid Extension, filed 1/31/1990.
MAD Rule 872, Medicaid Extension, filed 3/11/1992.
MAD Rule 872, Medicaid Extension, filed 8/20/1992.
MAD Rule 872, Medicaid Extension, filed 9/26/1994.

History of Repealed Material:
MAD Rule 872, Medicaid Extension, filed 9/26/1994 - Repealed effective 2/1/1995.
8.201.600 NMAC - Medicaid Eligibility - Medical Extension - Benefit Description filed 9/2/2009 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 206 MEDICAID ELIGIBILITY - RECIPIENTS FOR WHOM CYFD HAS FULL OR PARTIAL RESPONSIBILITY
PART 400 RECIPIENT REQUIREMENTS

8.206.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.206.400.1 NMAC - Rp, 8.206.400.1 NMAC, 10/1/2015; A, 7/1/2024]

8.206.400.2 SCOPE: The rule applies to the general public.
[8.206.400.2 NMAC - Rp, 8.206.400.2 NMAC, 10/1/2015]

8.206.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.206.400.3 NMAC - Rp, 8.206.400.3 NMAC, 10/1/2015; A, 7/1/2024]

8.206.400.4 DURATION: Permanent.
[8.206.400.4 NMAC - Rp, 8.206.400.4 NMAC, 10/1/2015]

8.206.400.5 EFFECTIVE DATE: October 1, 2015, unless a later date is cited at the end of a section.
[8.206.400.5 NMAC - Rp, 8.206.400.5 NMAC, 10/1/2015]

8.206.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) medical assistance programs (MAP) eligibility manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAP eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.206.400.6 NMAC - Rp, 8.206.400.6 NMAC, 10/1/2015]

8.206.400.7 DEFINITIONS:
A. "Full or partial financial responsibility" means a payment has been made by the children, youth and families department (CYFD) on behalf of the eligible recipient during each month for which MAP eligibility is sought. The nature of CYFD's financial responsibility must be documented. Documentation must include either the court-ordered placement or custody award, and CYFD payments made on behalf of the eligible recipient at the time of application and each subsequent periodic review.
B. "Private institutions" includes accredited and non-accredited residential treatment centers and group homes, and treatment foster care. Institutions specifically excluded from this definition are the youth diagnostic development center, New Mexico boys and girls schools and reintegration centers which are not certified to furnish medical care. A child placed in one of these facilities is not eligible for a MAP category of eligibility.
C. "Substitute care placement" includes placement in a foster home or private institution.
[8.206.400.7 NMAC - Rp, 8.206.400.7 NMAC, 10/1/2015]

8.206.400.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.206.400.8 NMAC - Rp, 8.206.8 NMAC, 10/1/2015]

8.206.400.9 MAP CATEGORY OF CYFD ELIGIBILITY:
A. MAD is required to furnish coverage to an eligible recipient under 18 years of age for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act (42 CFR Section 436.118).

B. MAD has opted to furnish coverage to an eligible recipient under 18 years of age who meets a MAP category of temporary assistance for needy families (TANF) eligibility requirements except for the definition of "dependent child" for whom CYFD has assumed full or partial financial responsibility (42 CFR Section 436.222).

C. MAD furnishes extended coverage to an eligible recipient over 18 years of age but under 21 years of age who is receiving Chafee independent living assistance.

[8.206.400.9 NMAC - Rp, 8.206.400.9 NMAC, 10/1/2015]

8.206.400.10 MAP CATEGORY OF PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) ELIGIBILITY: MAD furnishes extended coverage under the Patient Protection and Affordable Care Act (ACA) to a former foster care recipient up to 26 years of age regardless if the individual also meets a MAP category of other adult eligibility when:

A. the applicant or recipient is a current resident of New Mexico; and

B. the applicant or recipient was in a medical assistance program in New Mexico or any other state at the time they turned 18 years of age or aged out of their foster care system; and

C. the applicant is not receiving supplemental security income (SSI).

[8.206.400.10 NMAC - N, 10/1/2015]

8.206.400.11 BASIS FOR DEFINING THE GROUP: An eligible recipient 18 years of age or under can be eligible for a MAP category of CYFD eligibility if New Mexico bears full or partial responsibility for the eligible recipient and makes a payment on their behalf. An eligible recipient 18 years of age or under will be assigned one of the following MAP categories of eligibility.

A. **Category 017:** The eligible recipient resides in New Mexico and receives a Title IV-E adoptive subsidy from another state.

B. **Category 037:** The eligible recipient resides in New Mexico and receives a Title IV-E adoptive subsidy from New Mexico.

C. **Category 046:** The eligible recipient resides out-of-state and receives a Title IV-E foster care payment from New Mexico. A MAP card is issued by the state in which the eligible recipient resides.

D. **Category 047:** The eligible recipient currently resides out-of-state and receives a Title IV-E adoption subsidy payment. MAP is issued by the state in which the eligible recipient resides.

E. **Category 066:** The eligible recipient is in the child protective service component of CYFD and is IV-E eligible or is from a home that meets TANF eligibility requirements.

F. **Category 086:** The eligible recipient resides in New Mexico, is in the custody of another state and receives Title IV-E foster care payment from that state.

[8.206.400.11 NMAC - Rp, 8.206.400.10 NMAC, 10/1/2015]

8.206.400.12 LIVING ARRANGEMENTS: To be eligible for CYFD medicaid, an individual must be under 18 years of age and must be in a substitute care placement or temporarily in a medical facility with an ultimate plan to be placed in substitute care arrangement.

A. **Removal from home:** An individual who is in the custody of their parent or guardian is not eligible for medicaid. When a CYFD medicaid eligible recipient is returned to their parent or guardian's custody, CYFD medicaid is terminated.

B. **Release from jurisdiction of non-Title XIX facility:** An eligible recipient who is released from the jurisdiction and control of the correctional system for whom CYFD has full or partial financial responsibility and is in a substitute care placement can be eligible for CYFD medicaid beginning the first of the month after release from the correctional system if all other eligibility criteria are met.

(1) **Permanent release from jurisdiction requirements:** An individual living in a correctional facility or under the jurisdiction and control of the correctional system is not eligible for MAD services. This includes an individual temporarily released from a correctional facility for the sole purpose of receiving medical treatment.

(2) **Documentation of release:** To document that the individual is no longer under the jurisdiction and control of the correctional system, the individual must be permanently released from the correction facility and the court or parole order must specify the following:

(a) the individual is in the custody of CYFD; or

(b) CYFD is required to make monthly payment for the care, maintenance and medical treatment of the individual; in addition, the individual must receive or be evaluated for (or both) the receipt of long-term medical treatment.

C. Independent living arrangements: MAD furnishes extended coverage to an eligible recipient between 18 and 21 years of age who is considered to be in an independent living arrangement if foster care payment is made to the eligible recipient and he or she meets all other MAD eligibility criteria.
[8.206.400.12 NMAC - Rp, 8.206.400.11 NMAC, 10/1/2015]

8.206.400.13 ENUMERATION: See 8.200.410 NMAC.
[8.206.400.13 NMAC - Rp, 8.206.400.13 NMAC, 10/1/2015]

8.206.400.14 CITIZENSHIP: See 8.200.410 NMAC.
[8.206.400.14 NMAC - Rp, 8.206.400.14 NMAC, 10/1/2015]

8.206.400.15 RESIDENCE: See 8.200.410 NMAC.
[8.206.400.15 NMAC - Rp, 8.206.400.15 NMAC, 10/1/2015]

8.206.400.16 AGE: To meet the requirements for a MAP category of CYFD eligibility, an applicant or re-determining recipient must be under 18 years of age, except as outlined in Section 9 and 10 of this rule.

A. Students under 19: When an eligible recipient reaches 18 years of age, they lose MAP eligibility unless (1) they are a full-time student in a secondary school or its equivalent and (2) they are expected to complete the program before reaching 19 years of age. In such cases, the individual's MAP category of CYFD eligibility is terminated when they leave school or upon their 19th birthday, whichever comes first. School attendance must be verified each semester as part of the recipient's MAP re-determination process.

B. Proof of age: The following documents constitute primary evidence of age:

(1) birth certificate;
(2) adoption papers or records;
(3) hospital or clinic records;
(4) church or baptismal records;
(5) bureau of vital statistics or local government records;
(6) United States passports or immigration and naturalization service's records;
(7) American Indian census reports; or
(8) birth records maintained by the social security administration (SSA).

C. If the age of the applicant or re-determining recipient cannot be established using primary evidence, a minimum of two pieces of corroborating secondary evidence must be used to establish their age, such as school records, census records, a court support order not generated by CYFD, their physical health practitioner's statement, juvenile court records not generated by CYFD, child welfare records not generated by CYFD, voluntary social services agency records, insurance policies, minister's signed statement, affidavits or military records.
[8.206.400.16 NMAC - Rp, 8.206.400.18 NMAC, 10/1/2015]

8.206.400.17 ASSIGNMENT OF MEDICAL SUPPORT: MAD has established requirements of CYFD when the applicant or re-determining recipient meets a MAP category of CYFD eligibility; see 8.200.420 NMAC.

A. CYFD requirements: The authorized representative of CYFD who signs the MAP eligibility application on behalf of the applicant or re-determining recipient must notify MAD of any available third-party medical coverage.

B. CYFD responsibilities for cooperation with HSD child support services division (CSSD): CYFD is responsible for cooperating with CSSD activities which include:

(1) identifying and locating the absent parent(s) of the eligible recipient receiving MAD services;
(2) establishing paternity of the applicant whose parents were not legally married at the time of the applicant's birth;
(3) obtaining child and medical support for the applicant or re-determining recipient;
(4) identifying and providing information necessary to pursue third-party health coverage; and
(5) developing procedures for referrals and determination of good cause for not pursuing child support or not requiring cooperation in pursuing such support.
[8.206.400.17 NMAC - Rp, 8.206.400.19 NMAC, 10/1/2015]

8.206.400.18 REPORTING REQUIREMENTS: When an applicant or re-determining recipient is approved for a MAP category of CYFD eligibility, the authorized CYFD representative must report within 10 calendar days any known change in the eligible recipient's circumstances which may affect his or her continued eligibility.
[8.206.400.18 NMAC - Rp, 8.206.400.20 NMAC, 10/1/2015]

HISTORY OF 8.206.400 NMAC:

History of Repealed Material:
8 NMAC 4.CYM.430 Recipient Rights and Responsibilities, filed 12/30/1994 - Repealed effective 7/1/2003.
8.206.400 NMAC, Recipient Policies, filed 6/11/2003 - Repealed effective 1/1/2014.
8.206.400 NMAC, Recipient Requirements, filed 12/2/2013 - Repealed effective 10/1/2015.

TITLE 8 SOCIAL SERVICES
CHAPTER 215 MEDICAID ELIGIBILITY - SUPPLEMENTAL SECURITY INCOME (SSI) METHODOLOGY
PART 400 RECIPIENT POLICIES

8.215.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.215.400.1 NMAC - Rp, 8.215.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.215.400.2 SCOPE: The rule applies to the general public.
[8.215.400.2 NMAC - Rp, 8.215.400.2 NMAC, 1/1/2019]

8.215.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.215.400.3 NMAC - Rp, 8.215.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.215.400.4 DURATION: Permanent.
[8.215.400.4 NMAC - Rp, 8.215.400.4 NMAC, 1/1/2019]

8.215.400.5 EFFECTIVE DATE: January 1, 2019, unless a later date is cited at the end of the section.
[8.215.400.5 NMAC - Rp, 8.215.400.5 NMAC, 1/1/2019]

8.215.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.215.400.6 NMAC - Rp, 8.215.400.6 NMAC, 1/1/2019]

8.215.400.7 DEFINITIONS: [**RESERVED**]
[8.215.400.7 NMAC - Rp, 8.215.400.7 NMAC, 1/1/2019]

8.215.400.8 [**RESERVED**]
[8.215.400.8 NMAC - Rp, 8.215.400.8 NMAC, 1/1/2019]

8.215.400.9 SUPPLEMENTAL SECURITY INCOME METHODOLOGY: All noninstitutionalized married couples who are eligible for supplemental security income (SSI) are treated as separate individuals for determining eligibility and benefit amounts, beginning the month after the month they begin living apart. In the case of an initial application or reinstatement following a period of ineligibility, each member of a married couple not living together is considered an individual as of the date of application or request for reinstatement, regardless of when the separation occurred. See 8.281 NMAC *Medicaid Eligibility - Institutional Care* (*Categories 081, 083 and 084*), for information on separation caused by the institutionalization of one member of a married couple.
[8.215.400.9 NMAC - Rp, 8.215.400.9 NMAC, 1/1/2019]

8.215.400.10 SUPPLEMENTAL SECURITY INCOME (Categories 001, 003, and 004):

A. The HCA has an agreement under Section 1634 of the Social Security Act with the social security administration (SSA) for SSA to make medicaid eligibility determinations. Supplemental security income (SSI) recipients (categories 001, 003, and 004) who receive an SSI cash payment or are Section 1619(b) recipients automatically have medicaid eligibility unless they fail to meet the assignment of rights or third party liability requirements; or HCA has determined ineligibility under the medicaid trust provision.

B. **Section 1619(b) recipients**: To qualify for continuing medicaid coverage, a 1619(b) individual must:

(1) have been eligible for an SSI cash payment for at least one month; and
(2) still meet the disability requirement; and
(3) still meet all other non-disability SSI requirements; and
(4) need medicaid benefits to continue to work; and

(5) have gross earnings that are insufficient to replace SSI, medicaid and publicly funded attendant care services.
[8.215.400.9 NMAC - N, 1/1/2019]

HISTORY OF 8.215.400 NMAC:
Pre NMAC History: The material in this part was derived from that previously filed with the State Records Center.
MAD Rule 860, SSI Methodology for Computation of Countable Resources and Income, filed 3/7/1989.
MAD Rule 860, SSI Methodology for Computation of Countable Resources and Income, filed 3/21/1990.
MAD Rule 860, SSI Methodology for Computation of Countable Resources and Income, filed 4/24/1991.
MAD Rule 860, SSI Methodology for Computation of Countable Resources and Income, filed 6/19/1992.
MAD Rule 861, Resources - SSI Methodology for Computation of Countable Resources and Income, filed 3/18/1993.
MAD Rule 861, Resources - SSI Methodology for Computation of Countable Resources and Income, filed 12/29/1994.
MAD Rule 862, Income - SSI Methodology for Computation of Countable Resources and Income, filed 3/18/1993.
MAD Rule 864, Potential Income or Resources - SSI Methodology for Computation of Countable Resources and Income, filed 3/18/1993.
MAD Rule 866, Deeming Income, filed 11/16/1994.

History of Repealed Material:
MAD Rule 860, SSI Methodology for Computation of Countable Resources and Income, filed 6/19/1992 - Repealed effective 2/1/1995.
MAD Rule 861, Resources - SSI Methodology for Computation of Countable Resources and Income, filed 12/29/1994 - Repealed effective 2/1/1995.
MAD Rule 862, Income - SSI Methodology for Computation of Countable Resources and Income, filed 3/18/1993 - Repealed effective 2/1/1995.
MAD Rule 864, Potential Income or Resources - SSI Methodology for Computation of Countable Resources and Income, filed 3/18/1993 - Repealed effective 2/1/1995.
MAD Rule 866, Deeming Income, filed 11/16/1994 - Repealed effective 2/1/1995.
8.215.400 NMAC - Recipient Policies, filed 9/3/2013 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 215 MEDICAID ELIGIBILITY - SUPPLEMENTAL SECURITY INCOME (SSI) METHODOLOGY
PART 500 INCOME AND RESOURCE STANDARDS

8.215.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.215.500.1 NMAC - Rp, 8.215.500.1 NMAC, 3/1/2018; A, 7/1/2024]

8.215.500.2 SCOPE: The rule applies to the general public.
[8.215.500.2 NMAC - Rp, 8.215.500.2 NMAC, 3/1/2018]

8.215.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.215.500.3 NMAC - Rp, 8.215.500.3 NMAC, 3/1/2018; A, 7/1/2024]

8.215.500.4 DURATION: Permanent.
[8.215.500.4 NMAC - Rp, 8.215.500.4 NMAC, 3/1/2018]

8.215.500.5 EFFECTIVE DATE: March 1, 2018, unless a later date is cited at the end of a section.
[8.215.500.5 NMAC - Rp, 8.215.500.5 NMAC, 3/1/2018]

8.215.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.215.500.6 NMAC - Rp, 8.215.500.6 NMAC, 3/1/2018]

8.215.500.7 DEFINITIONS: Relative: A son/daughter; grandson/granddaughter; step-son/step-daughter; in-laws; mother/father; step-mother/step-father; half sister/half brother; grandmother/grandfather; aunt/uncle; sister/brother; step-brother/step-sister; and niece/nephew.
[8.215.500.7 NMAC - Rp, 8.215.500.7 NMAC, 3/1/2018]

8.215.500.8 [RESERVED]

8.215.500.9 NEED DETERMINATION: This section describes the methodology to be used in determining countable resources and income for medicaid eligibility categories which use supplemental security income (SSI) methodology. These guidelines are used for retroactive medicaid eligibility for SSI recipients as well as initial and on-going eligibility for qualified medicare beneficiaries (QMB), qualified disabled working individuals (QD), medicaid extension and specified low income medicare beneficiaries (SLIMB). Medicaid eligibility is determined prospectively. Applicants/recipients must meet, or expect to meet, all financial and nonfinancial eligibility criteria in the month for which a determination of eligibility is made. Applicants for and recipients of medicaid must apply for and take all necessary steps to obtain any income or resources to which they may be entitled. Such steps must be taken within 30 days of the date the HCA furnishes notice of the potential entitlement.

A. Failure to apply for and take steps to determine eligibility for other benefits: Failure or refusal to apply for and take all necessary steps to determine eligibility for other benefits after notice is received results in an applicant/recipient becoming ineligible for medicaid.

B. Exceptions to general requirement: Applicants/recipients who have elected a lower VA payment do not need to reapply for veterans administration improved pension (VAIP) benefits. Crime victims are not required to accept victims compensation payments from a state-administered fund as a condition of medicaid eligibility.
[8.215.500.8 NMAC - Rp, 8.215.500.8 NMAC, 3/1/2018]

8.215.500.10 APPLICATION PROCESS: [RESERVED]

8.215.500.11 RESOURCE STANDARDS: A "resource" is defined as cash or liquid assets and real or personal property which is owned and can be used either directly, or by sale or conversion, for the applicant/recipient's support and maintenance. Resources may be liquid or non-liquid and may be excluded from the eligibility determination process under certain conditions. A liquid resource is an asset which can readily be converted to cash. A non-liquid resource is an asset or property which cannot readily be converted to cash.

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

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

[8.215.500.11 NMAC - Rp, 8.215.500.11 NMAC, 3/1/2018]

8.215.500.12 APPLICABLE RESOURCE STANDARDS: The resource standard for medicaid extension as well as retroactive SSI medicaid eligibility determinations is $2,000. See Section 8.240.500.10 NMAC for resource standards applicable to QMB. See Section 8.242.500.10 NMAC for standards applicable to the qualified disabled working individuals program. See Section 8.245.500.10 NMAC for standards applicable to the SLIMB program.

A. Liquid resources: The face value of liquid resources such as cash, savings or checking accounts is considered in determining medicaid eligibility. The countable value of resources such as securities, bonds, real estate contracts and promissory notes is based on their current fair market value.

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

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

B. Non-liquid resources: The value of non-liquid resources is computed at current fair market value. See below for discussion of equity value.

(1) Real property: If an applicant/recipient is the sole owner of real property other than a home and has the right to dispose of it, the entire equity value is included as a countable resource. If an applicant/recipient owns property with one or more individuals and the applicant/recipient has the right, authority or power to liquidate the property or their share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource to the individual. The applicant/recipient must provide a copy of the legal document which indicates their interest in the property.

(2) Vehicles: One automobile is totally excluded regardless of value if it is used for transportation for the individual or a member of the individual's household. Any other automobiles are considered to be Non-liquid resources. Equity in the other automobiles is counted as a resource. Recreational vehicles and boats are considered household goods and personal effects rather than vehicles.

(3) Household goods and personal effects: Household goods and personal effects are considered countable resources if the items were acquired or are held for their value or are held as an investment. Such items can include but are not limited to: gems, jewelry that is not worn or held for family significance, or collectibles.

[8.215.500.12 NMAC - Rp, 8.215.500.12 NMAC, 3/1/2018]

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

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

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

(1) Physical possession of resource: The fact that an applicant/recipient does not have

physical possession of a resource does not mean it is not their resource. If they have the legal ability to spend the funds or convert the resource to cash, the resource is considered countable. Physical possession of savings bonds is a legal requirement for cashing them.

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

(3) If there is a legal bar to the sale of a resource, the resource is not countable. If the co-owner of real property can bring an action to partition and sell the property, their interest in the property is a countable resource.

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

D. **Joint ownership of resources:** If an applicant/recipient owns either liquid or non-liquid resources jointly with others, they have 30 days from the date requested by the ISD worker to submit all documentation required to prove their claims regarding ownership of, access to, and legal ability to use the resource for personal support and maintenance. Failure to do so results in the presumption that the resource is countable and belongs to the applicant/recipient.

(1) **Jointly held property:** If jointly held property is identified during review of an active case, the ISD worker must:

(a) determine whether the property is a countable resource;

(b) determine whether the value of the jointly held property plus the value of other countable resources exceeds the allowable resource maximum;

(c) if the value of countable resources exceeds the allowable maximum, advance notice is furnished to the applicant/recipient of the intent to close the case and their right to verify claims regarding ownership of, access to and legal ability to use the property for personal support and maintenance;

(d) if the applicant/recipient fails to provide required information or respond within the advance notice period, the case is closed; and

(e) if, after expiration of the advance notice period but prior to the end of the month in which the advance notice expires, the applicant/recipient provides the required evidence to show the property is not a countable resource, or is countable in an amount which, when added to the value of other countable resources, does not exceed the maximum allowable limit, and eligibility continues to exist on all other factors, the case is reinstated for the next month.

(2) **Joint bank accounts:** If liquid resources are in a joint bank account of any type, the applicant/recipient's ownership interest, while the parties to the account are alive, is presumed to be proportionate to the applicant/recipient's contributions to the total resources on deposit.

(a) The applicant/recipient is presumed to own a proportionate share of the funds on deposit unless they present clear and convincing evidence that the parties to the account intended the applicant/recipient to have a different ownership interest.

(b) To establish the applicant/recipient's ownership interest in a joint account, the following are required:

(i) statement by the applicant/recipient regarding contributions to the account; reasons for establishing the account; who owns the funds in the account; and any supporting documentation; plus

(ii) corroborating statements from the other account holder(s); if either the applicant/recipient or the other account holder is not capable of making a statement, the applicant/recipient or representative must obtain a statement from a third party who has knowledge of the circumstances surrounding the establishment of the joint account.

(c) Failure to provide required documentation within 30 days of the date requested by the ISD worker results in a determination that the entire account amount belongs to the applicant/recipient.

(d) If the existence of a jointly held bank account is identified during the review of an active case, the ISD worker requests evidence of ownership and accessibility. If the evidence is not furnished within 30 days of the request, the case is closed.

E. **Other countable resources:** Other liquid or non-liquid resources must be considered in the calculation of total countable resources. Under certain circumstances, the following non-liquid resources may be included in the calculation of countable resources:

(1) burial funds;

(2) burial spaces;

(3) life estates;
(4) life insurance and other insurance products;
(5) income-producing property; and
(6) other financial investment products.

F. The home as a countable resource: If the applicant/recipient or their representative states the applicant/recipient does not intend to return to the home and it is not the residence of the applicant/recipient's spouse or dependent relative, the home is considered a countable resource. If the applicant/recipient or their representative puts the home up for sale and it is not the primary residence of the applicant/recipient's spouse or a dependent relative, the home is considered a countable resource.

G. Value of property: The applicant/recipient must supply the ISD worker with written documentation regarding the fair market value of the property from a real estate agent, title company or mortgage insurance company in and familiar with the area in which the property is located in addition to any encumbrances against the property. The ISD worker determines the equity value of the property by subtracting the amount of the encumbrances from the fair market value of the property.

H. ABLE ACT: as Public Law 113-295, The Stephen Beck, Jr., Achieving a Better Life Experience Act (ABLE Act) - enacted December 19, 2014. The ABLE Act shall establish state-run tax advantaged accounts for eligible individuals to use for disability related expenses. Tax-advantaged accounts allow an eligible individual to save and use the funds for disability-related expenses. An ABLE program has been established and maintained by the state. An eligible individual can open an ABLE account through the ABLE program in any state.

(1) Under the ABLE act, individual eligibility is determined if the person is:

(a) Entitled to benefits based on blindness or disability under Title II or Title XVI of the Social Security Act; or

(b) Has a disability certification filed with the U.S. secretary of the treasury and a disability that began before age 26.

(2) ABLE account balances and distributions are considered in determining eligibility for SSI.

(a) Amounts over $100,000 count toward the $2,000 SSI resource limit.

(b) If an ABLE account balance exceeds $100,000 by an amount that causes the recipient to exceed the SSI resource limit the recipient is ineligible for SSI.

(c) The social security administration (SSA) will place such an ineligible individual into a special ABLE suspension period where:

(i) The recipient's SSI benefits are suspended without time limit (as long as they remain otherwise eligible).

(ii) The recipient will still be considered to be SSI eligible for the SSI medical assistance program (MAP).

(iii) After 12 months of suspension, eligibility is terminated and the person must reapply for benefits.

(iv) If a person who does not meet other SSI eligibility criteria during a suspension period is ineligible for SSI during a suspension period they are also ineligible for the SSI MAP.

(3) Section 529A(d)(4) of the act requires that the state electronically submit on a monthly basis to the Commissioner of Social Security statements on relevant distributions and account balances from all ABLE accounts.

(4) Resource exclusions related to the ABLE ACT can be found at Subsection N of Section 8.215.500.14 NMAC *resource exclusions*.

(5) For how the ABLE ACT contributions treatment in regards to income please see Section 8.215.500.18 NMAC *income*.

(6) For how the ABLE ACT distributions please see Subsection D of Section 8.215.500.20 NMAC. *unearned income exclusions*.

[8.215.500.13 NMAC - Rp, 8.215.500.13 NMAC, 3/1/2018]

8.215.500.14 RESOURCE EXCLUSIONS: Some types of resources can be excluded from the calculation of countable resources if they meet the specific criteria listed below.

A. Burial fund exclusion: Up to $1,500 can be excluded from the countable liquid resources of an applicant/recipient if designated as burial funds. An additional amount of up to $1,500 can be excluded from countable liquid resources if designated as burial funds for the spouse of the applicant/recipient. The burial fund exclusion is separate from the burial space exclusion.

(1) Retroactive designation of burial funds: An applicant/recipient can retroactively designate funds for burial back to the first day of the month in which the applicant/recipient intended the funds to be set aside for burial. The applicant/recipient must sign a statement indicating the month the funds were set aside for burial.

(2) Limit on exclusion: An applicant/recipient can designate as much of their liquid resources as they wish for burial purposes. However, only one burial fund allowance of up to $1,500 each for the applicant/recipient and their spouse can be excluded from countable resources. A burial fund does not continue from one period of eligibility to another (i.e., across a period of ineligibility). For each new period of eligibility, any exclusion of burial funds must be developed as for an initial application.

(3) Removal of designation: An applicant/recipient cannot "undesignate" burial funds unless one of the following occurs:

(a) eligibility terminates;

(b) part, or all, of the funds can no longer be excluded because the applicant/recipient purchased excluded life insurance or an irrevocable burial contract which partially or totally offsets the available burial fund exclusion; or

(c) the applicant/recipient uses the funds for another purpose.

(4) Reduction of burial fund exclusion: The $1,500 burial fund exclusion is reduced by the following:

(a) the face value of excluded life insurance policies;

(b) assets held in irrevocable burial trusts; irrevocable means the value paid cannot be returned to the applicant/recipient;

(c) assets that are not burial space items held in irrevocable burial contracts;

(d) assets held in other irrevocable burial arrangements.

(5) Interest from burial fund: Interest derived from a burial fund is not considered a countable resource or income if all of the following conditions exist:

(a) the original amount is excluded;

(b) the excluded burial fund is not commingled with non-excluded burial funds; and

(c) the interest earned remains with the excluded burial funds.

(6) Commingling of burial funds: Burial funds cannot be commingled with non-burial funds. If only part of the funds in an account is designated for burial, the burial fund exclusion cannot be applied until the funds designated for burial expenses are separated from the non-burial funds. Countable and excluded burial funds can be commingled.

(7) Life insurance policy designated as burial fund: An applicant/recipient can designate a life insurance policy as a burial fund at the time of application. The ISD worker must first analyze the rule according to Subsection H of Section 8.215.500.14.NMAC, *life insurance exclusion*, and following subsections.

(8) Burial contracts: If an applicant/recipient has a prepaid burial contract, the ISD worker determines whether it is revocable or irrevocable and whether it is paid for. Until all payments are made on a burial contract, the amounts paid are considered burial funds and no burial space exclusions apply. An applicant/recipient may have a burial contract which is funded by a life insurance policy. The life insurance may be either revocably or irrevocably assigned to a funeral director or mortuary. A revocable contract exists if the value can be returned to the applicant/recipient. An irrevocable contract exists when the value cannot be returned.

(a) If the contract or insurance policy assignment is revocable, the following apply.

(i) If the burial contract is funded by a life insurance policy, the policy is the resource which must be evaluated. The burial contract itself has no value. It exists only to explain the applicant/recipient's burial arrangements.

(ii) No exclusions can be made for burial space items because the applicant/recipient does not have a right to them if the contract is not paid for or the policy is not paid up.

(b) If the assignment is irrevocable, the life insurance or burial contract is not a countable resource because the applicant/recipient does not own it.

(i) The burial space exclusions can apply if the applicant/recipient has the right to the burial space items.

(ii) The value of the irrevocable burial arrangement is applied against the $1,500 burial fund exclusion only if the applicant/recipient has other liquid resources to designate for burial.

B. Burial space exclusion: A burial space or an agreement which represents the purchase of a burial space held for the burial of an applicant/recipient, their spouse, or any other member of their immediate family, is an excluded resource regardless of value. Interest and accruals on the value of a burial space are excluded from

consideration as countable income or resources. When calculating the value of resources to be deemed to an applicant/recipient from their parent(s) or spouse, the value of spaces held by the parent(s)/spouse which are to be used for the burial of the applicant/recipient or any other member of the applicant/recipient's immediate family, including the deemer parent/spouse, must be excluded. The burial space exclusion is separate from, and in addition to, the burial fund exclusion.

(1) Burial space definitions: "Burial space" is defined as a(n) burial plot, gravesite, crypt, mausoleum, casket, urn, niche, or other repository customarily used for the deceased's bodily remains. A burial space also includes necessary and reasonable improvements or additions, such as vaults, headstones, markers, plaques, burial containers (e.g., caskets), arrangements for the opening and closing of a gravesite, and contracts for care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care. Items that serve the same purpose are excluded once per individual, such as excluding a cemetery lot and a casket, but not a casket and an urn.

(2) Burial space contract: An agreement which represents the purchase of a burial space is defined as a contract with a burial provider for a burial space held for the eligible applicant/recipient or a member of their immediate family. Until all payments are made on the contract, the amounts paid are considered burial funds and no burial space exclusions apply. An eligible applicant/recipient's immediate family includes:

(a) the spouse;
(b) natural or adoptive parents;
(c) minor or adult children, including adoptive and stepchildren;
(d) siblings, including adoptive and stepsiblings; and
(e) spouse of any of the above relatives;
(f) if a relative's relationship to an applicant/recipient is by marriage only, the relationship ceases to exist upon the dissolution of the marriage.

(3) Burial space "held" for an applicant/recipient: A burial space is considered held for an applicant/recipient if:

(a) someone has title to or possesses a burial space intended for the use of the applicant/recipient or a member of their immediate family; or
(b) someone has a contract with a funeral service company for a specified burial space for the applicant/recipient or a member of their immediate family, such as an agreement which represents the individual's current right to the use of the items at the amount shown.
(c) until the purchase price is paid in full, a burial space is not considered "held for" an individual under an installment sales contract or similar device if:

(i) the individual does not currently own the space;
(ii) the individual does not currently have the right to use the space; and
(iii) the seller is not currently obligated to provide the space.

C. Life estate exclusion: A life estate gives an applicant/recipient certain rights to real property. These rights determine how the resource is treated in determining eligibility for medicaid.

(1) Possession: An applicant/recipient has the right to live on the real property for the rest of their life. If it is their principal place of residence (home), the life estate is evaluated in accordance with Subsection E of Section 8.215.500.14.NMAC, *exclusions for real property and home*, and following subsections.

(2) Use and profit: An applicant/recipient has the right to use and obtain profit from the real property. If it is income producing property, such as a rental or farm, the life estate is evaluated as income producing property. See Subsection F of Section 8.215.500.14 NMAC, *income-producing property exclusion*, and following subsections.

(3) Sale of the life estate interest: An applicant/recipient has the right to sell their life estate interest. The value of this interest is less than the fair market value of the property and is similar to a lease because of the time frame involved. The value of the life estate is based on the age and life-expectancy of the applicant/recipient.

(4) Valuation of life estates: The "unisex life estate and remainder interest tables" are used to determine the value of a life estate. See Section 8.200.520.14 NMAC, *resource exclusions*. The value is computed by multiplying the current market value by the percentage reduction on the unisex table under the column for the applicant/recipient's age. If an applicant/recipient feels the value calculated based on this method is overstated, they can obtain a valuation of the life estate in the area for use as documentation of lesser value.

(5) Legal documentation establishing life estate: The legal document establishing a life estate may affect one or more of the rights discussed above. Joint ownership of a life estate may require the co-owner's approval for sale. See Section 8.215.500.13 NMAC, *countable resources*, and following subsections for

criteria to use in evaluating the count ability of the resource.

D. Settlement exclusions:

(1) Agent orange settlement payments made to veterans or their survivors are excluded from consideration as resources.

(2) Payments made under the Radiation Exposure Compensation Act are excluded from consideration as resources.

(3) Payments by the remembrance, responsibility and the future foundation to individual survivors forced into slave labor by the Nazis are excluded as resources.

(4) Payments received from a state-administered fund established to aid victims of crime are excluded for nine months, beginning the month after the month of receipt.

E. Exclusions for real property and home: A home is any shelter used by an applicant/recipient or their spouse as the principal place of residence. The home includes any buildings and contiguous land used in the operation of the home. A home is not considered a countable resource while in use by the applicant/recipient as their principal place of residence. The home continues to be excluded during periods when the applicant/recipient resides in an acute care or long term care medical facility if the applicant/recipient, or their representative, states that the applicant/recipient intends to return to the home. If the applicant/recipient or their representative states the applicant/recipient does not intend to return to the home but the home is the residence of the applicant/recipient's spouse or dependent relative, the home is an excluded resource. If the applicant/recipient or their representative puts the home up for sale and it is *not* the primary residence of the applicant/recipient's spouse or a dependent relative, the home is considered a countable resource.

F. Income-producing property exclusion: To be excluded from consideration as a countable resource, income-producing property that does not qualify as a bona fide business (e.g., rental property or mineral rights) must have an equity value of no more than $6,000 and an annual rate of return of at least six percent of the equity value. See Subparagraph (b) of Paragraph (1) of Subsection F of Section 8.215.500.14 NMAC, *determination of rate of return*, below if the equity value exceeds $6,000 but the rate of return is at least six percent annually. The $6,000 and six percent limitation does not apply to property used in a trade or bona fide business, or to property used by an applicant/recipient as an employee which is essential to the applicant/recipient's self-support (e.g., tools used in employment as a mechanic, property owned or being purchased in conjunction with operating a business). Existence of a bona fide business can be established by documentation such as business tax returns.

(1) Determination of rate of return: To calculate the annual rate of return for income producing property when the $6,000 and six percent limits apply, the previous year's income tax statement, or at least three months earnings is used to project the rate of return for the year.

(a) If the income is sporadic or has decreased from that needed to maintain a six percent rate of return for the coming year, the property is reevaluated at appropriate intervals.

(b) If the annual rate of return is at least six percent of the equity value but the equity exceeds $6,000, only the excess equity is a countable resource.

(c) If the annual rate of return is less than six percent but the usual rate of return is more, the property is excluded as a countable resource if all of the following conditions are met:

(i) unforeseeable circumstances, such as a fire, cause a temporary reduction in the rate of return;

(ii) the previous year's rate of return, as documented by the income tax statement or several months receipts, is at least six percent; and

(iii) the property is expected to produce a rate of return of at least six percent six percent within 18 months of the end of the year in which the adverse circumstances occurred; the ISD worker records in the case narrative the plan of action which is expected to increase the rate of return.

(d) The ISD worker notifies the applicant/recipient in writing that the property is excluded based on its expected increase in return and that it will be reevaluated at the end of the 18 month grace period. When this period ends, the property must be producing an annual rate of at least six percent to continue to be excluded as a countable resource.

(2) Types of income-producing property: Income- producing property includes:

(a) a business, such as a farm or store, including necessary capital and operating assets such as land and buildings, inventory, or livestock; the property must be in current use or have been used with a reasonable expectation of resumed use within a year of its most recent use; the ISD worker must account for the cash actually required to operate the business; liquid business assets of any amount are excluded;

(b) non-business property includes rental property, leased property, land leased for its mineral rights and property producing items for home consumption; property which produces items solely for

home use is assumed to be producing an annual rate of return of at least six percent;

(c) employment-related property, such as tools or equipment; the applicant/recipient must provide a statement from their employer to establish that tools or equipment are required for continued employment; if the applicant/recipient is self-employed, only those tools normally required to perform the job adequately are excluded; the applicant/recipient must obtain a statement from someone in the same line of self-employment to establish what is excludable.

G. Vehicle exclusion: The term "vehicle" includes any mode of transportation, such as a passenger car, truck or special vehicle. Included in this definition are vehicles which are unregistered, inoperable, or in need of repair. Vehicles used solely for purposes other than transportation, such as disassembly to resell parts, racing, or as an antique are not included in this definition. Recreational vehicles and boats are classified as personal effects and are evaluated under the household goods and personal effects exclusion. One vehicle is totally excluded regardless of value if it is used for transportation for the individual or a member of the individual's household. Any other automobiles are considered to be Non-liquid resources. Equity in the other automobiles is counted as a resource.

H. Life insurance exclusion: The value of life insurance policies is not considered a countable resource if the total cumulative face value of all policies owned by the applicant/recipient does not exceed $1,500. A policy is considered to be "owned" by the applicant/recipient if the applicant/recipient is the only one who can surrender the policy for cash.

(1) Consideration of burial insurance and term insurance: Burial insurance and term insurance are not considered when computing the cumulative face value because this insurance is redeemable only upon death.

(2) Calculation when value exceeds limit: If the total cumulative face value of all countable life insurance policies owned by the applicant/recipient exceeds $1,500, the ISD worker:

(a) verifies the total cash surrender value of all policies and considers the total amount a countable resource; and

(b) informs the applicant/recipient that the insurance policies can be converted to term insurance or ordinary life insurance of lower face value at their option, if the cash surrender value, alone or in combination with other countable resources, exceeds the resource standard.

I. Produce for home consumption exclusion: The value of produce for home consumption is totally excluded.

J. Exclusion of settlement payments from the department of housing and urban development: Payments from the department of housing and urban development (HUD) as defined in *Underwood v. Harris* are excluded as income and resources. These one-time payments were made in the spring of 1980 to certain eligible tenants of subsidized housing (Section 236 of the National Housing Act).

(1) Segregation of payment: To be excluded as a resource, payments retained by an applicant/recipient must be kept separate. These payments must not be combined with any other countable resources.

(2) Income from segregated funds: Interest or dividend income received from segregated payment funds is not excluded from income, or, if retained, is not an excluded resource. This interest or dividend income must be kept separate from excludable payment funds.

K. Lump sum payments exclusion: SSI and social security lump sum payments for retroactive periods are excluded as countable resources for nine months after the month in which they are received. See Paragraph (4) of Subsection A of Section 8.215.500.16 NMAC, *treatment of SSI or social security lump sum payments*, for policy regarding SSI and social security lump sums which are placed into the ownership of a medicaid qualifying trust. Social security lump sum payments are considered infrequent income.

L. Home replacement exclusion: The value of a promissory note or similar installment sales contract which constitutes proceeds from the sale of an excluded home is excluded from countable resources if all of the following conditions are met:

(1) the note results from the sale of the applicant/recipient's home as described in Subsection E of Section 8.215.500.14 NMAC, *exclusion for real property and home*, and following subsections;

(2) within three months of receipt (execution) of the note, the applicant/recipient purchases a replacement home which meets the definition of a home in Subsection E of Section 8.215.500.14 NMAC, *exclusion for real property and home*, and following subsections; and

(3) all note-generated proceeds are reinvested in the replacement home within three months of receipt.

(4) Additional exclusions: In addition to excluding the value of the note itself, the down payment received from the sale of the former home, as well as that portion of any installment amount constituting

payment on the principal are also excluded from countable resources.

(5) Failure to purchase another excluded home timely: If the applicant/recipient does not purchase another home which can be excluded under the provisions of Subsection E of Section 8.215.500.14 NMAC, *exclusions for real property and home*, and following subsections within three months, the value of the promissory note or similar installment sales contract received from the sale of an excluded home becomes a countable resource as of the first moment of the first day of the month following the month the note is executed. If the applicant/recipient purchases a replacement home after the expiration of the three month period, the value of the promissory note or similar installment sales contract becomes an excluded resource effective the month following the month of purchase of the replacement home provided that all other proceeds are fully and timely reinvested.

(6) Failure to reinvest proceeds timely: If the proceeds from the sale of an excluded home under a promissory note or similar installment sales contract are not reinvested fully within three months of receipt in a replacement home, the following resources become countable as of the first moment of the first day of the month following receipt of the payment:

(a) the fair market value of the note;

(b) the portion of the proceeds, retained by the individual, which was not timely reinvested; and

(c) the fair market value of the note remains a countable resource until the first moment of the first day of the month following the receipt of proceeds that are fully and timely reinvested in the replacement home; failure to reinvest proceeds for a period of time does not permanently preclude exclusion of the promissory note or installment sales contract; however, previously received proceeds that were not timely reinvested remain countable resources to the extent they are retained.

(7) Interest payments: If interest is received as part of an installment payment resulting from the sale of an excluded home under a promissory note or similar installment sales contract, the interest payments are considered countable unearned income in accordance with Paragraph (3) of Subsection C of Section 8.215.500.20 NMAC, *interest on promissory note or sales contract*.

(8) When the home replacement exclusion does not apply: If the home replacement exclusion does not apply, the market value of a promissory note or sales contract as well as the portion of the payment received on the principal are considered countable resources.

M. Household goods and personal effects exclusion: Household goods and personal effects are excluded if they meet one of the following four criteria. They are:

(1) items of personal property, found in or near the home, which are used on a regular basis; items may include but are not limited to: furniture, appliances, recreational vehicles (i.e. boats and RVs), electronic equipment (i.e. computers and television sets), and carpeting;

(2) items needed by the householder for maintenance, use and occupancy of the premises as a home; items may include but are not limited to: cooking and eating utensils, dishes, appliances, tools, and furniture.

(3) items of personal property ordinarily worn or carried by the individual; items may include but are not limited to: clothing, shoes, bags, luggage, personal jewelry including wedding and engagement rings, and personal care items;

(4) items otherwise having an intimate relation to the individual; items may include but are not limited to: prosthetic devices, educational or recreational items such as books or musical instruments, items of cultural or religious significance to an individual; or items required because of an individual's impairment.

N. ABLE act exclusions:

(1) For most federal means-tested programs:

(a) ABLE account balances are excluded.

(b) Limitation is the maximum amount that can be contributed under a state plan.

(2) For the SSI program:

(a) ABLE account balances are excluded up to $100,000.

(b) Amounts over $100,000 count toward the $2,000 SSI resource limit.

(c) If an ABLE account balance exceeds $100,000 by an amount that causes the recipient to exceed the SSI resource limit the recipient is ineligible for SSI.

O. Indian per capita: Public Law 97-458 (section 4) Amended Public Law 93-134, the Judgement Award Authorization Act, to require the exclusion of per capita payments under the Indian Judgement Fund Act of $2,000 or less. Initial purchases made with exempt payments distributed between January 1, 1982, and January 12, 1983, are excluded from resources to the extent that excluded funds were used.

[8.215.500.14 NMAC - Rp, 8.215.500.14 NMAC, 3/1/2018]

8.215.500.15 ASSET TRANSFERS:

A. Transfers of assets for less than fair market value by SSI applicants/recipients are considered only if/when an applicant/recipient becomes institutionalized. For medicaid categories using SSI resource determination methodology, transfers by non-institutionalized applicants/recipients are not considered a factor of eligibility.

B. Transfer of resources by an SSI recipient: An institutionalized SSI applicant/recipient who transfers resources without fair return may become ineligible for medicaid coverage of nursing home care for a specified period of time. See Section 8.281.500.14 NMAC and following subsections for information on resource transfer policies and penalties applicable to institutionalized applicants/recipients.

[8.215.500.15 NMAC - Rp, 8.215.500.15 NMAC, 3/1/2018]

8.215.500.16 TRUSTS: In some instances, an applicant/recipient with a trust can be eligible for SSI cash benefits but not be automatically eligible for medicaid. If the social security administration (SSA) determines that an SSI recipient has a trust, SSI notifies the HCA of the existence of the trust. The recipient is then notified that the trust document must be submitted to and reviewed by HCA before medicaid eligibility is determined.

A. Medicaid qualifying trusts: A "medicaid-qualifying trust" (MQT) is a trust or similar legal device established prior to August 11, 1993, other than by will, by an applicant/recipient or spouse, under which the applicant/recipient may be the beneficiary of all or part of the payments from the trust. The distribution of trust payments is determined by one or more trustees who are permitted to exercise discretion with respect to the distribution of payments to the applicant/recipient. When the use of an attorney is solicited to establish a trust, the beneficiary of that trust is not exempt from the requirements of MQT provisions. Legal instruments such as trusts are almost always drafted by an attorney. It is the grantor who actually establishes of creates the trust when they sign or execute it.

(1) Amount deemed available from an MQT: The amount from an MQT that is deemed available to an applicant/recipient is the maximum amount that could be distributed to the applicant/ recipient, or for the care of the applicant/ recipient, regardless of restrictions imposed by the trust on the allowable use of the funds. If, for example, the trustee can make payments to a health care provider for medical services, the applicant/recipient beneficiary is considered to be receiving benefits from the trust even though these benefits are not paid directly to the beneficiary. This provision applies regardless of whether the MQT was set up for the purpose of qualifying for medicaid or whether the trust is irrevocable.

(2) Revocable trusts: Revocable trusts that limit access to the assets held in trust must be dissolved and the assets spent down before eligibility can be established.

(3) Beneficiary of trust lives in an ICF-MR: If the beneficiary of a trust is an applicant/recipient who is mentally retarded and resides in an intermediate care facility for the mentally retarded (ICF-MR), that applicant/recipient's trust is not considered an MQT if the trust or trust decree was established prior to April 7, 1986, and is solely for the benefit of that applicant/recipient.

(4) Treatment of SSI or social security lump sum payments: SSI or social security lump sum payments for retroactive periods which are placed into an MQT do not qualify for the nine month exclusion from countable resources.

B. Trusts creating medicaid eligibility: [RESERVED]

[8.215.500.16 NMAC - Rp, 8.215.500.16 NMAC, 3/1/2018]

8.215.500.17 DEEMING RESOURCES:

A. Deeming resources when an applicant/recipient lives with an ineligible spouse: If an eligible noninstitutionalized applicant/recipient lives in the same household with an ineligible spouse, the resources of the ineligible spouse are considered to belong to the applicant/recipient. The resource standard for a couple applies.

B. Deeming resources for minor applicant living with ineligible parent(s): If an applicant/recipient is a minor under 18 years of age, the resources of the parent(s) are deemed to the applicant/recipient if the parent(s) live in the same household.

(1) Computing deemed resources: To determine the amount of resources deemed to an applicant/recipient who is a minor, the following computation is made:

(a) determine the parent(s) resources;

(b) allow the parent(s) all the resource exclusions that an applicant/recipient receives; and

(c) remaining resources in excess of $2,000 for one parent or $3,000 for two parents

are deemed to the eligible minor.

(2) Computing countable resources: The deemed resources are added to the applicant/recipient's own countable resources. The minor applicant/recipient is eligible if countable resources do not exceed resource standards.

[8.215.500.17 NMAC - Rp, 8.215.500.17 NMAC, 3/1/2018]

8.215.500.18 INCOME:

A. An applicant/recipient's gross countable monthly income must be less than the maximum allowable monthly standard for the applicable medicaid category. Income may be in the form of cash, checks, money orders, or in-kind, including personal property or food. If income is not received in the form of cash, the cash value of the item is determined and counted as income. Income is counted in the month received. Income is considered available throughout the month, regardless of when in the month it is received. The ISD worker verifies and documents all income.

B. Types of income: Countable income is the sum of unearned income or earned income, less disregards or exclusions, plus deemed income.

(1) Earned income: Earned income consists of the total gross income received by an individual for services performed as an employee or as a result of self-employment.

(a) Royalties earned in connection with the publication of the applicant/recipient's work and any honorarium/fees received for services rendered are considered earned income.

(b) The self-employed applicant/recipient must provide an estimate of their current income based on the tax return filed for the previous year or current records maintained in the regular course of business. The estimate of net earnings for the entire previous taxable year is prorated equally among all months of the current year, even if the business is seasonal.

(i) Consideration is given to the applicant/recipient's explanation as to why they believe the estimated net earnings for the current year vary substantially from the information shown on their tax return for past years.

(ii) A satisfactory explanation is that the business suffered heavy loss or damage from fire, flood, burglary, serious illness or disability of the owner, or other such catastrophic events. Documentation must include copies of newspaper accounts or medical reports and must be filed in the case record to substantiate the need for a reduced estimate of current self-employment income.

(2) Unearned income: Unearned income consists of all other income (minus exclusions and disregards) that is not earned in the course of employment or self-employment.

(3) Deemed income: Deemed income is income which must be considered available to the assistance unit and counted in determining eligibility whether or not the income is actually made available. For household member(s) who are not members of the assistance unit but who have a support obligation to the assistance unit, income can only be deemed from a parent to their minor child(ren) who live in the same household and from one spouse to the other when both live in the same household.

C. Contributions to the able account:

(1) Contributions from any source to an ABLE account are not considered income to an SSI recipient.

(2) However:

(a) An SSI recipient’s earnings contributed to an ABLE account are still considered wages and counted (even if payroll deduction).

(b) Gifts to an SSI recipient to be deposited into an ABLE account are considered as income.

(c) Gifts made directly into an ABLE account are not income.

[8.215.500.18 NMAC - Rp, 8.215.500.18 NMAC, 3/1/2018]

8.215.500.19 INCOME STANDARDS: See 8.200.520 NMAC and following subsections for income standards applicable to the SSI-related medicaid categories.

A. Income exclusions: Income exclusions are applied before income disregards. Exclusions are applied in determining eligibility whether the income belongs to the applicant/recipient or to an individual from whom income is deemed.

B. Infrequent or irregular income: Exclude the first $30 per calendar quarter of earned income; and the first $60 per calendar quarter of unearned income. The following definitions apply.

(1) "Irregular income" is income received on an unscheduled or unpredictable basis.

(2) "Infrequent income" is income received only once during a calendar quarter from a single source and includes:

(a) proceeds of life insurance policies;
(b) prizes and awards;
(c) gifts;
(d) support and alimony;
(e) inheritances;
(f) interest per account, and royalties;
(g) one-time lump sum payments, such as social security or retroactive SSI.

(3) "Frequency" is evaluated for the calendar quarter (i.e., January - March, April - June, July - September, October - December) but the dollar amount is considered in the month received.

C. Foster care: Foster care payments are totally excluded if:

(1) the foster child is not eligible for SSI; and
(2) the child was placed in the applicant/recipient's home by a public or private nonprofit child placement or child care agency.

D. Domestic volunteer services exclusions: Payments to volunteers under domestic volunteer services (ACTION) programs are excluded from consideration as income in the eligibility determination process. These programs include the following:

(1) volunteers in service to America (VISTA);
(2) university year for action (UYA);
(3) special demonstration and volunteer programs;
(4) retired senior volunteer program (RSVP);
(5) foster grandparent program;
(6) senior companion program.

E. Census bureau employment: Wages paid by the census bureau for temporary employment related to the census are excluded from consideration as income in the eligibility determination process.
[8.215.500.19 NMAC - Rp, 8.215.500.19 NMAC, 3/1/2018]

8.215.500.20 UNEARNED INCOME:

A. Unearned income includes all income not earned in the course of employment or self-employment.

B. Income paid to one spouse is considered the income of that spouse. One-half the total income paid to a couple is considered available to each member of the couple.

(1) If payment is made in the name of either or both spouses and another party, only the applicant/recipient's proportionate share is considered available to him/her.

(2) If income is derived from property for which ownership is not established, such as unprobated property, one-half of the income is considered available to each member of a married couple.

C. Standards for unearned income: Unearned income is computed on a monthly basis. If there are no expenses incurred with the receipt of unearned income, such as annuities, pensions, retirement payments or disability benefits, the gross amount is considered countable unearned income.

(1) Social security overpayments: If the social security administration withholds an amount because of an overpayment, the gross social security payment amount is used to determine eligibility.

(2) Rental income: If an applicant/recipient has rental property, the ISD worker allows the cost of real estate taxes, maintenance and repairs, advertising, mortgage insurance and interest payments on the mortgage as deductions from the amount received as rent.

(3) Interest on promissory note or sales contract: The portion of the payment representing interest received from a promissory note or sales contract is considered unearned income. The market value of promissory notes or sales contracts and the portion of the payment representing payment of the principal are considered resources. See also Subsection L of Section 8.215.500.14 NMAC, *home replacement exclusion*.

D. Unearned income exclusions:

(1) Interest from an excluded burial fund: Interest from an excluded burial fund is not considered unearned income if the interest is applied toward the fund balance. If the interest is paid to the applicant/recipient, it is considered unearned income.

(2) Tax refunds and earned income tax credit: Tax refunds from any public agency for property taxes or taxes on food purchases are totally excluded. Any portion of a federal income tax return which constitutes an earned income tax credit is excluded.

(3) Grants, scholarships and fellowships: All grants, scholarships and fellowships used to

pay tuition and fees at an educational institution, including vocational and technical schools, are totally excluded. Any portion of a grant, scholarship or fellowship used to pay any other expense, such as food, clothing or shelter, is not excluded.

(4) Veterans payments: Veterans aid and attendance (A&A) payments are excluded from unearned income for determination of eligibility.

(a) If an applicant/recipient receives an augmented VA payment as a veteran or veteran's widow or widower, the payment amount may include an increment for a dependent. If so, the VA must be contacted to provide documentation of the portion of the payment which represents the dependent's increment. When verified, this amount of the VA payment is considered the dependent's income.

(b) The portion of a veterans administration improved pension (VAIP) benefit intended for unreimbursed medical expenses is excluded for purposes of eligibility determination.

(5) Payments by a third party: Third party payments are excluded as income if made directly to the applicant/recipient's creditor.

(a) Third party payments may include mortgage payments by credit life or credit disability insurance and installment payments by a family member on a burial plot or prepaid burial contract.

(b) Interest from a burial contract that is automatically applied to the outstanding balance is excluded from unearned income. If the payment or interest is sent to the individual, it is counted as unearned income regardless of the sender's (third party's) intentions. This applies even if the sender specifies the purpose of the payment on the check.

(c) This provision does not apply if the signature of the creditor and the individual must both be present in order to negotiate the check (two-party check).

(6) Indian tribe per capita payments: Certain per capita payments are excluded from income and resources.

(a) Up to two thousand dollars $2,000 of per capita distributions of judgment funds to members of the confederated tribes of the Warm Springs Reservation are excluded except for funds held by Alaska native regional and village corporations (ANRVC) that are not held in trust by the secretary of the interior. ANRVC dividend distributions are not excluded from countable income under this exclusion (per Public Law 97-436 section 4, 98-64, and 100-580).

(b) All distributions to heirs of certain deceased Indians under the Old Age Assistance Claims Settlement Act except for per capita shares in excess of $2,000 (per Public Law 98-500 section 8).

(c) Up to $2,000 per year received by Indians that is derived from individual interests in trust or restricted lands (per Public Law 103-66 section 13736, 92-203, and 100-241).

(d) Up to $2,000 per year received by Indians that is derived from individual interests in trust or restricted lands (per Public Law 111-291).

(e) Amounts received by an individual as a lump sum or a periodic payment via the Cobell settlement cannot be counted as income in the month received or as a resource for a one year period beginning with the date of receipt (per Public Law 111-291 section 101).

(7) Plans for achieving self-support: Income derived from, or necessary to, an approved plan for achieving self-support for a blind or disabled applicant/recipient under 65 years of age is excluded.

(a) For an applicant/recipient who is blind or disabled and over 65 years of age, this exclusion applies only if they received medicaid for the month preceding their 65th birthday.

(b) The self-support plan must be in writing and contain the following:

(i) designated occupational objective;

(ii) specification of any savings (resource) or earnings needed to complete the plan, such as amounts needed for purchase of equipment or for financial independence;

(iii) identification and segregation of any income saved to meet the occupational goal; and

(iv) designation of a time period for completing the plan and achieving the occupational goal.

(c) Plans for achieving self-support are developed by vocational rehabilitation counselors. If a self-support plan is not in place, the ISD worker makes a referral to the division of vocational rehabilitation (DVR).

(d) The ISD worker forwards the written plan and documentation to the MAD eligibility unit. The plan must be approved by that unit.

(e) An approved plan is valid for the following specified time periods:

(i) initial period of no more than 18 months;
(ii) extension period of no more than 18 months;
(iii) final period of no more than 12 months; and
(iv) total period of no more than 48 months.

(8) Agent orange settlement payments: Agent orange settlement payments made to veterans or their survivors are excluded from consideration as income in determining eligibility.

(9) Radiation Exposure Compensation Act payments: Payments made under the Radiation Exposure Compensation Act are excluded from consideration as income in determining eligibility.

(10) Remembrance, responsibility and the future foundation: Payments to individual survivors forced into slave labor by the Nazis are excluded.

(11) Victims compensation payments: Payments made by a state-administered fund established to aid victims of crime are excluded from consideration as income in determining eligibility.

(12) SSI lump sums for retroactive periods: Supplemental security income (SSI) lump sum payments for retroactive periods are excluded from consideration as countable income in the month received.

(13) Life insurance and other burial benefits: Life insurance and other burial benefits are unearned income to the beneficiary (not the owner). The ISD worker must subtract the amount spent on the insured individual's last illness or burial up to $1,500. Any excess is counted as unearned income.

(14) One hundred percent state-funded assistance payment: Any one hundred percent state-funded assistance payment based on need, such as general assistance (GA), is excluded. Any interim payments made by a state or municipality from all state or local funds while an SSI application is pending are excluded.

(15) ABLE ACT distributions: Distributions from an ABLE account are excluded as income of the designated beneficiary. Qualified disability expenses (QDEs) are expenses related to the blindness or disability of the designated beneficiary and for the benefit of the designated beneficiary. The following (QDEs) are excluded:

(a) Housing related QDEs: mortgages (including house insurance), real property taxes, rent, heating fuel, gas, electricity, water, sewer, and garbage removal.

(b) Non-housing related QDEs: education, transportation, employment training and support, assistive technology and related services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for ABLE account oversight and monitoring, funeral and burial, and basic living expenses.

(c) Non-qualified expenses.

(d) QDEs for non-housing: Distributions for other non-housing expenses are excluded if retained beyond the month received in their current ABLE account if the distribution is identifiable and is intended to eventually be expended for non-housing costs.

(e) Non-qualified expenses: Not excluded under the ABLE Act are housing-related or other QDEs if retained by the beneficiary for two months.

[8.215.500.20 NMAC - Rp, 8.215.500.20 NMAC, 3/1/2018]

8.215.500.21 DEEMED INCOME:

A. Availability: Deemed income is income which must be considered available to members of an assistance unit regardless of whether the income is actually made available.

B. Situations in which deeming occurs: For household member(s) who are not members of the assistance unit but who have a support obligation to the assistance unit member(s), income can only be deemed from a parent(s) to their minor child(ren) who live in the same household and from one spouse to the other when both live in the same household.

C. Parent or spouse receiving benefits based on economic need: In a deeming situation where one parent or the spouse is receiving a needs benefit, the benefit plus all of the income of the spouse/parent who receives the benefit is excluded from the deeming process. This exclusion applies only to the income of the individual who receives the benefit.

(1) Needs benefit defined: "Needs benefit" is any benefit or assistance which is paid by a governmental agency on the basis of economic need.

(2) Consideration of household membership: Even if the income of one parent is excluded from the deeming process, the parent is considered a member of the household for purposes of determining the parental allocation. This does not apply to benefits received under the temporary assistance to needy families (TANF) program. No income is allocated to a parent or child if that parent or child is receiving TANF assistance.

D. Applicant living with ineligible spouse:

(1) If an applicant/recipient is living in the same household with an ineligible spouse, income may be deemed from the ineligible spouse to the applicant/recipient.

(2) The methodology described below does not apply to the qualified medicare beneficiaries (QMB) program. See Paragraph (1) of Subsection B of Section 8.240.500.15 NMAC for methodology applicable to the QMB program only.

(a) Evaluation of applicant's income: Determine the amount of income available to the applicant using only the applicant's own income and allow the $20 disregard. If the applicant/recipient has earned income, the first $65 plus one-half of the remainder is also disregarded.

(i) If an applicant/recipient's own income exceeds the income standard for an individual, the applicant/recipient is ineligible. No further calculation needs to be done.

(ii) If an applicant/recipient's countable income is less than the standard for an individual, determine the ineligible spouse's gross income.

(b) Evaluation of ineligible spouse's gross income: Determine the ineligible spouse's gross income (both earned and unearned). Subtract the $20 general disregard plus the first $65 and one-half of the remainder from any earned income. If there are no children in the household, compare the ineligible spouse's countable income to one-half of the SSI federal benefit rate (FBR) for an individual not living in the household of others. If the ineligible spouse's countable income is less than one-half of the SSI FBR, no income is deemed from the ineligible spouse to the applicant/recipient. If the ineligible spouse's countable income equals or exceeds one-half of the SSI FBR, income is deemed from the ineligible spouse to the applicant.

E. Applicant living with ineligible spouse and children:

(1) A “child” is under 18 years of age or under 21 years of age if a full-time student at an accredited institution of learning.

(2) If there are children in the household, subtract a living allowance for each ineligible child from the ineligible spouse's countable income. The living allowance is one-half of the monthly SSI FBR for an individual not living in a household with others less any income attributable to the child. If the remaining amount is less than one-half of the SSI FBR, no income is deemed from the ineligible spouse to the applicant/recipient. If the remaining amount equals or exceeds one-half of the SSI FBR, income is deemed from the ineligible spouse to the applicant/recipient.

(3) Determination of countable income: Add the total gross unearned income of the ineligible spouse to the total gross unearned income of the applicant/recipient. The $20 disregard is deducted from the combined total of the couple's unearned income. If the total unearned income is less than $20 the remainder is deducted from the combined total of the couple's earned income. The first $65 and one half of the remainder is subtracted from the combined total of the couple's earned income. After all applicable disregards have been subtracted, the remaining earned and unearned income amounts are combined to arrive at the total countable income. If the total countable income is less than the income standard for a couple, the applicant/recipient is eligible.

F. Applicant child living with ineligible parents: A "child" applicant/recipient is under 18 years of age. The ISD worker determines the total gross monthly amount of parental income, both unearned and earned. The ISD worker applies appropriate income disregards to calculate the countable deemed income. See Section 8.200.520.18 NMAC, *deemed income worksheet*. If the deemed income plus the child's separate income exceeds the income standard for an applicant/recipient, the child is not eligible for that month.

G. Applicant/recipient parent and applicant/recipient child(ren): If a household is composed of an applicant/recipient parent and an applicant/recipient child(ren), the income is deemed from the ineligible spouse to the applicant/recipient spouse if appropriate. See Subsection B of Section 8.215.500.21 NMAC, *deemed income*.

(1) If there is enough total income to make the applicant/recipient parent ineligible, the remainder of the income is carried over to be deemed to the child(ren). Deemed income is divided equally among the applicant/recipient children.

(2) If the total countable income of the child, including the deemed income, is more than the applicable income standard, the child is ineligible.

[8.215.500.21 NMAC - Rp, 8.215.500.21 NMAC, 3/1/2018]

8.215.500.22 DISREGARDS: Income disregards are allowed as described below when applicable.

A. Child support payments: One-third of the amount of child support payments made to a child applicant/recipient is disregarded. The remainder is considered unearned income, subject to the appropriate disregards.

B. Twenty dollar disregard: The first $20 of unearned or earned income received in a month is

disregarded. This disregard is applied first to unearned income, then to earned income if the unearned income is less than $20. If there is no unearned income, the entire $20 is applied to the gross earned income. This disregard is not applicable to payments made to an applicant/recipient through a state or other government assistance program, or by a private charitable organization, where such payments are based on the applicant/recipient's need.

C. Additional earned income disregard: After disregarding the first $20 as specified in Subsection B of Section 8.215.500.22 NMAC above, if appropriate, earned income of $65 per month plus one-half of the remainder is disregarded.

D. Work-related expenses of the blind or disabled: Work-related expenses of an employed applicant/recipient or couple who is/are legally blind or disabled are disregarded. This disregard is for earned income only. The dollar amount of expenses which may be disregarded must be items or services directly related to enabling a person to work and which are necessarily incurred by that individual because of a physical or mental disability or blindness. Such costs incurred must be reasonable. Expenses are disregarded when paid and must be verified.

(1) This disregard does not apply to an applicant/recipient who is blind and is 65 years of age or older, unless they were receiving SSI payments due to blindness or disability in the month before turning 65 or received payments under a state aid to the blind or disabled program.

(2) Types of work-related expenses which may be disregarded include:

(a) federal, state, and local income taxes;

(b) social security contributions;

(c) union dues;

(d) transportation costs, including actual cost of bus/taxi cab fare, or 15 cents per mile for private automobile;

(e) lunches;

(f) child care costs, if not otherwise provided;

(g) uniforms, tools, and other necessary equipment;

(h) special vehicle modifications to enable transportation to and from work, but not the cost of the vehicle itself;

(i) attendants who may be hired for the purpose of taking applicant/recipient to and from work, and getting ready for work;

(j) durable medical equipment that is medically related and generally not useful in absence of the blindness or disability yet are necessary to attend and perform tasks in the work place;

(k) expenses for work related equipment which is impairment related and necessary for the individual to perform their tasks;

(l) prostheses necessary to perform work related tasks;

(m) design modifications related to blindness or disability that enable the applicant/recipient to leave home in order to attend work, or design modifications made to the work area of the home in the case where the applicant/recipient engages in a home based business; and

(n) special expenses necessary to enable an applicant/recipient who is blind or disabled to engage in employment, such as a seeing-eye dog, braille instructions, or instructions on using special equipment.

(3) If items or services above are purchased through an installment contract, the payments are disregarded. Should the item or service be a one time purchase, the purchase may be pro-rated over a 12 month period, or over the life of the contract.

(4) For items which are leased, the monthly payment would be disregarded.

E. Student earned income:

(1) This disregard applies only to a student's own earned income and includes all payments made as compensation for services, such as wages from employment or self-employment, or payments from programs such as neighborhood youth corps or work-study.

(2) This disregard is available in addition to any exclusions applied to grants, scholarships or fellowships and in addition to any other allowable disregards.

(3) Up to $1,200 per quarter, or a maximum of $1,620 per calendar year, of the earned income of certain students may be disregarded. To qualify for this disregard, the applicant/recipient must meet all of the following requirements:

(a) under 22 years of age;

(b) unmarried;

(c) not the head of a household; and

(d) in regular attendance at a college or university for at least 12 semester hours or a school or vocational or technical training course for at least 20 hours per week.
[8.215.500.22 NMAC - Rp, 8.215.500.22 NMAC, 3/1/2018]

8.215.500.23 INCOME STANDARD: When computing an applicant/recipient's eligibility, the applicable income standard is that of the SSI-related category being applied for/received. See Section 8.200.520 NMAC and following subsections.
[8.215.500.23 NMAC - Rp, 8.215.500.23 NMAC, 3/1/2018]

HISTORY OF 8.215.500 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
MAD Rule 860, SSI Methodology For Computation Of Countable Resources And Income, 3/17/1990.
MAD Rule 860, SSI Methodology For Computation Of Countable Resources And Income, 3/21/1990.
MAD Rule 860, SSI Methodology For Computation Of Countable Resources And Income, 4/24/1991.
MAD Rule 860, SSI Methodology For Computation Of Countable Resources And Income, 6/19/1992.
MAD Rule 861, Resources - SSI Methodology For Computation Of Countable Resources And Income, 3/18/1993.
MAD Rule 861, Resources - SSI Methodology For Computation Of Countable Resources And Income, 12/29/1994.
MAD Rule 862, Income - SSI Methodology For Computation Of Countable Resources And Income, 3/18/1993.
MAD Rule 864, Potential Income Or Resources - SSI Methodology For Computation Of Countable Resources And Income, 3/18/1993.
MAD Rule 866, Deeming Income, 11/16/1994.

History of Repealed Material:
8.215.500 NMAC, Medicaid Eligibility Supplemental Security Income (SSI) Methodology - Income And Resource Standards filed 2/15/2001) - Repealed effective 3/1/2018.

TITLE 8 SOCIAL SERVICES
CHAPTER 215 MEDICAID ELIGIBILITY - SUPPLEMENTAL SECURITY INCOME (SSI) METHODOLOGY
PART 600 BENEFIT DESCRIPTION

8.215.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.215.600.1 NMAC - Rp, 8.215.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.215.600.2 SCOPE: The rule applies to the general public.
[8.215.600.2 NMAC - Rp, 8.215.600.2 NMAC, 1/1/2019]

8.215.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.215.600.3 NMAC - Rp, 8.215.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.215.600.4 DURATION: Permanent.
[8.215.600.4 NMAC - Rp, 8.215.600.4 NMAC, 1/1/2019]

8.215.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.215.600.5 NMAC - Rp, 8.215.600.5 NMAC, 1/1/2019]

8.215.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.215.600.6 NMAC - Rp, 8.215.600.6 NMAC, 1/1/2019]

8.215.600.7 DEFINITIONS: [**RESERVED**]

8.215.600.8 [**RESERVED**]

8.215.600.9 GENERAL BENEFIT COVERAGE: Medicaid coverage for services based on determinations made using the SSI methodology varies based on the category of eligibility. For applicants/recipients who are eligible for SSI, full medicaid coverage for services is available. If applicants/recipients are eligible for medicare coverage, medicaid covers medicare premium amounts.
[8.215.600.9 NMAC - Rp, 8.215.600.9 NMAC, 1/1/2019]

8.215.600.10 SSI RETROACTIVE BENEFIT COVERAGE: Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.215.600.10 NMAC - Rp, 8.215.600.10 NMAC, 1/1/2019]

8.215.600.11 CHANGES IN ELIGIBILITY: A case is closed, with provision of advance notice when the recipient becomes ineligible. If a recipient dies, the case is closed the following month.
[8.215.600.11 NMAC - Rp, 8.215.600.11 NMAC, 1/1/2019]

HISTORY OF 8.215.600 NMAC:
Pre NMAC History: The material in this part was derived from that previously filed with the State Records Center.
MAD Rule 860, SSI Methodology for Computation of Countable Resources and Income, filed 3/7/1989.
MAD Rule 860, SSI Methodology for Computation of Countable Resources and Income, filed 3/21/1990.
MAD Rule 860, SSI Methodology for Computation of Countable Resources and Income, filed 4/24/1991.
MAD Rule 860, SSI Methodology for Computation of Countable Resources and Income, filed 6/19/1992.
MAD Rule 861, Resources - SSI Methodology for Computation of Countable Resources and Income, filed 3/18/1993.

MAD Rule 861, Resources - SSI Methodology for Computation of Countable Resources and Income, filed 12/29/1994.
MAD Rule 862, Income - SSI Methodology for Computation of Countable Resources and Income, filed 3/18/1993.
MAD Rule 864, Potential Income or Resources - SSI Methodology for Computation of Countable Resources and Income, filed 3/18/1993.
MAD Rule 866, Deeming Income, filed 11/16/1994.

History of Repealed Material:
MAD Rule 860, SSI Methodology for Computation of Countable Resources and Income, filed 6/19/1992 - Repealed effective 2/1/1995.
MAD Rule 861, Resources - SSI Methodology for Computation of Countable Resources and Income, filed 12/29/1994 - Repealed effective 2/1/1995.
MAD Rule 862, Income - SSI Methodology for Computation of Countable Resources and Income, filed 3/18/1993- Repealed effective 2/1/1995.
MAD Rule 864, Potential Income or Resources - SSI Methodology for Computation of Countable Resources and Income, filed 3/18/1993 - Repealed effective 2/1/1995.
MAD Rule 866, Deeming Income, filed 11/16/1994 - Repealed effective 2/1/1995.
8.215.600 NMAC - Benefit Description filed 9/3/2013 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 231 MEDICAID ELIGIBILITY - INFANTS OF MOTHERS WHO ARE MEDICAID ELIGIBLE (CATEGORY 031)
PART 400 RECIPIENT POLICIES

8.231.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.231.400.1 NMAC - Rp, 8.231.400.1 NMAC, 10/1/2017; A, 7/1/2024]

8.231.400.2 SCOPE: The rule applies to the general public.
[8.231.400.2 NMAC - Rp, 8.231.400.2 NMAC, 10/1/2017]

8.231.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.231.400.3 NMAC - Rp, 8.231.400.3 NMAC, 10/1/2017; A, 7/1/2024]

8.231.400.4 DURATION: Permanent
[8.231.400.4 NMAC - Rp, 8.231.400.4 NMAC, 10/1/2017]

8.231.400.5 EFFECTIVE DATE: October 1, 2017, unless a later date is cited at the end of a section.
[8.231.400.5 NMAC - Rp, 8.231.400.5 NMAC, 10/1/2017]

8.231.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.231.400.6 NMAC - Rp, 8.231.400.6 NMAC, 10/1/2017]

8.231.400.7 DEFINITIONS: [**RESERVED**]

8.231.400.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.231.400.8 NMAC - Rp, 8.231.400.8 NMAC, 10/1/2017; A, 1/1/2022]

8.231.400.9 NEWBORN - CATEGORY 031: The New Mexico medicaid program covers infants for 13 months born to mothers who are eligible for and receiving New Mexico medicaid at the time of the child's birth including during a period of retroactive eligibility. Mothers eligible to receive emergency medical services for non-citizens (EMSNC) at the time of labor and delivery are considered to meet the standard of medicaid eligibility for the mother.
[8.231.400.9 NMAC - Rp, 8.231.400.9 NMAC, 10/1/2017; A, 1/1/2022]

8.231.400.10 BASIS FOR DEFINING THE GROUP (42 CFR 435.177):

A. Eligibility: HCA provides medicaid to children from birth through the month of the child's first birthday without application if, for the date of the child's birth, the child's mother was eligible for and received covered services under:

(1) the medicaid state plan (including during a period of retroactive eligibility under 42 CFR 435.915) regardless of whether payment for services for the mother is limited to services necessary to treat an emergency medical condition, as defined in section 1903(v)(3) of the Act and 8.285.400.10 NMAC under the emergency medical services for non-citizens (EMSNC) program.

(2) the child is deemed to have applied and been determined eligible under the medicaid state plan effective as of the date of birth, and remains eligible regardless of changes in circumstances through the month of the child's first birthday, unless the child dies or ceases to be a resident of the state or the child's representative requests a voluntary termination of eligibility.

B. Medicaid identification number: The medicaid identification number of the mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the state issues the child a separate identification number. HCA will issue a separate medicaid identification number for the child prior to the effective date of any termination of the mother's eligibility or prior to the date of the child's first birthday, whichever is sooner, except that HCA will issue a separate medicaid identification number in the case of a child born to a mother:

(1) whose coverage is limited to services necessary for the treatment of an emergency medical condition, consistent with 42 CFR 435.139 or 435.350 and 8.285.400.10 NMAC under the EMSNC program; or

(2) who received medicaid in another state on the date of birth.

[8.231.400.10 NMAC - Rp, 8.231.400.10 NMAC, 10/1/2017; A, 1/1/2022]

8.231.400.11 GENERAL RECIPIENT REQUIREMENTS: [RESERVED]
[8.231.400.11 NMAC - Rp, 8.231.400.11 NMAC, 10/1/2017]

8.231.400.12 USE OF SOCIAL SECURITY NUMBER: The infant is not required to have a social security number as a condition of eligibility.
[8.231.400.12 NMAC - Rp, 8.231.400.12 NMAC, 10/1/2017]

8.231.400.13 CITIZENSHIP: An eligible newborn is considered to have met the citizenship and identity requirements.
[8.231.400.13 NMAC - Rp, 8.231.400.13 NMAC, 10/1/2017]

8.231.400.14 RESIDENCE: To be eligible for medicaid, an applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have demonstrated intent to remain in the state. A temporary absence from the state does not prevent eligibility. A temporary absence exists if the applicant/recipient leaves the state for a specific purpose with a time-limited goal and intends to return to New Mexico when the purpose is accomplished.
[8.231.400.14 NMAC - Rp, 8.231.400.14 NMAC, 10/1/2017]

8.231.400.15 SPECIAL RECIPIENT RESPONSIBILITIES: [RESERVED]
[8.231.400.15 NMAC - Rp, 8.231.400.15 NMAC, 10/1/2017]

8.231.400.16 AGE: An applicant/recipient newborn is eligible for medicaid under this category from birth through the month of the child's first birthday.
[8.231.400.16 NMAC - Rp, 8.231.400.16 NMAC, 10/1/2017]

8.231.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: An applicant/recipient is responsible for establishing their eligibility for medicaid. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant/recipient must also grant the HCA permission to contact other persons, agencies or sources of information which are necessary to establish eligibility.
[8.231.400.17 NMAC - Rp, 8.231.400.17 NMAC, 10/1/2017]

8.231.400.18 ASSIGNMENT OF SUPPORT: Assignment of child support rights is not required for applicants/recipients eligible for category 031.
[8.231.400.18 NMAC - Rp, 8.231.400.18 NMAC, 10/1/2017]

HISTORY OF 8.231.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center.
ISD 290.1000, Medical Assistance for Woman and Children, filed 11/13/1984.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2/10/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8/11/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9/8/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9/30/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12/1/1988.

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3/31/1989.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6/8/1989.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12/28/1989.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12/29/1989.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3/1/1991.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6/5/1992.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6/5/1992 - Repealed effective 2/1/1995.
8.231.400 NMAC, Recipient Policies, (filed 12/10/2007) - Repealed effective 10/1/2017.

NMAC History:
8.231.400 NMAC, Recipient Policies (filed 12/10/2007) was replaced by 8.231.400 NMAC, Recipient Policies, effective 10/1/2017.

TITLE 8 SOCIAL SERVICES
CHAPTER 231 MEDICAID ELIGIBILITY - INFANTS OF MOTHERS WHO ARE MEDICAID ELIGIBLE (CATEGORY 031)
PART 500 INCOME AND RESOURCE STANDARDS

8.231.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.231.500.1 NMAC - Rp, 8.231.500.1 NMAC, 10/1/2017; A, 7/1/2024]

8.231.500.2 SCOPE: The rule applies to the general public.
[8.231.500.2 NMAC - Rp, 8.231.500.2 NMAC, 10/1/2017]

8.231.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.231.500.3 NMAC - Rp, 8.231.500.3 NMAC, 10/1/2017; A, 7/1/2024]]

8.231.500.4 DURATION: Permanent.
[8.231.500.4 NMAC - Rp, 8.231.500.4 NMAC, 10/1/2017]

8.231.500.5 EFFECTIVE DATE: October 1, 2017, unless a later date is cited at the end of a section.
[8.231.500.5 NMAC - Rp, 8.231.500.5 NMAC, 10/1/2017]

8.231.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.231.500.6 NMAC - Rp, 8.231.500.6 NMAC, 10/1/2017]

8.231.500.7 DEFINITIONS: [**RESERVED**]

8.231.500.8 [**RESERVED**]

8.231.500.9 NEED DETERMINATION:
[8.231.500.9 NMAC - Rp, 8.231.500.9 NMAC, 10/1/2017]

8.231.500.10 RESOURCE STANDARDS: Resources are not a factor in the eligibility determination for category 031.
[8.231.500.10 NMAC - Rp, 8.231.500.10 NMAC, 10/1/2017]

8.231.500.11 INCOME STANDARDS: Income is not a factor in the eligibility determination for category 031.
[8.231.500.11 NMAC - Rp, 8.231.500.11 NMAC, 10/1/2017]

HISTORY OF 8.231.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center.
ISD 290.1000, Medical Assistance for Woman and Children, filed 11/13/1984.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2/10/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8/11/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9/8/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9/30/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12/1/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3/31/1989.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6/8/1989.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12/28/1989.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12/29/1989.

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3/1/1991.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6/5/1992.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6/5/1992 - Repealed effective 2/1/1995.
8.231.500 NMAC, Income and Resource Standards (filed 12/10/2007) - Repealed effective 10/1/2017.

NMAC History:
8.231.500 NMAC, Income and Resource Standards (filed 12/10/2007) was replaced by 8.231.500 NMAC, Income and Resource Standards (filed 12/10/2007) effective 10/1/2017.

TITLE 8 SOCIAL SERVICES
CHAPTER 231 MEDICAID ELIGIBILITY - INFANTS OF MOTHERS WHO ARE MEDICAID OR MEDICAL ASSISTANCE PROGRAM ELIGIBLE
PART 600 BENEFIT DESCRIPTION

8.231.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.231.600.1 NMAC - Rp, 8.231.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.231.600.2 SCOPE: The rule applies to the general public.
[8.231.600.2 NMAC - Rp, 8.231.600.2 NMAC, 1/1/2019]

8.231.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.231.600.3 NMAC - Rp, 8.231.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.231.600.4 DURATION: Permanent.
[8.231.600.4 NMAC - Rp, 8.231.600.4 NMAC, 1/1/2019]

8.231.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.231.600.5 NMAC - Rp, 8.231.600.5 NMAC, 1/1/2019]

8.231.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapters located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.231.600.6 NMAC - Rp, 8.231.600.6 NMAC, 1/1/2019]

8.231.600.7 DEFINITIONS: [RESERVED]

8.231.600.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.231.600.8 NMAC - Rp, 8.231.600.8 NMAC, 1/1/2019; A, 1/1/2022]

8.231.600.9 BENEFIT DESCRIPTION: An applicant or recipient who is eligible for medicaid under this category is eligible to receive the full range of medicaid services.
[8.231.600.9 NMAC - Rp, 8.231.600.9 NMAC, 1/1/2019]

8.231.600.10 BENEFIT DETERMINATION:

A. Medical service providers must give the name and case number of the New Mexico medicaid eligible mother and the name, birth date, sex of the newborn, and the name of the hospital where the birth occurred to local county income support division (ISD) office. Within three days after receipt of this information, the income support specialist (ISS):

(1) determines if the mother was eligible for New Mexico medicaid at the time of birth or if the birth and delivery was covered by emergency medical services to undocumented non-citizens (EMSNC);

(2) registers the newborn for medicaid on the system; a signed application is not required;

(3) provides eligibility information to the hospital; and

(4) notifies the mother that a signed application is necessary to establish the newborn's eligibility for temporary assistance for needy families (TANF), if applicable.

B. **Processing time limit:** All applications must be processed within 45 days from the date of application. The time limit begins on the day the signed application is received. Applications must be acted upon

and notice of approval, denial or delay sent out within the required time limit. The ISS explains the time limit and that the applicant may request an administrative hearing if the application pends longer than the time limit allows.
[8.231.600.10 NMAC - Rp, 8.231.600.10 NMAC, 1/1/2019; A, 1/1/2022]

8.231.600.11 ONGOING BENEFITS: A newborn remains eligible for assistance under Category 031 from birth through the month of the child's first birthday as long as the newborn remains in New Mexico.
[8.231.600.11 NMAC - Rp, 8.231.600.12 NMAC, 1/1/2019]

8.231.600.12 RETROACTIVE BENEFIT COVERAGE: Retroactive medicaid coverage is provided in accordance with Subsection H of 8.200.400.14 NMAC.
[8.231.600.12 NMAC - Rp, 8.231.600.13 NMAC, 1/1/2019]

8.231.600.13 CHANGE IN ELIGIBILITY: If the newborn is placed on MAD Category 400 or 420 and then loses eligibility for either of these categories, the newborn can still be eligible for Category 031 if they meet Category 031 requirements for the remainder of the 12 month period. A new application is not required.
[8.231.600.13 NMAC - Rp, 8.231.600.14 NMAC, 1/1/2019]

8.231.600.14 PERIODIC REDETERMINATIONS OF ELIGIBILITY (42 CFR 435.117(d)): A redetermination of eligibility must be completed on behalf of the children described in this provision in accordance with 8.291.410.19 NMAC.
[8.231.600.14 NMAC - Rp, 8.231.600.14 NMAC, 1/1/2019]

8.231.600.15 ENUMERATION AND CITIZENSHIP:

A. HCA requires, as a condition of eligibility, that each individual (including children) seeking medicaid furnish each of their social security numbers (SSN) per paragraph (a) of 42 CFR 435.910 and 8.200.410.10 NMAC. HCA will request an SSN at renewal if not already provided.

B. Newborns who were initially eligible for medicaid as deemed newborns are considered to have provided satisfactory documentation of citizenship, identity, and age.

[8.231.600.15 NMAC - Rp, 8.231.600.15 NMAC, 1/1/2019]

HISTORY OF 8.231.600 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 290.1000, Medical Assistance for Woman and Children, filed 11/13/1984.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2/10/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8/11/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 9/8/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 9/30/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 12/1/1988.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 3/31/1989.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 6/8/1989.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 12/28/1989.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 12/29/1989.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 3/1/1991.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 6/5/1992.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 6/5/1992 - Repealed effective 2/1/1995.
8.231.600 NMAC, Benefit Description, filed 12/10/2007 - Repealed 1/1/2014.
8.231.600 NMAC, Benefit Description, filed 12/2/2013 - Repealed effective 10/1/2017.
8.231.600 NMAC, Benefit Description, filed 9/14/2017 - Repealed effective 1/1/2019.

NMAC History:
8.231.600 NMAC, Benefit Description, filed 12/2/2013 was replaced by 8.231.600 NMAC, Benefit Description, effective 10/1/2017.

8.231.600 NMAC, Benefit Description, filed 9/14/2017 was replaced by 8.231.600 NMAC, Benefit Description, effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 234 MEDICAID ELIGIBILITY - SSI INELIGIBILITY - DUE TO INCOME OR RESOURCES FROM A NON-CITIZEN SPONSOR
PART 400 RECIPIENT REQUIREMENTS

8.234.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.234.400.1 NMAC - Rp, 8.234.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.234.400.2 SCOPE: The rule applies to the general public.
[8.234.400.2 NMAC - Rp, 8.234.400.2 NMAC, 1/1/2014]

8.234.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.234.400.3 NMAC - Rp, 8.234.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.234.400.4 DURATION: Permanent.
[8.234.400.4 NMAC - Rp, 8.234.400.4 NMAC, 1/1/2014]

8.234.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.234.400.5 NMAC - Rp, 8.234.400.5 NMAC, 1/1/2014]

8.234.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility – General Recipient Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.234.400.6 NMAC - Rp, 8.234.400.6 NMAC, 1/1/2014]

8.234.400.7 DEFINITIONS: [**RESERVED**]

8.234.400.8 MISSION: To transform lives. Working with our partners we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.200.400.8 NMAC - N, 1/1/2014; A, 1/1/2022]

8.234.400.9 MEDICAID ELIGIBILITY FOR INDIVIDUALS INELIGIBILE FOR SSI DUE TO DEEMED INCOME OR RESOURCES FROM A NON-CITIZEN SPONSOR - CATEGORY 034:

A. An individual must meet specific eligibility requirements. These include:

(1) an individual meets the social security administration (SSA) definitions of aged, blind, or disabled and is ineligible for supplemental security income (SSI) solely because of deemed income or resource considered available from a non-citizen sponsor;

(2) an individual who meets the eligibility requirements pursuant to 8.200.410 NMAC and 8.200.420 NMAC for citizenship or non-citizen status, enumeration, residence; non-concurrent receipt of assistance, and applications for other benefits;

(3) an applicant or recipient must assign medical support rights to HCA and agree to cooperate with third party liability responsibilities pursuant to 8.200.430 NMAC; and

(4) appropriate to the budget group size, countable income must be less than the SSI federal benefit rate (FBR) income pursuant to 8.200.520 NMAC, 8.215 NMAC and 8.234.500 NMAC.

B. Individuals may have other creditable health insurance coverage.

C. An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.
[8.234.400.9 NMAC - Rp, 8.234.400.9 NMAC, 1/1/2014; A, 1/1/2022]

8.234.400.10 [**RESERVED**]

8.234.400.11 ENUMERATION: Refer to 8.200.410.10 NMAC.
[8.234.400.11 NMAC - Rp, 8.234.400.11 NMAC, 1/1/2014]

8.234.400.12 CITIZENSHIP: Refer to 8.200.410.11 NMAC.
[8.234.400.12 NMAC - Rp, 8.234.400.12 NMAC, 1/1/2014]

8.234.400.13 RESIDENCE: Refer to 8.200.410.12 NMAC.
[8.234.400.13 NMAC - Rp, 8.234.400.13 NMAC, 1/1/2014]

8.234.400.14 [**RESERVED**]

8.234.400.15 SSI STATUS:

A. An applicant or re-determining recipient for Category 034 must meet all other SSI eligibility standards, including:

(1) applicant or re-determining recipient's own income and resources must be below SSI standards;

(2) nonconcurrent receipt of assistance;

(3) residence;

(4) aged, blind, or disabled status; and

(5) citizenship or permanent non-citizen status.

B. See 8.215.500.11 NMAC and 8.215.500.18 NMAC for information on SSI income and resource standards.

[8.234.400.15 NMAC - Rp, 8.234.400.15 NMAC, 1/1/2014; A, 1/1/2022]

8.234.400.16 RECIPIENT RIGHTS AND RESPONSIBILITIES: Refer to 8.200.430 NMAC.
[8.234.400.16 NMAC - Rp, 8.234.400.16 NMAC, 1/1/2014]

8.234.400.17 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP: At the time of application, an applicant shall identify everyone who is to be considered for inclusion in the assistance unit and budget group. The composition of the assistance unit and budget group is based on the relationship of the household members. Each member of the assistance unit and budget group, including an unborn child, is counted as one in the household size.
[8.234.400.17 NMAC - N, 1/1/2014]

8.234.400.18 ASSISTANCE UNIT: The assistance unit includes the applicant and may include others in the household who are determined eligible.
[8.234.400.18 NMAC - N, 1/1/2014]

8.234.400.19 BUDGET GROUP: The budget group includes all members of the assistance unit. Additional budget group members include individuals who live in the household with the assistance unit and have a financial obligation of support.

A. Except for an SSI recipient, the following individuals have a financial obligation of support for medicaid eligibility:

(1) spouses: married individuals as defined under applicable New Mexico state law (New Mexico recognizes common law and same sex marriages established in other states); and

(2) parents for children: there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process.

B. The following individuals do not have a financial obligation of support for medicaid eligibility:

(1) an SSI recipient to the assistance unit;

(2) a father of the unborn child who is not married to the pregnant woman;

(3) a stepparent to a stepchild;

(4) a grandparent to a grandchild;

(5) a legal guardian or conservator of a child;

(6) a non-citizen sponsor to the assistance unit; and

(7) a sibling to a sibling.
[8.234.400.19 NMAC - N, 1/1/2014; A, 1/1/2022]

8.234.400.20 LIVING IN THE HOME:

A. Living in the home with a relative: To be included in the assistance unit, a child must be living, or considered to be living, in the home of:

(1) a natural or an adoptive parent; there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process; or

(2) a specified relative who is related within the fifth degree of relationship by blood, marriage or adoption and assumes responsibility for the day-to-day care and control of the child; the determination of whether an individual functions as the specified relative shall be made by the specified relative unless other information known to the worker clearly indicates otherwise.

B. A child considered to be living in the home: A child is considered to be part of the assistance unit as evidenced by the child's customary physical presence in the home. If a child is living with more than one household, the following applies:

(1) when the child is actually spending more time with one household than the other, the child would be determined to be living with the household with whom the child spends the most time; and

(2) when the child is actually spending equal amounts of time with each household, the child shall be considered to be living with the household who first applies for medicaid enrollment.

C. Extended living in the home: An individual may be physically absent from the home for longer or shorter periods of time and be a member of the assistance unit and budget group.

(1) Extended living in the home includes:

(a) when an individual is attending college or a boarding school; or

(b) when an individual is receiving treatment in a Title XIX medicaid facility (including institutionalized when meeting a nursing facility (NF) level of care (LOC) and intermediate care facilities for individuals with an intellectual disability (ICF-IID) LOC.

(2) When an individual has been a member of the assistance unit, eligibility for another medicaid eligibility category, such as long term care medicaid, should be evaluated. Until a determination of eligibility for another category can be made, the individual is considered to be living with the budget group.

D. Temporary absence - extended living in the home: An individual may be physically absent from the home and be a member of the assistance unit and budget group. These other temporary absences include:

(1) an individual not living in the home due to an emergency who is expected to return to the household within 60 calendar days, continues to be a member of the household;

(2) a child removed from the home of a parent or a specified relative by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and families department), until an adjudicatory custody hearing takes place; if the adjudicatory hearing results in custody being granted to some other entity, the child will be removed from the assistance unit; or

(3) a child residing in a detention center:

(a) continues to be a member of the household if they reside fewer than 60 calendar days who is either adjudicated or not adjudicated as an inmate of a public institution; or

(b) the individual is not eligible for medicaid enrollment if they reside 60 calendar days or more as an adjudicated inmate of a public institution pursuant to 8.200.410 NMAC.
[8.234.400.20 NMAC - N, 1/1/2014]

HISTORY OF 8.234.400 NMAC:

History of Repealed Material:
8.234.400 NMAC, Recipient Policies, filed 9-3-13 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 234 MEDICAID ELIGIBILITY - SSI INELIGIBILITY - DUE TO INCOME OR RESOURCES FROM A NON-CITIZEN SPONSOR
PART 500 INCOME AND RESOURCE STANDARDS

8.234.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.234.500.1 NMAC - Rp, 8.234.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.234.500.2 SCOPE: The rule applies to the general public.
[8.234.500.2 NMAC - Rp, 8.234.500.2 NMAC, 1/1/2014]

8.234.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.234.500.3 NMAC - Rp, 8.234.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.234.500.4 DURATION: Permanent.
[8.234.500.4 NMAC - Rp, 8.234.500.4 NMAC, 1/1/2014]

8.234.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.234.500.5 NMAC - Rp, 8.234.500.5 NMAC, 1/1/2014]

8.234.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200 400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions policy manual, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.234.500.6 NMAC - Rp, 8.234.500.6 NMAC, 1/1/2014]

8.234.500.7 DEFINITIONS: [**RESERVED**]

8.234.500.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.234.500.8 NMAC - N, 1/1/2014; A, 1/1/2022]

8.234.500.9 NEED DETERMINATION: An individual's financial need is based on meeting supplemental security income (SSI) federal benefit rate (FBR) income and resource methodology pursuant to 8.215.500 NMAC.
[8.234.500.9 NMAC - Rp, 8.234.500.9 NMAC, 1/1/2014]

8.234.500.10 RESOURCE STANDARDS: The resource standards for establishing eligibility are described in 8.215.500 NMAC. The resources of a non-citizen sponsor are not considered when determining eligibility.
[8.234.500.10 NMAC - Rp, 8.234.500.10 NMAC, 1/1/2014; A, 1/1/2022]

8.234.500.11 INCOME STANDARDS: The income standards for establishing eligibility are described in 8.215.500 NMAC. The income of a non-citizen sponsor is not considered when determining eligibility.
[8.234.500.11 NMAC - Rp, 8.234.500.11 NMAC, 1/1/2014; A, 1/1/2022]

HISTORY OF 8.234.500 NMAC:

History of Repealed Material:
8.234.500 NMAC, Income and Resource Standards, filed 9/3/2013 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 234 MEDICAID ELIGIBILITY - SSI INELIGIBILITY - DUE TO INCOME OR RESOURCES FROM A NON-CITIZEN SPONSOR
PART 600 BENEFIT DESCRIPTION

8.234.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.234.600.1 NMAC - Rp, 8.234.600.1 NMAC, 1/1/2014; A, 7/1/2024]

8.234.600.2 SCOPE: The rule applies to the general public.
[8.234.600.2 NMAC - Rp, 8.234.600.2 NMAC, 1/1/2014]

8.234.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.234.600.3 NMAC - Rp, 8.234.600.3 NMAC, 1/1/2014; A, 7/1/2024]

8.234.600.4 DURATION: Permanent.
[8.234.600.4 NMAC - Rp, 8.234.600.4 NMAC, 1/1/2014]

8.234.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.234.600.5 NMAC - Rp, 8.234.600.5 NMAC, 1/1/2014]

8.234.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions Chapter 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.234.600.6 NMAC - Rp, 8.234.600.6 NMAC, 1/1/2014]

8.234.600.7 DEFINITIONS: [RESERVED]

8.234.600.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.234.600.8 NMAC - N, 1/1/2014]

8.234.600.9 BENEFIT DESCRIPTION: Under the eligibility Category 034, an eligible recipient receives the full range of medicaid covered services.
[8.234.600.9 NMAC - Rp, 8.234.600.9 NMAC, 1/1/2014]

8.234.600.10 BENEFIT DETERMINATION:
A. Income support division (ISD) determines initial and ongoing eligibility.
B. Up to three months of retroactive medicaid coverage is provided to an applicant who has received a medicaid covered service during the retroactive period and who would have met applicable eligibility criteria had they applied earlier. Eligibility for each retroactive month is determined separately. An application for retroactive medicaid enrollment must be made within 180 calendar days from the date of the medicaid application.
[8.234.600.10 NMAC - Rp, 8.234.600.10 NMAC, 1/1/2014]

8.234.600.11 INITIAL BENEFITS:
A. Move during eligibility determination: If an applicant moves to another county while the eligibility determination is pending, the county ISD office in which the application was originally registered shall transfer the case to the new responsible office.

B. Delays in eligibility determination: If an eligibility determination is not made within the time limit, the applicant is notified in writing of the reason for the delay. This notice also informs the applicant or re-determining recipient of the right to request an administrative hearing.
[8.234.600.11 NMAC - Rp, 8.234.600.11 NMAC, 1/1/2014]

8.234.600.12 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A re-determination of eligibility is made every 12 months.

B. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change as detailed in 8.200.430 NMAC.
[8.234.600.12 NMAC - Rp, 8.234.600.12 NMAC, 1/1/2014]

8.234.600.13 SSI RETROACTIVE BENEFIT COVERAGE: Up to three months of retroactive medicaid coverage can be furnished to applicants who have received medicaid covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three months prior to the month of application [42 CFR 435.914].

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

B. Approval requirements: To establish retroactive eligibility, the income support specialist (ISS) must verify that all conditions of eligibility were met for each of the three retroactive months and that the applicant received medicaid covered services. Eligibility for each month is approved or denied on its own merits.

(1) Applicable benefit rate: The federal benefit rate (FBR) in effect during the retroactive months based on the applicant's living arrangements is applicable for retroactive medicaid eligibility determinations. See 8.200.520.10 NMAC. If the applicant's countable income in a given month exceeds the applicable FBR, the applicant is not eligible for retroactive medicaid for that month. If the countable income is less that the FBR, the applicant is eligible on the factor of income for that month. A separate determination must be made for each of the three months in the retroactive period.

(2) Disability determination required: If a determination is needed of the date of onset of blindness or disability, the ISS must send a referral to disability determination services (ISD 305) to the disability determination unit.

C. Notice:

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

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISS must notify the recipient that he or she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient does not inform all providers and furnish verification of eligibility which can be used for billing and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the recipient is responsible for payment of the bill.
[8.234.600.13 NMAC - Rp, 8.234.600.13 NMAC, 1/1/2014]

HISTORY OF 8.234.600 NMAC:

History of Repealed Material:
8.234.600 NMAC, Benefit Description, filed 9/3/2013 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 242 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED DISABLED INDIVIDUALS WHOSE INCOME EXCEEDS QMB AND SLIMB
PART 400 RECIPIENT REQUIREMENTS

8.242.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.242.400.1 NMAC - Rp, 8.242.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.242.400.2 SCOPE: The rule applies to the general public.
[8.242.400.2 NMAC - Rp, 8.242.400.2 NMAC, 1/1/2014]

8.242.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.242.400.3 NMAC - Rp, 8.242.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.242.400.4 DURATION: Permanent.
[8.242.400.4 NMAC - Rp, 8.242.400.4 NMAC, 1/1/2014]

8.242.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.242.400.5 NMAC - Rp, 8.242.400.5 NMAC, 1/1/2014]

8.242.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility - General Recipient Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.242.400.6 NMAC - Rp, 8.242.400.6 NMAC, 1/1/2014]

8.242.400.7 DEFINITIONS: [RESERVED]

8.242.400.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.242.400.8 NMAC - N, 1/1/2014]

8.242.400.9 QUALIFIED DISABLED WORKING INDIVIDUALS (QD) - CATEGORY 050:

A. To qualify as a qualified disabled working individual (QD), an applicant or re-determining recipient must meet the following requirements:

(1) lose entitlement to free medicare Part A due to substantial gainful employment;
(2) continue to meet the social security administration (SSA) disability criteria; and
(3) be enrolled for premium Part A medicare.

B. The date of eligibility is based on the date of application and the date that all eligibility standards, including enrollment for medicare Part A, are met.
[8.242.400.9 NMAC - Rp, 8.242.400.9 NMAC, 1/1/2014]

8.242.400.10 [RESERVED]

8.242.400.11 ENUMERATION: An applicant or a re-determining recipient must have a social security number. Refer to 8.200.410.10 NMAC.
[8.242.400.11 NMAC - Rp, 8.242.400.11 NMAC, 1/1/2014]

8.242.400.12 CITIZENSHIP: Refer to 8.200.410.11 NMAC.
[8.242.400.12 NMAC - Rp, 8.242.400.12 NMAC, 1/1/2014]

8.242.400.13 RESIDENCE: An individual must be either be physically present in New Mexico on the date of their application or re-determination or on the eligibility determination date and intend to remain in the state. A temporary absence from the state does not preclude eligibility. A temporary absence is considered to exist when the eligible recipient leaves the state for a specific purpose with a time-limited goal, after accomplishment of which the eligible recipient intends to return to New Mexico. Refer to 8.200.410.12 NMAC.
[8.242.400.13 NMAC - Rp, 8.242.400.13 NMAC, 1/1/2014]

8.242.400.14 NONCONCURRENT RECEIPT OF ASSISTANCE: An applicant or re-determining recipient is not eligible for category 050 if they are eligible under another medical assistance division (MAD) category of eligibility or if receiving medicaid services from another state.
[8.242.400.14 NMAC - Rp, 8.242.400.14 NMAC, 1/1/2014]

8.242.400.15 [RESERVED]

8.242.400.16 AGE: A recipient must be under 65 years of age. When a recipient reaches 65 years of age they become entitled to free medicare Part A.
[8.242.400.16 NMAC - Rp, 8.242.400.16 NMAC, 1/1/2014]

8.242.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: It is the responsibility of the applicant or re-determining recipient to provide the required information, documents or undertake the actions necessary for HCA to establish eligibility. The applicant or re-determining recipient must grant HCA permission to contact other persons, agencies or sources of information which are necessary in the establishment of eligibility. Failure of the applicant or re-determining recipient to provide or take action will result in an HCA action to deny eligibility. Refer to 8.200.430 NMAC.
[8.242.400.17 NMAC - Rp, 8.242.400.17 NMAC, 1/1/2014]

8.242.400.18 ASSIGNMENT OF SUPPORT: Assignment of medical support rights is not a factor of eligibility for this category, since medicaid coverage is limited to medicare Part A premium.
[8.242.400.18 NMAC - Rp, 8.242.400.18 NMAC, 1/1/2014]

8.242.400.19 REPORTING REQUIREMENTS: An applicant, re-determining, or eligible recipient must report any change in their circumstances which can affect their eligibility within 10 calendar days after the change to their local income support division (ISD) office. Refer to 8.200.430.19 NMAC.
[8.242.400.19 NMAC - Rp, 8.242.400.19 NMAC, 1/1/2014]

HISTORY OF 8.242.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 842.00, Qualified Disabled Working Individuals, filed 10/11/1990.
MAD Rule 842, Qualified Disabled Working Individuals, filed 6/30/1992.
MAD Rule 842, Qualified Disabled Working Individuals, filed 9/26/1994.

History of Repealed Material:
MAD Rule 842, Qualified Disabled Working Individuals, filed 9/26/1994 - Repealed effective 2/1/1995.
8.242.400 NMAC, Recipient Requirements, filed 9/3/2013 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 242 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED DISABLED INDIVIDUALS WHOSE INCOME EXCEEDS QMB AND SLIMB
PART 500 INCOME AND RESOURCE STANDARDS

8.242.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.242.500.1 NMAC - Rp, 8.242.500.1 NMAC, 1/1/2014; A, 7 /1/2024]

8.242.500.2 SCOPE: The rule applies to the general public.
[8.242.500.2 NMAC - Rp, 8.242.500.2 NMAC, 1/1/2014]

8.242.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.242.500.3 NMAC - Rp, 8.242.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.242.500.4 DURATION: Permanent.
[8.242.500.4 NMAC - Rp, 8.242.500.4 NMAC, 1/1/2014]

8.242.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.242.500.5 NMAC - Rp, 8.242.500.5 NMAC, 1/1/2014]

8.242.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining medical assistance eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.242.500.6 NMAC - Rp, 8.242.500.6 NMAC, 1/1/2014]

8.242.500.7 DEFINITIONS: [RESERVED]

8.242.500.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.242.500.8 NMAC - N, 1/1/2014]

8.242.500.9 NEED DETERMINATION: An applicant or a re-determining recipient for MAD eligibility Category 050 qualified disabled individuals (QD) must apply for and take all necessary actions to obtain any resources to which they may be entitled. See 8.215.500 NMAC.
[8.242.500.9 NMAC - Rp, 8.242.500.9 NMAC, 1/1/2014]

8.242.500.10 RESOURCE STANDARDS: The total value of an applicant or a re-determining recipient's countable resources must not exceed $4,000. The resource limit for an applicant or re-determining recipient couple is $6,000. An applicant or a re-determining recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed $6,000 at the time resources are deemed. The resource determination is always made as of the first moment of the first day of the month. An applicant or a re-determining recipient is ineligible for any month in which countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the value of countable resources during a month do not affect eligibility for that month.
[8.242.500.10 NMAC - Rp, 8.242.500.10 NMAC, 1/1/2014]

8.242.500.11 RESOURCE TRANSFERS: The social security administration (SSA) excluded transfer of resources as a factor of eligibility for a non-institutionalized recipient who receives supplemental security income

(SSI) benefits. Transfer of resources is not a factor for consideration in categories that use SSI methodology in the eligibility determination.
[8.242.500.11 NMAC - Rp, 8.242.500.11 NMAC, 1/1/2014]

8.242.500.12 INCOME STANDARDS: The income ceiling for QD eligibility is two hundred percent of the federal income poverty (FPL) guidelines. These guidelines are updated annually effective April 1. See 8.200.520 NMAC and 8.215.500 NMAC.
[8.242.500.12 NMAC - Rp, 8.242.500.12 NMAC, 1/1/2014]

8.242.500.13 UNEARNED INCOME: Unearned income exclusions: All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The income support specialist (ISS) must disregard the COLA from January through March when determining or re-determining QD eligibility. For re-determinations made in January, February and March or new QD applications registered in January, February or March, the ISS uses the December social security and railroad retirement benefit amounts. For QD applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April FPL. This exclusion does not apply to other types of income.
[8.242.500.13 NMAC - Rp, 8.242.500.13 NMAC, 1/1/2014]

8.242.500.14 DEEMED INCOME: If an applicant or a re-determining recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500 NMAC.
[8.242.500.14 NMAC - Rp, 8.242.500.14 NMAC, 1/1/2014]

HISTORY OF 8.242.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 842.00, Qualified Disabled Working Individuals, filed 10/11/1990.
MAD Rule 842, Qualified Disabled Working Individuals, filed 6/30/1992.
MAD Rule 842, Qualified Disabled Working Individuals, filed 9/26/1994.

History of Repealed Material:
MAD Rule 842, Qualified Disabled Working Individuals, filed 9/26/1994 - Repealed effective 2/1/1995.
8.242.500 NMAC, Income and Resource Standards, filed 9/3/2013 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 242 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED DISABLED INDIVIDUALS WHOSE INCOME EXCEEDS QMB AND SLIMB
PART 600 BENEFIT DESCRIPTION

8.242.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.242.600.1 NMAC - Rp, 8.242.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.242.600.2 SCOPE: The rule applies to the general public.
[8.242.600.2 NMAC - Rp, 8.242.600.2 NMAC, 1/1/2019]

8.242.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.242.600.3 NMAC - Rp, 8.242.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.242.600.4 DURATION: Permanent.
[8.242.600.4 NMAC - Rp, 8.242.600.4 NMAC, 1/1/2019]

8.242.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.242.600.5 NMAC - Rp, 8.242.600.5 NMAC, 1/1/2019]

8.242.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.242.600.6 NMAC - Rp, 8.242.600.6 NMAC, 1/1/2019]

8.242.600.7 DEFINITIONS: [**RESERVED**]

8.242.600.8 [RESERVED]
[8.242.600.8 NMAC - Rp, 8.242.600.8 NMAC, 1/1/2019]

8.242.600.9 BENEFIT DESCRIPTION: For category 050, medicaid coverage is limited to payment of the medicare Part A premium. No medicaid card is issued.
[8.242.600.9 NMAC - Rp, 8.242.600.9 NMAC, 1/1/2019]

8.242.600.10 BENEFIT DETERMINATION: Application for category 050 is made on the assistance application form. Applications must be acted on and notice of action taken must be sent to the applicant within 45 days of receipt of the application.
[8.242.600.10 NMAC - Rp, 8.242.600.10 NMAC, 1/1/2019]

8.242.600.11 INITIAL BENEFITS: The effective date of eligibility for qualified disabled working individuals (QD) is based on the date of application and the date on which all eligibility criteria, including enrollment for medicare Part A, are met. Verification of the effective date of medicare Part A enrollment must be obtained from the social security administration (SSA). When the eligibility determination is made, notice of the approval or denial is sent to the applicant. If denied, this notice includes the reason for the denial and an explanation of rights to a hearing.
[8.242.600.11 NMAC - Rp, 8.242.600.11 NMAC, 1/1/2019]

8.242.600.12 ONGOING BENEFITS: A redetermination of eligibility must be made every 12 months.

[8.242.600.12 NMAC - Rp, 8.242.600.12 NMAC, 1/1/2019]

8.242.600.13 RETROACTIVE BENEFIT COVERAGE: Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.242.600.13 NMAC - Rp, 8.242.600.13 NMAC, 1/1/2019]

8.242.600.14 CHANGES IN ELIGIBILITY: The case is closed when an eligible recipient becomes ineligible and is notified of the ineligibility in an advance notice. The case is closed in the month following the death of an eligible recipient.
[8.242.600.14 NMAC - Rp, 8.242.600.14 NMAC, 1/1/2019]

HISTORY OF 8.242.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 842.00, Qualified Disabled Working Individuals, filed 10/11/1990.
MAD Rule 842, Qualified Disabled Working Individuals, filed 6/30/1992.
MAD Rule 842, Qualified Disabled Working Individuals, filed 9/26/1994.

History of Repealed Material:
MAD Rule 842, Qualified Disabled Working Individuals, filed 9/26/1994 - Repealed effective 2/1/1995.
8.242.600 NMAC, Benefit Description, filed 9/3/2013 - Repealed effective 1/1/2014.
8.242.600 NMAC, Benefit Description, filed 12/2/2013 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 243 MEDICAID ELIGIBILITY - WORKING DISABLED INDIVIDUALS (WDI) (CATEGORY 043)
PART 400 RECIPIENT POLICIES

8.243.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.243.400.1 NMAC - Rp, 8.243.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.243.400.2 SCOPE: This rule applies to the general public.
[8.243.400.2 NMAC - Rp, 8.243.400.2 NMAC, 1/1/2019]

8.243.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended by the state human services department pursuant to state statute. See 27-2-12 et. seq., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.243.400.3 NMAC - Rp, 8.243.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.243.400.4 DURATION: Permanent.
[8.243.400.4 NMAC - Rp, 8.243.400.4 NMAC, 1/1/2019]

8.243.400.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.243.400.5 NMAC - Rp, 8.243.400.5 NMAC, 1/1/2019]

8.243.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.243.400.6 NMAC - Rp, 8.243.400.6 NMAC, 1/1/2019]

8.243.400.7 DEFINITIONS: [RESERVED]

8.243.400.8 MISSION: To transform lives. Working with our partners we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.243.400.8 NMAC - Rp, 8.243.400.8 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.9 WORKING DISABLED INDIVIDUALS (WDI) - CATEGORY 043: The working disabled individuals program covers:

A. disabled individuals who are employed; or

B. disabled individuals who have lost eligibility for supplemental security income (SSI) and medicaid due to initial receipt of social security disability insurance (SSDI) and who are not yet qualified for medicare; this group is referred to as "medigap"; once the medigap individual begins receiving medicare, they must become employed, as defined in Paragraph (1) of Subsection C of 8.243.400.10 NMAC, to retain their eligibility for WDI.
[8.243.400.9 NMAC - Rp, 8.243.400.9 NMAC, 1/1/2019]

8.243.400.10 BASIS FOR DEFINING THE GROUP: Individuals eligible for medicaid coverage under the working disabled individuals program (WDI) must meet the following requirements:

A. must meet the social security administration disability criteria without regard to "substantial gainful activity", and

B. must have a recent attachment to the workforce.

C. Recent attachment to workforce defined: Medicaid for the working disabled individuals defines recent attachment to the workforce as either:

(1) having enough gross earnings in a quarter to meet social security administration's definition of a qualifying quarter, see 8.200.520.20 NMAC; or

(2) having lost SSI and medicaid due to the initial receipt of SSDI benefits, and being within the 24-month waiting period for medicare.
[8.243.400.10 NMAC - Rp, 8.243.400.10 NMAC, 1/1/2019]

8.243.400.11 GENERAL RECIPIENT REQUIREMENTS: [RESERVED]

8.243.400.12 ENUMERATION: To be eligible an individual must report their social security account number(s) to the HCA. If an individual does not have a valid social security number, the individual must apply for one as a condition of medicaid eligibility. Applications for social security numbers can be made by completing an application form and providing proof of application to local income support division (ISD) offices.
[8.243.400.12 NMAC - Rp, 8.243.400.12 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.13 CITIZENSHIP: To be eligible for medicaid, an individual must be:

A. a citizen of the United States; or

B. a non-citizen who entered the United States prior to August 22, 1996, as one of the classes of non-citizens described in Subsection A of 8.200.410.11 NMAC, or a non-citizen who entered the United States as a qualified non-citizen on or after August 22, 1996, and who has met the five-year bar, or are exempt as listed in Subsection B of 8.200.410.11 NMAC.

C. Refer to 8.200.410.11 NMAC.
[8.243.400.13 NMAC - Rp, 8.243.400.13 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.14 RESIDENCE: To be eligible for medicaid, individuals must be living in New Mexico on the date of application or final determination of eligibility and have demonstrated intent to remain in the state.

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

B. Recipients receiving benefits out-of-state: Individuals who receive medical assistance in another state are considered residents of that state until the ISD staff receives verification from the other state agency indicating that it has been notified by an individual of the abandonment of residence in that state.

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

(1) the individual leaves New Mexico and indicates that they intend to establish residence in another state;

(2) the individual leaves New Mexico for no specific purpose with no clear intention of returning;

(3) the individual leaves New Mexico and applies for financial, food or medical assistance in another state.
[8.243.400.14 NMAC - Rp, 8.243.400.14 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.15 NON-CONCURRENT RECEIPT OF ASSISTANCE: The individual may not be receiving assistance in another medicaid category with the exception of the qualified medicare beneficiaries (QMB) and specified low income medicare beneficiaries (SLIMB) programs. ISD staff will look at other categories of eligibility and make the appropriate eligibility determination, or referrals.
[8.243.400.15 NMAC - Rp, 8.243.400.15 NMAC, 1/1/2019]

8.243.400.16 AGE: The individual must be 18 years of age or older.
[8.243.400.16 NMAC - Rp, 8.243.400.16 NMAC, 1/1/2019]

8.243.400.17 DISABILITY: The individual must meet social security administration's disability or blindness criteria, without regard to "substantial gainful activity."
[8.243.400.17 NMAC - Rp, 8.243.400.17 NMAC, 1/1/2019]

8.243.400.18 RECIPIENT RIGHTS AND RESPONSIBILITIES: The individual is responsible for establishing their eligibility for medicaid. As part of this responsibility, the individual must provide required

information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. The individual must also grant the HCA permission to contact other persons, agencies or sources of information which are necessary to establish eligibility.
[8.243.400.18 NMAC - Rp, 8.243.400.18 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.19 ASSIGNMENT OF MEDICAL SUPPORT: The individual must assign their right to medical support or other third party payments to the state.

A. Assignment of medical support rights occurs through the application for medicaid benefits.

B. Medicaid is not denied to an otherwise eligible individual solely because they cannot legally assign their own medical support rights and the party who is legally able to assign those rights refuses to assign or cooperate, as required by law.

[8.243.400.19 NMAC - Rp, 8.243.400.19 NMAC, 1/1/2019; A, 1/1/2022]

8.243.400.20 REPORTING REQUIREMENTS: An applicant/recipient is responsible to report changes affecting eligibility by the end of the calendar quarter in which the change took place.
[8.243.400.20 NMAC - Rp, 8.243.400.20 NMAC, 1/1/2019]

HISTORY OF 8.243.400 NMAC: [**RESERVED**]

History of Repealed Material:
8.243.400 NMAC - Recipient Policies, filed 12/13/2000 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 243 MEDICAID ELIGIBILITY - WORKING DISABLED INDIVIDUALS (WDI) (CATEGORY 043)
PART 500 INCOME AND RESOURCE STANDARDS

8.243.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.243.500.1 NMAC - N, 1/1/2001; A, 7/1/2024]

8.243.500.2 SCOPE: This rule applies to the general public.
[8.243.500.2 NMAC - N, 1/1/2001]

8.243.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.243.500.3 NMAC - N, 1/1/2001; A, 7/1/2024]

8.243.500.4 DURATION: Permanent
[8.243.500.4 NMAC - N, 1/1/2001]

8.243.500.5 EFFECTIVE DATE: January 1, 2001, unless a later date is cited at the end of a section.
[8.243.500.5 NMAC - N, 1/1/2001]

8.243.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.243.500.6 NMAC - N, 1/1/2001]

8.243.500.7 DEFINITIONS: [RESERVED]

8.243.500.8 [RESERVED]

8.243.500.9 WORKING DISABLED INDIVIDUALS: Income and resources are determined based on SSI methodology, except when deeming income from an ineligible spouse. See 8.215.500 NMAC. Individuals must meet all financial and non-financial eligibility criteria in the month(s) for which a determination of eligibility is made.
[8.243.500.9 NMAC - N, 1/1/2001; A, 6/1/2004]

8.243.500.10 RESOURCE STANDARDS: A "resource" is defined as cash or liquid assets and real or personal property which is owned and can be used either directly, or by sale or conversion, for the applicant's/recipient's support and maintenance. Resources may be liquid or non-liquid and may be excluded from the eligibility determination process under certain conditions.

A. A liquid resource is an asset, which can readily be converted to cash.

B. A non-liquid resource is an asset or property, which cannot readily be converted to cash.

[8.243.500.10 NMAC - N, 1/1/2001]

8.243.500.11 APPLICABLE RESOURCE STANDARDS: The resource determination is made as of the first moment of the first day of the month. For determination of continued eligibility, see Section 8.243.600.12 NMAC.
[8.243.500.11 NMAC - N, 1/1/2001]

8.243.500.12 COUNTABLE RESOURCES:

A. An individual's countable resources must be less than $10,000.

B. Married individuals' countable resources must be less than $15,000.

[8.243.500.12 NMAC - N, 1/1/2001]

8.243.500.13 RESOURCE EXCLUSIONS: Specified types of resources are excluded from the calculation of countable resources as described in 8.215.500.14 NMAC as follows:

A. Retirement funds: Internal revenue service-recognized retirement fund accounts are excludable resources in the eligibility determination so long as funds are not withdrawn from the account.

B. Examples of such retirement fund accounts include: PERA, ERA, an employer's qualifying pension plan, 401(k) plan, civil service annuity, IRA, Roth IRA, KEOUGH plan, etc.

[8.243.500.13 NMAC - N, 1/1/2001]

8.243.500.14 RESOURCES TRANSFERS: See 8.215.500.15 NMAC.

[8.243.500.14 NMAC - N, 1/1/2001]

8.243.500.15 TRUSTS: See 8.281.510 NMAC and following subsections.

[8.243.500.15 NMAC - N, 1/1/2001; A, 10/1/2012]

8.243.500.16 DEEMING RESOURCES: If an eligible noninstitutionalized applicant/recipient lives in the same household with an ineligible spouse, resources are considered to belong to the applicant/recipient. The resource standard for a couple applies.

[8.243.500.16 NMAC - N, 1/1/2001]

8.243.500.17 INCOME:

A. Earned income consists of the total gross income received by an applicant/recipient for services performed as an employee or net income as a result of self-employment.

(1) Royalties earned in connection with the publication of the applicant's/recipient's work and any honoraria/fees received for services rendered are considered earned income.

(2) In any given calendar quarter, an applicant/recipient must have earnings equal to social security administration's definition of a covered quarter. See 8.200.520.20 NMAC.

B. Unearned income consists of all other income (minus exclusions and disregards) that is not earned in the course of employment or self employment.

C. Deemed income is income which must be considered available to the applicant/recipient from the ineligible spouse when both live in the same household. Deemed income is counted in determining eligibility for the applicant/recipient.

[8.243.500.17 NMAC - N, 1/1/2001; A, 1/1/2002; A, 6/1/2004]

8.243.500.18 INCOME STANDARDS: The applicable income standard of countable earned income for this category is less than two hundred-fifty percent of the federal poverty level for a household size of one. See Subsection H of 8.200.520.11 NMAC. The applicant/recipient must meet two income tests to qualify for working disabled individuals. These are as follows:

A. TEST 1

(1) Determine applicant's/recipient's gross monthly earnings.

(2) Apply a $20.00 general disregard.

(3) Apply a $65.00 earned income disregard.

(4) Disregard one-half of the remainder of income.

(5) Disregard work-related expenses for the blind or disabled.

(6) If the countable earned income is less than two hundred-fifty percent of the applicable federal poverty level (FPL) for a household of one, the individual is eligible.

(7) If the countable earned income is less than two hundred-fifty percent of the applicable FPL for a household size of one, determine if there is an ineligible spouse or children in the household.

B. If applicant/recipient lives with an ineligible spouse, see 8.215.500.21 NMAC to determine if deeming income is applicable.

C. TEST 2

(1) Determine applicant's/recipient's gross unearned income.

(2) Add ineligible spouse's deemable income, if applicable.

(3) Apply a $20.00 disregard.

(4) Subtract an amount equal to the current SSI federal benefit rate (FBR) for an individual. See 8.200.520.13 NMAC.

(5) Compare the total countable income to the SSI FBR for an individual or couple, as applicable.

(6) If the total countable income is less than the applicable SSI FBR, the individual is eligible.

D. Income exclusions: Income exclusions for the applicant/recipient are applied before income disregards. Exclusions are not applied to the income of the ineligible spouse from whom income may be deemed.
[8.243.500.18 NMAC - N, 1/1/2001; A, 6/1/2004; A, 3/14/2008]

8.243.500.19 UNEARNED INCOME

A. Standards for unearned income and exclusions: See 8.215.500.20.C. & D. NMAC.

B. Unearned income is computed on a monthly basis. If there are no expenses incurred with the receipt of unearned income, such as annuities, pensions, retirement payments or disability benefits, the gross amount is considered countable unearned income.
[8.243.500.19 NMAC - N, 1/1/2001]

8.243.500.20 DEEMED INCOME: [RESERVED]
[8.243.500.20 NMAC - N, 1/1/2001; Repealed, 6/1/2004]

8.243.500.21 DISREGARDS: Income disregards are allowed as described below when applicable.

A. Twenty dollar disregard: The first $20 of unearned or earned income received in a month is disregarded. This disregard is not applicable to payments made to an applicant/recipient through a state or other government assistance program, or by a private charitable organization, where such payments are based on the applicant's/recipient's need.

B. Additional earned income disregard: If appropriate, earned income of $65 per month, plus one-half of the remainder is disregarded.

C. Work-related expenses defined: Work-related expenses of an employed applicant/recipient who is blind or disabled are disregarded. This disregard is applied to earned income only. Disregarded expenses must be for items or services directly related to enabling a person to work, and which are necessarily incurred by that individual because of a physical or mental disability or blindness. Such expenses are disregarded if not covered by other third party payers, including medicaid.

(1) Types of work-related expenses which may be disregarded include:

(a) federal, state, and local income taxes;

(b) social security contributions;

(c) union dues;

(d) transportation costs, including actual cost of bus or taxi cab fare, or 15 cents per mile for private automobile;

(e) lunches;

(f) child care costs, if not otherwise provided;

(g) uniforms, tools, and other necessary equipment;

(h) special vehicle modifications to enable transportation to and from work, but not the cost of the vehicle itself;

(i) attendants who may be hired for the purpose of taking applicant/recipient to and from work, and getting ready for work;

(j) durable medical equipment that is medically related and generally not useful in absence of the blindness or disability yet, are necessary to attend and perform tasks in the work place;

(k) expenses for work related equipment, which is impairment related and necessary for the individual to perform their tasks;

(l) prostheses necessary to perform work related tasks.

(m) design modifications related to blindness or disability that enable the applicant/recipient to leave home in order to attend work, or design modifications made to the work area of the home in the case where the applicant/recipient engages in a home-based business;

(n) special expenses necessary to enable an applicant/recipient who is blind or disabled to engage in employment, such as a seeing-eye dog, braille instructions, or instructions on using special equipment and,

(o) health insurance premiums.

(2) If items or services above are purchased through an installment contract, the payments are disregarded. Should the item or service be a one-time purchase, the purchase may be pro-rated over a 12-month period, or over the life of the contract.

(3) If items are leased, the monthly payment would be disregarded.

D. **NONDEDUCTIBLE ITEMS:** The following items cannot be deducted from earned income:

(1) in-kind payments;

(2) expenses deducted under other provisions;

(3) expenses which will be reimbursed;

(4) life maintenance expenses; although not all-inclusive, life maintenance items include the following:

(a) meals consumed outside of work hours;

(b) self-care items (including items of cosmetic rather than work related nature);

(c) general educational development;

(d) deposits into retirement accounts intended as an IRA, Keogh, 401K, PERA or voluntary pensions;

(e) life insurance premiums;

(f) items furnished by others that are needed in order to work (the value of such items is not income), and

(g) expenses claimed on a self-employment tax return.

[8.243.500.21 NMAC - N, 1/1/2001]

HISTORY OF 8.243.500 NMAC: [RESERVED]

History of Repealed Material: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 243 MEDICAID ELIGIBILITY - WORKING DISABLED INDIVIDUALS (WDI) (CATEGORY 043)
PART 600 BENEFIT DESCRIPTION

8.243.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.243.600.1 NMAC - Rp, 8.243.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.243.600.2 SCOPE: This rule applies to the general public.
[8.243.600.2 NMAC - Rp, 8.243.600.2 NMAC, 1/1/2019]

8.243.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.243.600.3 NMAC - Rp, 8.243.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.243.600.4 DURATION: Permanent.
[8.243.600.4 NMAC - Rp, 8.243.600.4 NMAC, 1/1/2019]

8.243.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.243.600.5 NMAC - Rp, 8.243.600.5 NMAC, 1/1/2019]

8.243.600.6 OBJECTIVE: The objective of these rules is to provide eligibility policy and procedures for the medical assistance programs.
[8.243.600.6 NMAC - Rp, 8.243.600.6 NMAC, 1/1/2019]

8.243.600.7 DEFINITIONS: [**RESERVED**]

8.243.600.8 [RESERVED]
[8.243.600.8 NMAC - Rp, 8.243.600.8 NMAC, 1/1/2019]

8.243.600.9 GENERAL BENEFIT DESCRIPTION: An individual who meets a medical assistance programs (MAP) category of eligibility for the working disabled individual program (WDI) is eligible to receive full state plan benefits.
[8.243.600.9 NMAC - Rp, 8.243.600.9 NMAC, 1/1/2019]

8.243.600.10 BENEFIT DETERMINATION: Completed applications must be acted upon and notice of approval, denial, or delay sent out within 60 days of the date of application. Individuals will have time limits explained, and be informed of the date by which the application should be processed.
[8.243.600.10 NMAC - Rp, 8.243.600.10 NMAC, 1/1/2019]

8.243.600.11 INITIAL BENEFITS: Eligibility begins the month of approval. When an eligibility determination is made, notice of the approval or denial is sent to the individual. If the application is denied, this notice includes the individual's right to request a hearing.
[8.243.600.11 NMAC - Rp, 8.243.600.11 NMAC, 1/1/2019]

8.243.600.12 ONGOING BENEFITS: A re-determination of MAP eligibility is made every 12 months or at such time the MAP eligible recipient begins receiving medicare benefits.
[8.243.600.12 NMAC - Rp, 8.243.600.12 NMAC, 1/1/2019]

8.243.600.13 RETROACTIVE BENEFIT COVERAGE: Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

[8.243.600.13 NMAC - Rp, 8.243.600.13 NMAC, 1/1/2019]

8.243.600.14 CHANGES IN ELIGIBILITY: A case is closed, with provision of advance notice, when the MAP eligible recipient becomes ineligible. If a MAP eligible recipient dies, the case is closed the following month.
[8.243.600.14 NMAC - Rp, 8.243.600.14 NMAC, 1/1/2019]

HISTORY OF 8.243.600 NMAC: [**RESERVED**]

History of Repealed Material:
8.243.600 NMAC - Medicaid Eligibility - Working Disabled Individuals (WDI) (Category 043) - Benefit Description, filed 12/13/2000 Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 245 MEDICAID ELIGIBILITY - SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) (CATEGORY 045)
PART 600 BENEFIT DESCRIPTION

8.245.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.245.600.1 NMAC - Rp, 8.245.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.245.600.2 SCOPE: The rule applies to the general public.
[8.245.600.2 NMAC - Rp, 8.245.600.2 NMAC, 1/1/2019]

8.245.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority (HCA) pursuant to state statute. See, Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.245.600.3 NMAC - Rp, 8.245.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.245.600.4 DURATION: Permanent.
[8.245.600.4 NMAC - Rp, 8.245.600.4 NMAC, 1/1/2019]

8.245.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.245.600.5 NMAC - Rp, 8.245.600.5 NMAC, 1/1/2019]

8.245.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.245.600.6 NMAC - Rp, 8.245.600.6 NMAC, 1/1/2019]

8.245.600.7 DEFINITIONS: [**RESERVED**]

8.245.600.8 [RESERVED]
[8.245.600.8 NMAC - Rp, 8.245.600.8 NMAC, 1/1/2019]

8.245.600.9 BENEFIT DESCRIPTION: Most individuals 65 or older receive free medicare part A. Those who do not receive free part A can voluntarily enroll for hospital insurance coverage and pay the monthly premium. Medicaid does not pay the medicare part A monthly premium for this category of recipients. Voluntary enrollees for premium/conditional medicare part A must enroll for supplementary medical insurance, medicare part B, and pay that premium also. After an application for SLIMB benefits is approved, medicaid begins to pay the medicare part B premium. Applicants/recipients eligible for medicaid coverage under another medicaid category may also be eligible for SLIMB. SLIMB eligibility allows the state to receive federal matching funding for the purchase of medicare part B. Since payment of the medicare part B premium is the only benefit, no medicaid card is issued and there is no interaction with the medicaid claims processing contractor.
[8.245.600.9 NMAC - Rp, 8.245.600.9 NMAC, 1/1/2019]

8.245.600.10 BENEFIT DETERMINATION: Application for SLIMB is made on the assistance application form. Applications are acted on and notice of action taken is sent to the applicant within 45 days of the application. Determination of SLIMB eligibility for current recipients of medicaid is made without a separate application. Recipients of supplemental security income (SSI) or qualified medicare beneficiaries are not eligible for SLIMB.
[8.245.600.10 NMAC - Rp, 8.245.600.10 NMAC, 1/1/2019]

8.245.600.11 INITIAL BENEFITS: Eligibility begins the month the case is approved. When an eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, this notice includes the recipient's right to request a hearing.
[8.245.600.11 NMAC - Rp, 8.245.600.11 NMAC, 1/1/2019]

8.245.600.12 ONGOING BENEFITS: A redetermination of eligibility is made every 12 months.
[8.245.600.12 NMAC - Rp, 8.245.600.12 NMAC, 1/1/2019]

8.245.600.13 RETROACTIVE BENEFIT COVERAGE: Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.245.600.13 NMAC - Rp, 8.245.600.13 NMAC, 1/1/2019]

8.245.600.14 CHANGES IN ELIGIBILITY: A case is closed, with provision of advance notice, when the recipient becomes ineligible. If a recipient dies, the case is closed the following month.
[8.245.600.14 NMAC - Rp, 8.245.600.14 NMAC, 1/1/2019]

HISTORY OF 8.245.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center: MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/1994.

History of Repealed Material: MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 2/1/1995.
8.245.600 NMAC - Specified Low Income Medicare Beneficiaries-Benefit Description, filed 11/16/2009 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 249 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEE MEDICAL ASSISTANCE (RMA) PROGRAM
PART 400 RECIPIENT REQUIREMENTS

8.249.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.249.400.1 NMAC - Rp, 8.249.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.249.400.2 SCOPE: The rule applies to the general public.
[8.249.400.2 NMAC - Rp, 8.249.400.2 NMAC, 1/1/2014]

8.249.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.249.400.3 NMAC - Rp, 8.249.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.249.400.4 DURATION: Permanent.
[8.249.400.4 NMAC - Rp, 8.249.400.4 NMAC, 1/1/2014]

8.249.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.249.400.5 NMAC - Rp, 8.249.400.5 NMAC, 1/1/2014]

8.249.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual 8.200 NMAC, *Medicaid Eligibility - General Recipients Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions policy manual 8.100 NMAC, *General Provisions for Public Assistance Programs*. Refugee medical assistance (RMA): The RMA offers health coverage for a refugee within the first 12 months from their date of entry to the United States (U.S.) when they do not qualify for other medicaid eligibility categories. An RMA eligible refugee has access to a benefit package that parallels the full medicaid services. This program is not funded by medicaid; funds are provided through a grant under Title IV of the Immigration and Nationality Act. The purpose of this grant is to provide for the effective resettlement of a refugee and to assist the refugee to achieve economic self-sufficiency as quickly as possible.
[8.249.400.6 NMAC - Rp, 8.249.400.6 NMAC, 1/1/2014; A, 1/1/2023]

8.249.400.7 DEFINITIONS: "Refugee" is an immigrant, who because of persecution or fear of persecution on account of race, religion or political opinion, fled from their home country and cannot return because of fear of persecution because of race, religion or political opinion.
[8.249.400.7 NMAC - N, 1/1/2014; A, 1/1/2023]

8.249.400.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.249.400.8 NMAC - N, 1/1/2014; A, 1/1/2022]

8.249.400.9 REFUGEE MEDICAL ASSISTANCE ONLY - CATEGORY 049 AND 059:

A. A medicaid eligible refugee recipient must meet the following non-financial eligibility requirements:

(1) is ineligible for full medicaid coverage;

(2) is not a full-time student in an institution of higher education, except where enrollment is part of an individual employability plan for a refugee enrolled in the refugee cash assistance program;

(3) is in the U.S. fewer than 12 months and meets one of the following statuses:

(a) is admitted as a refugee under Section 207 of the Immigration and Nationality Act;

(b) is paroled into the U.S. as a refugee or asylee under Section 212 (d)(5) of the Immigration and Nationality Act;

(c) is granted asylum under Section 208 of the Immigration and Nationality Act;

(d) is admitted as an Amerasian immigrant from Vietnam through the orderly departure program, under Section 584 of the Foreign Operations Appropriations Act, incorporated in the fiscal year 1988 Continuing Resolution P.L. 100-212;

(e) is a Cuban-Haitian entrant who was admitted as a public interest parolee under Section 212 (d)(5) of the Immigration and Nationality Act;

(f) is certified as a victim of human trafficking by the federal office of refugee resettlement (ORR);

(g) is an eligible family member of a victim of human trafficking certified by ORR who has a T-2, T-3, T-4, or T-5 Visa;

(h) is admitted as a special immigrant from Iraq or Afghanistan under Section 101 (a)(27) of the Immigration and Nationality Act; or

(i) is a lawful permanent resident (LPR) when the individual had previously met a status as listed in Subparagraphs (a) through (h) above;

(4) an individual who meets the following eligibility requirements pursuant to 8.200.410 NMAC and 8.200.420 NMAC of citizenship or non-citizen status, enumeration, residence, non-concurrent receipt of assistance and applications for other benefits;

(5) appropriate to the size of the budget group (not including the ineligible parent due to citizenship or non-citizen status or enumeration), countable gross income must be less than one hundred and eighty-five percent of the standard of need (SON) countable net income must be less than the SON pursuant to 8.200.520 NMAC and 8.202.500 NMAC; and

(6) an applicant or an eligible recipient may have other creditable health insurance coverage.

B. An eligible recipient may have other creditable health insurance coverage. If the eligible recipient has other creditable health insurance coverage, RMA is the second payor.

C. An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.
[8.249.400.9 NMAC - Rp, 8.249.400.9 NMAC, 1/1/2014; A, 1/1/2022; A, 1/1/2023]

8.249.400.10 BASIS FOR DEFINING GROUP: At the time of application, an applicant or an eligible recipient and HCA shall identify everyone who is to be considered for inclusion in the assistance unit and budget group. Each member of the assistance unit and budget group, including each unborn child, is counted as one in the household size.
[8.249.400.10 NMAC - Rp, 8.249.400.10 NMAC, 1/1/2014]

8.249.400.11 [**RESERVED**]

8.249.400.12 ENUMERATION: Refer to 8.200.410.10 NMAC.
[8.249.400.12 NMAC - Rp, 8.249.400.12 NMAC, 1/1/2014]

8.249.400.13 CITIZENSHIP: Refer to 8.200.410.11 NMAC.
[8.249.400.13 NMAC - Rp, 8.249.400.13 NMAC, 1/1/2014]

8.249.400.14 RESIDENCE: Refer to 8.200.410.12 NMAC.
[8.249.400.14 NMAC - Rp, 8.249.400.14 NMAC, 1/1/2014]

8.249.400.15 [**RESERVED**]

8.249.400.16 [**RESERVED**]

8.249.400.17 AGE: Age is not an eligibility requirement.
[8.249.400.17 NMAC - Rp, 8.249.400.17 NMAC, 1/1/2014]

8.249.400.18 NON-CITIZEN SPONSORSHIP: The income support division (ISD) caseworker must notify the refugee's sponsor or local affiliate which provided for the resettlement of the refugee, when a refugee applies for refugee medical assistance.
[8.249.400.18 NMAC - Rp, 8.249.400.18 NMAC, 1/1/2014; A, 1/1/2022]

8.249.400.19 RECIPIENT RIGHTS AND RESPONSIBILITIES: Refer to 8.200.430 NMAC.
[8.249.400.19 NMAC - Rp, 8.249.400.19 NMAC, 1/1/2014]

8.249.400.20 ASSIGNMENT OF SUPPORT:

A. Assignment of medical support: Refer to 8.200.420.12 NMAC.

B. Assignments of child support: Assignment of child support is not required for refugee medical assistance.
[8.249.400.20 NMAC - Rp, 8.249.400.20 NMAC, 1/1/2014]

8.249.400.21 REPORTING REQUIREMENTS: Refer to 8.200.430.19 NMAC.
[8.249.400.21 NMAC - Rp, 8.249.400.21 NMAC, 1/1/2014]

8.249.400.22 ELIGIBLE ASSISTANCE UNIT: The assistance unit includes individuals who apply for RMA and who are determined eligible. Individuals may be ineligible for refugee cash assistance and eligible for RMA. An eligible recipient of refugee cash assistance who is not eligible for full medicaid services is eligible for RMA.
[8.249.400.22 NMAC - N, 1/1/2014]

8.249.400.23 BUDGET GROUP: The budget group includes all members of the assistance unit. Additional budget group members include individuals who live in the household with the assistance unit and have a financial obligation of support.

A. Except for a supplemental security income (SSI) recipient, the following individuals have a financial obligation of support for medicaid eligibility:

(1) spouses: married individuals as defined under applicable New Mexico state law (New Mexico recognizes common law and same sex marriages established in other states); and

(2) parents for children: there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process.

B. The following individuals do not have a financial obligation of support for medicaid eligibility:

(1) an SSI recipient to the assistance unit;

(2) a father of the unborn child who is not married to the pregnant woman;

(3) a stepparent to a stepchild;

(4) a grandparent to a grandchild;

(5) a legal guardian or a conservator of a child;

(6) a non-citizen sponsor to the assistance unit; and

(7) a sibling to a sibling.

C. Budget group earned income disregards and child care deductions vary based on the age group of the child. Refer to 8.232.500 NMAC.
[8.249.400.23 NMAC - N, 1/1/2014; A, 1/1/2022]

8.249.400.24 LIVING IN THE HOME

A. To be included in the assistance unit and budget group, an individual must be living, or considered to be living, in the budget group's home.

B. A child considered to be living in the home: A child is considered to be part of the budget group as evidenced by the child's customary physical presence in the home. If a child is living with more than one household, the following applies:

(1) when the child is actually spending more time with one household than the other, the child would be determined to be living with the household with whom the child spends the most time; or

(2) when the child is actually spending equal amounts of time with each household, the child shall be considered to be living with the household who first applies for medicaid enrollment.

C. Extended living in the home: An individual may be physically absent from the home for longer or shorter periods of time and be a member of the assistance unit and budget group.

(1) Extended living in the home includes:

(a) when an individual is attending college or boarding school; or

(b) when an individual is receiving treatment in a Title XIX medicaid facility, including institutionalized when meeting a nursing facility (NF) level of care (LOC) and intermediate care facilities for individuals with an intellectual disability (ICF-IID) LOC.

(2) When an individual has been a member of the assistance unit, eligibility for another medicaid eligibility category, such as long term care medicaid, should be evaluated; until a determination of eligibility for another category can be made, the individual is considered to be living with the budget group.

D. Temporary absence such as extended living in the home: An individual may be physically absent from the home and be a member of the assistance unit and budget group. These other temporary absences include:

(1) an individual not living in the home due to an emergency, who is expected to return to the household within 60 calendar days, continues to be a member of the household;

(2) a child removed from the home of a parent or a specified relative by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and families department), until an adjudicatory custody hearing takes place; if the adjudicatory hearing results in custody being granted to some other entity, the child will be removed from the assistance unit; or

(3) a child residing in a detention center:

(a) continues to be a member of the household if they reside fewer than 60 calendar days, regardless of adjudication as an inmate of a public institution; or

(b) is not eligible for medicaid enrollment if they reside 60 calendar days or more as an adjudicated inmate of a public institution pursuant to 8.200.410 NMAC.

[8.249.400.13 NMAC - N, 1/1/2014]

HISTORY OF 8.249.400 NMAC:

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

MAD Rule 822, Refugee Medical Assistance, filed 5/22/1992.

History of Repealed Material:

MAD Rule 822 Refugee Medical Assistance, filed 5/22/1992 - Repealed effective 2/1/1995.

8.249.400 NMAC Recipient Policies, filed 9/3/2013 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 249 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEE MEDICAL ASSISTANCE (RMA) PROGRAM
PART 500 INCOME AND RESOURCE STANDARDS

8.249.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.249.500.1 NMAC - Rp, 8.249.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.249.500.2 SCOPE: The rule applies to the general public.
[8.249.500.2 NMAC - Rp, 8.249.500.2 NMAC, 1/1/2014]

8.249.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.249.500.3 NMAC - Rp, 8.249.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.249.500.4 DURATION: Permanent.
[8.249.500.4 NMAC - Rp, 8.249.500.4 NMAC, 1/1/2014]

8.249.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.249.500.5 NMAC - Rp, 8.249.500.5 NMAC, 1/1/2014]

8.249.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.249.500.6 NMAC - Rp, 8.249.500.6 NMAC, 1/1/2014]

8.249.500.7 DEFINITIONS: [**RESERVED**]

8.249.500.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.249.500.8 NMAC - N, 1/1/2014; A, 1/1/2022]

8.249.500.9 NEED DETERMINATION:

A. Financial need: The budget group's eligibility is based on financial need. See Section 1931 of the Social Security Act, the rules in this chapter and in 8.200.520 NMAC.

B. Financial eligibility: Pursuant to Section 1931 of the Social Security Act, enacted by Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), a new medicaid financial eligibility standard was created. Refugee medical assistance (RMA) uses this same standard.

(1) Income eligibility criteria: The income eligibility criteria for Category 049 are based on New Mexico's aid to families with dependent children (AFDC) program as of July 16, 1996. This is defined as the standard of need (SON) used in AFDC as of July 16, 1996. A refugee can be eligible for Category 059 if income would be below AFDC after deducting medical expenses incurred and paid in that month. Eligibility for Category 059 is determined on a month-to-month basis.

(2) Less restrictive income and resource methodology: Pursuant to Section 1931 of the Social Security Act, as a state option, New Mexico may use income and resource eligibility methodologies that are less restrictive than the AFDC methodologies used as of July 16, 1996. This chapter defines less restrictive methodologies to be used by New Mexico for resources, countable and excluded earned or unearned income, available or unavailable income and income deductions or disregards.

C. Gross and net income tests: Determining financial need is a two-step process. When the countable gross or net income is exactly equal to the income eligibility standards, eligibility does not exist.

(1) Gross income test: The first step is determining the countable gross income of the budget group. Gross income includes all countable income before taking into account taxes or deductions. Only self employment deductions are allowed in the gross income test. The calculated gross income must be less than one hundred and eighty-five percent of the SON. If the budget group's income is more than one hundred and eighty-five percent of the SON, the assistance unit is not eligible.

(2) Net income test: The second step is determining the countable net income of the budget group. From the countable gross income in step one, deduct all allowable work related expenses (WRE) and unearned income deductions/disregards. The countable net income must be less than the SON appropriate to the budget group size. If the budget group's income is more than the SON, the assistance unit is not eligible.

[8.249.500.9 NMAC - Rp, 8.249.500.9 NMAC, 1/1/2014; A, 1/1/2022]

8.249.500.10 RESOURCE STANDARDS: Resources are not an eligibility factor.

[8.249.500.10 NMAC - Rp, 8.249.500.10 NMAC, 1/1/2014]

8.249.500.11 INCOME STANDARDS: Refer to 8.249.500.9 NMAC.

[8.249.500.11 NMAC - Rp, 8.249.500.11 NMAC, 1/1/2014]

8.249.500.12 INCOME ELIGIBILITY: Income consists of money received by a person whose income is considered available to the budget group as described in this chapter.

A. Income from a 30 day-period is used to determine eligibility. The 30-day period may be any consecutive 30-day period that is prior to the date of the application through the date of timely disposition. The applicant and the caseworker must agree on the 30-day period. Income from a terminated source is not counted.

B. Income received less frequently than monthly: If an amount of gross income is received less frequently than monthly, that amount is converted to a monthly amount to determine financial eligibility. The conversion is obtained by dividing the total income by the number of months the income is intended to cover. For the purposes of this calculation, a partial month is considered to be one full month. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It includes contract income as well as income for a tenured teacher who may not have a contract.

C. Use of conversion factors: Whenever a full month's income is received on a weekly or biweekly basis, the income is converted to a monthly amount. Income is rounded down to the nearest whole dollar prior to application of the conversion factor. Weekly income is multiplied by four and biweekly income is multiplied by two.

[8.249.500.12 NMAC - N, 1/1/2014]

8.249.500.13 AVAILABLE INCOME:

A. Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined using allowable income exemptions, deductions and disregards. The income of a budget group member who is not included in the assistance unit is deemed available to the assistance unit.

B. Available income includes:

(1) income received by the budget group;

(2) income received by someone not included in the budget group for someone included in the budget group and which is available to the budget group;

(3) income that is withheld as a result of a garnishment or wage withholding; and

(4) income withheld by a source at the request of a budget group member.

[8.249.500.13 NMAC - N, 1/1/2014]

8.249.500.14 UNAVAILABLE INCOME:

A. Individuals included in the budget group may have a legal right to income but not access to it; such income is not counted as available income:

(1) old age, survivors, and disability insurance (OASDI);

(2) railroad retirement benefits (RRB);

(3) veterans administration (VA) benefits:

(a) income available to veterans and their dependents from the VA as compensation for service-connected disability;

(b) pension for non-service connected disability;

(c) dependency and indemnity compensation; and

(d) death benefits paid from a government issue (GI) life insurance;

(4) unemployment compensation benefits (UCB);

(5) military allotments;

(6) worker's compensation;

(7) pension, annuity, and retirement benefits;

(8) union benefits;

(9) lodge or fraternal benefits;

(10) real property income that is not earned income;

(11) shared shelter and utility payments when the budget group shares shelter with others:

(a) payments which exceed the budget group's cost are considered income;

(b) payments which are less than the budget group's cost are not considered; these are the others' share of the shelter cost and are treated as pass-through payments;

(12) income from the sale of goods or property which are obtained in finished condition;

(13) child support payments received directly by the budget group and retained for its use;

(14) settlement payments which are received from worker's compensation settlements, insurance claims, damage claims, litigation, trust distributions which are made on a recurring basis;

(15) individual Indian monies (IIM) payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual member of a tribe;

(16) bureau of Indian affairs (BIA) or tribal general assistance (GA) payments; and

(17) income that is not listed as available in this chapter where the budget group cannot gain access to the income; this includes wages withheld by an employer that refuses to pay.

B. Individuals may receive payment of funds "passed through" the individual for the benefit of someone other than themselves. Such pass through payments are not considered available.

C. A recipient of supplemental security income (SSI) is not part of the budget group. Their other income is not considered available to the budget group.

D. Non-citizen sponsor deeming is not applicable pursuant to 8.200.410 NMAC.

[8.249.500.14 NMAC - N, 1/1/2014; A, 1/1/2022]

8.249.500.15 EARNED INCOME: Includes all wages, salaries, tips, and other employee pay from employment and net earnings from self-employment.

[8.249.500.15 NMAC - N, 1/1/2014]

8.249.500.16 EARNED INCOME DEDUCTIONS/DISREGARDS:

A. Self employment: Certain self-employment deductions allowed by the federal internal revenue service (IRS) are allowed in the net and gross income test.

(1) Self-employment income will be annualized for income projection purposes. If the IRS Form 1040 has been filed, the previous year's tax return is used to anticipate future income, if no significant changes in circumstances have occurred. An alternative method of income anticipation should be used when the amount of self employment income reported on tax returns would no longer be a good indicator of expected income, i.e., loss of cattle or crops due to disease.

(2) If tax returns are used for annualized projected income, self-employment expenses listed on the return are allowable except:

(a) the mileage allowance is the New Mexico department of finance and administration (DFA) rate as detailed in 2.42.2 NMAC unless proof that the actual expense is greater; and

(b) no deduction is allowed for rent or purchase of the place of business if the individual operates the business out of their residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines.

(3) The following deductions are not allowed:

(a) depreciation;

(b) personal business and entertainment expenses;

(c) personal transportation to and from work;

(d) purchase of capital equipment; and

(e) payments on the principal of loans for capital assets or durable goods.

B. WRE income disregards: The WRE disregard of $120 and one third of the remaining balance is disregarded from earned income during the net income test.

C. Child care expenses:

(1) To be eligible for a child care deduction, the child receiving the care must be:

(a) a dependent of the employed person;

(b) younger than 13; and

(c) included in the budget group.

(2) Standards: Actual costs of child care, not to exceed the applicable limits set forth below are deducted from earnings. The amount to be deducted depends upon whether the person is employed full or part-time and the age of the child. Full-time employment is considered to be 30 hours or more of employment per week; part time is any employment of less than 30 hours per week.

(a) up to $200 per month per child if the person is employed full-time and the child is under age two;

(b) up to $100 per month per child if the person is employed part-time and the child is under age two;

(c) up to $175 per month per child if the person is employed full-time and the child's age is two through12; and

(d) up to $87.50 per month per child if the person is employed part-time and the child's age is two through 12.

(3) Third party child care payments: Child care costs paid by third parties directly to the child care provider cannot be used as child care deductions. Such payments are classified as vendor payments and are not counted as income. If such payments do not meet the full cost of child care, the difference between the deduction and the vendor payment is the amount allowed, up to the stated child care deductions in Paragraph (2) of Subsection C of 8.249.500.16 NMAC. If the third party child care payments are made to the budget group, the payments would be treated as pass through payments and not counted.

[8.249.500.16 NMAC - N, 1/1/2014; A, 1/1/2022]

8.249.500.17 UNEARNED INCOME: Unearned income includes benefits, pensions, etc.

A. The following types of unearned income are counted:

(1) old age, survivors, and disability insurance (OASDI);

(2) railroad retirement benefits (RRB);

(3) veterans administration (VA) benefits:

(a) income available to veterans and their dependents from the VA as compensation for service-connected disability;

(b) pension for non-service connected disability;

(c) dependency and indemnity compensation; and

(d) death benefits paid from a government issue (GI) life insurance;

(4) unemployment compensation benefits (UCB);

(5) military allotments;

(6) worker's compensation;

(7) pension, annuity, and retirement benefits;

(8) union benefits;

(9) lodge or fraternal benefits;

(10) real property income that is not earned income;

(11) shared shelter and utility payments when the budget group shares shelter with others:

(a) payments which exceed the budget group's cost are considered income;

(b) payments which are less than the budget group's cost are not considered; these are the others' share of the shelter cost and are treated as pass-through payments;

(12) income from the sale of goods or property which are obtained in finished condition;

(13) child support payments received directly by the budget group and retained for its use;

(14) settlement payments which are received from worker's compensation settlements, insurance claims, damage claims, litigation, trust distributions which are made on a recurring basis;

(15) individual Indian monies (IIM) payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual member of a tribe; and

(16) bureau of Indian affairs (BIA) or tribal general assistance (GA) payments.

B. The following types of unearned income are not considered in determining eligibility:

(1) cash assistance from HCA or a tribal entity;

(2) supplemental nutritional assistance program (SNAP);

(3) low income home energy assistance program (LIHEAP);

(4) foster care or adoption subsidy;

(5) supplemental security income (SSI);

(6) Child Nutrition and National School Lunch Act;

(7) nutrition programs for the elderly, including meals on wheels and lunches at senior citizen's centers;

(8) bona fide loans from private individuals and commercial institutions as well as loans for the purpose of educational assistance;

(9) work study funds paid by an educational institution, when the purpose is to assist with educational expenses, regardless of the actual use of the funds;

(10) domestic volunteers compensation or any other payments made to or on behalf of volunteers under the Domestic Volunteers Services Act of 1973 including:

(a) volunteers in service to America (VISTA);

(b) university year for action (UYA);

(c) special volunteer programs (SVP);

(d) retired senior volunteer program (RSVP);

(e) foster grandparents program (FGP);

(f) older American community service program (OACSP);

(g) service corps of retired executives (SCORE); and

(h) active corps of executives (ACE);

(11) state and federal income tax returns;

(12) American Indian payments including:

(a) per capita payments distribution of tribal funds to an Indian tribe member by the tribe or by the secretary of the United States department of the interior;

(b) interest derived from retained per capita payments (if kept separately identifiable); and

(c) tribal land claims payments settled by means of case payments;

(13) Job Training Partnership Act of 1982 (JTPA) payments made to dependent children;

(14) Title II Uniform Relocation Assistance and Real Property Acquisition Act of 1970 payments;

(15) supportive service payments made for reimbursement of transportation, child care, or training related expenses under NMW work programs, tribal work programs, and other employment assistance programs;

(16) division of vocational rehabilitation (DVR) training payments made by the for training expenses;

(17) gifts, donations or contribution from other agencies which are intended to meet needs not covered as a benefit; to be exempt, the payment must:

(a) be paid under the auspices of an organization or non-profit entity; and

(b) be for a specific identified purpose, to supplement not duplicate covered benefits for the intended beneficiary of the donation/contribution;

(18) educational loans and grants intended for educational expenses; regardless of actual utilization of the funds;

(19) agent orange settlement fund payments or any fund established pursuant to the agent orange product liability litigation settlement;

(20) radiation exposure compensation settlement fund payments;

(21) Nazi victim payments made to individuals per P.L. 103-286, August 1, 1994; and

(22) vendor payments made on behalf of a budget group member when an individual or organization outside the budget group uses its own funds to make a direct payment to a budget group's service provider.

[8.249.500.17 NMAC - N, 1/1/2014]

HISTORY OF 8.249.500 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 822, Refugee Medical Assistance, filed 5/22/1992.

History of Repealed Material:
MAD Rule 822 Refugee Medical Assistance, filed 5/22/1992 - Repealed effective 2/1/1995.
8.249.500 NMAC, Income and Resource Standards, filed 3/25/2010 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 249 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEE MEDICAL ASSISTANCE (RMA) PROGRAM
PART 600 BENEFIT DESCRIPTION

8.249.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.249.600.1 NMAC - Rp, 8.249.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.249.600.2 SCOPE: The rule applies to the general public.
[8.249.600.2 NMAC - Rp, 8.249.600.2 NMAC, 1/1/2019]

8.249.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.249.600.3 NMAC - Rp, 8.249.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.249.600.4 DURATION: Permanent.
[8.249.600.4 NMAC - Rp, 8.249.600.4 NMAC, 1/1/2019]

8.249.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.249.600.5 NMAC - Rp, 8.249.600.5 NMAC, 1/1/2019]

8.249.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.249.600.6 NMAC - Rp, 8.249.600.6 NMAC, 1/1/2019]

8.249.600.7 DEFINITIONS: [RESERVED]

8.249.600.8 [RESERVED]
[8.249.600.8 NMAC – Rp, 8.249.600.8 NMAC, 1/1/2019]

8.249.600.9 BENEFIT DESCRIPTION: Refugee medical assistance (RMA) offers health coverage for refugees within the first 12 months from their date of entry to the United States, when they do not qualify for medicaid. RMA eligible refugees have access to a benefit package that parallels the full coverage medicaid benefit package. This program is not funded by medicaid. RMA is funded through a grant under Title IV of the Immigration and Nationality Act. The purpose of this grant is to provide for the effective resettlement of refugees and to assist them to achieve economic self-sufficiency as quickly as possible. Refer to 8.100.100 NMAC.
[8.249.600.9 NMAC - Rp, 8.249.600.9 NMAC, 1/1/2019; A, 1/1/2023]

8.249.600.10 BENEFIT DETERMINATION: Application for refugee medical assistance is made on the assistance application form. The application is acted on and notice of the action sent to the applicant within 45 days of the date of application.
[8.249.600.10 NMAC - Rp, 8.249.600.10 NMAC, 1/1/2019]

8.249.600.11 INITIAL BENEFITS:

A. Approval or denial of application: After the eligibility determination is made, the income support specialist (ISS) sends notice to the applicant or applicant group. The denial notice contains information on the reason for the denial and explanation of appeal rights to the applicant(s).

B. **Date of eligibility:** Eligibility starts with the first day of the month of application after all eligibility requirements are met. The 12-month period begins with the month the refugee enters the United States, as documented by the immigration and naturalization service (INS) (form I-94). For cases involving children born in the United States, the child's eligibility period expires when the refugee parent who arrived last in the United States has been in this country for 12 months.
[8.249.600.11 NMAC - Rp, 8.249.600.11 NMAC, 1/1/2019; A, 1/1/2023]

8.249.600.12 ONGOING BENEFITS: No periodic review is required, since coverage is limited to a maximum of 12 months from the date of entry into the United States.
[8.249.600.12 NMAC - Rp, 8.249.600.12 NMAC, 1/1/2019; A, 1/1/2023]

8.249.600.13 RETROACTIVE BENEFIT COVERAGE: Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.249.600.13 NMAC - Rp, 8.249.600.13 NMAC, 1/1/2019]

8.249.600.14 CASE CLOSURES: Cases are closed when refugee medical assistance recipients no longer meet eligibility standards or after the 12-month eligibility period expires, whichever comes first.
[8.249.600.14 NMAC - Rp, 8.249.600.14 NMAC, 1/1/2019; A, 1/1/2023]

8.249.600.15 CHANGES AND REDETERMINATIONS OF ELIGIBILITY:

A. A re-determination of eligibility is not required.

B. Changes in income are not reportable. Reported income changes are not acted upon.

C. A refugee who received medicaid for 11 or fewer months during the RMA period is eligible for RMA for any remaining months in the 12-month RMA period. Eligibility for RMA is determined without a new eligibility determination or application.

D. Residence changes must be reported within 10 days after the change for individuals placed in a public institution or those individuals moving out of New Mexico. Refer to 8.200.450 NMAC.
[8.249.600.15 NMAC – Rp, 8.249.600.15 NMAC, 1/1/2019; A, 1/1/2023]

HISTORY OF 8.249.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 822, Refugee Medical Assistance, filed 5/22/1992.

History of Repealed Material:
MAD Rule 822, Refugee Medical Assistance, filed 5/22/1992 - Repealed effective 2/1/1995.
8.249.600 NMAC, Benefit Description, filed 9/3/2013 - Repealed effective 1/1/2014.
8.249.600 NMAC - Benefit Description, filed 12/2/2013 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 250 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY – QUALIFIED INDIVIDUALS WHOSE INCOME EXCEEDS QMB AND SLIMB
PART 400 RECIPIENT REQUIREMENTS

8.250.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.250.400.1 NMAC - Rp, 8.250.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.250.400.2 SCOPE: The rule applies to the general public.
[8.250.400.2 NMAC - Rp, 8.250.400.2 NMAC, 1/1/2014]

8.250.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.250.400.3 NMAC - Rp, 8.250.400.3 NMAC, 1/1/2014 ; A, 7/1/2024]

8.250.400.4 DURATION: Permanent.
[8.250.400.4 NMAC - Rp, 8.250.400.4 NMAC, 1/1/2014]

8.250.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.250.400.5 NMAC - Rp, 8.250.400.5 NMAC, 1/1/2014]

8.250.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility – General Recipient Policies* Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.250.400.6 NMAC - Rp, 8.250.400.6 NMAC, 1/1/2014]

8.250.400.7 DEFINITIONS: [**RESERVED**]

8.250.400.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.250.400.8 NMAC - Rp, 8.250.400.8 NMAC, 1/1/2014; A, 1/1/2022]

8.250.400.9 QUALIFIED INDIVIDUALS 1 (QI1s) - CATEGORY 042: Medical assistance division (MAD) pays the monthly medicare Part B insurance premium for eligible recipients with income between one hundred and twenty percent and one hundred and thirty-five percent of the federal poverty level (FPL) who are not otherwise eligible for another medical assistance program category of eligibility (QI1s). A QI1 recipient must be covered by medicare Part A. The Part A insurance is a free entitlement to social security beneficiaries who are 65 years of age or older or who have received social security disability payments for 24 months. Fully or currently insured workers, or their dependents, with end-stage renal disease are also covered under medicare. Eligible recipients will be served on a first come, first served basis, contingent upon availability of federal funds. Eligibility will be offered to individuals on a yearly basis. After 1998, eligible recipients currently enrolled in the program will get the first opportunity to continue to receive benefits under this program.
[8.250.400.9 NMAC - Rp, 8.250.400.9 NMAC, 1/1/2014; A, 1/1/2022]

8.250.400.10 BASIS FOR DEFINING THE GROUP: QI1s are individuals who would be qualified medicare beneficiaries (QMB) but for the fact that their income exceeds the income levels established for QMB and specified low income medicare beneficiaries (SLIMB). Income eligibility for the QI1s is at least one hundred and twenty percent of the FPL, but less than one hundred thirty-five percent. The state of New Mexico (the state) will permit all individuals to apply for assistance during a calendar year beginning 1998. However, because of the capped

allotments, the state shall limit the number of participants in QI1s selected in a calendar year so that the aggregate amount of benefits provided to such individuals in the calendar year is estimated not to exceed the state's allocation for the fiscal year ending in that calendar year. The state shall select QI1s on a first-come, first-served basis (in the order in which they apply). For calendar years after 1998, the state shall give preference to individuals who were QI1s, QMBs, SLIMBs, or qualified disabled working individuals (QDWI) in the last month of the previous year and who continue to be or become QI1s.
[8.250.400.10 NMAC - Rp, 8.250.400.10 NMAC, 1/1/2014; A, 1/1/2022]

8.250.400.11 [**RESERVED**]

8.250.400.12 ENUMERATION: QI1 applicants or re-determining recipients must furnish their social security numbers (SSN). QI1 eligibility shall be denied or terminated for applicants or re-determining recipients who fail to furnish social security numbers.
[8.250.400.12 NMAC - Rp, 8.250.400.12 NMAC, 1/1/2014]

8.250.400.13 CITIZENSHIP:

A. Undocumented non-citizens cannot purchase medicare coverage and, therefore, are not eligible for QI1 benefits. To be eligible for QI1 an applicant or re-determining recipient must be one of the following:

(1) a citizen of the United States; or

(2) a non-citizen who entered the United States prior to August 22, 1996, as one of the classes of non-citizens described in 8.200.410 NMAC or a non-citizen who entered the United States as a qualified non-citizen on or after August 22, 1996, and who has met the five year bar listed in 8.200.410 NMAC.

B. Verification of citizenship: Individuals entitled to or receiving medicare already meet citizenship and identity requirements.
[8.250.400.13 NMAC - Rp, 8.250.400.13 NMAC, 1/1/2014; A, 1/1/2022]

8.250.400.14 RESIDENCE: An individual must physically present in New Mexico on the date of application or re-determination or on the eligibility determination date and intends to remain in the state. If the applicant or re-determining recipient does not have the present mental capacity to declare intent, the parent, guardian, or adult child can assume responsibility for a declaration of intent. If there is no guardian or relative to assume responsibility for a declaration of intent, the state in which the applicant or re-determining recipient is living is recognized as the state of residence. A temporary absence from the state does not preclude eligibility. A temporary absence is considered to exist when the eligible recipient leaves the state for a specific purpose with a time-limited goal, after the accomplishment of which the eligible recipient intends to return to New Mexico. Refer to 8.200.410.12 NMAC.
[8.250.400.14 NMAC - Rp, 8.250.400.14 NMAC, 1/1/2014]

8.250.400.15 NONCONCURRENT RECEIPT OF ASSISTANCE: An applicant or re-determining recipient is not eligible for Category 042 if they are eligible under another medical assistance category of eligibility or if receiving medicaid services from another state.
[8.250.400.15 NMAC - Rp, 8.250.400.15 NMAC, 1/1/2014]

8.250.400.16 SPECIAL RECIPIENT REQUIREMENTS: An applicant or re-determining recipient for QI1 eligibility must meet the specified age or disability requirements to be eligible for medicare Part A.
[8.250.400.16 NMAC - Rp, 8.250.400.16 NMAC, 1/1/2014]

8.250.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: It is the responsibility of the applicant or re-determining recipient to provide the required information, documents or undertake the actions necessary for HCA to establish eligibility. The applicant or re-determining recipient must grant HCA permission to contact other persons, agencies or sources of information which are necessary in the establishment of eligibility. Failure of the applicant or re-determining recipient to provide or take action will result in a HCA action to deny eligibility.
[8.250.400.17 NMAC - Rp, 8.250.400.17 NMAC, 1/1/2014]

8.250.400.18 [**RESERVED**]

8.250.400.19 REPORTING REQUIREMENTS: An applicant, re-determining or eligible recipient must report any change in their circumstances which can affect their eligibility within 10 calendar days after the change to their local income support division (ISD) office. Refer to 8.200.430.19 NMAC.
[8.250.400.19 NMAC - Rp, 8.250.400.19 NMAC, 1/1/2014]

HISTORY OF 8.250.400 NMAC:

History of Repealed Material:
8.250.400 NMAC, Recipient Policies, filed 11/16/2009 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 250 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED DISABLED INDIVIDUALS
PART 500 INCOME AND RESOURCE STANDARDS

8.250.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.250.500.1 NMAC - Rp, 8.250.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.250.500.2 SCOPE: The rule applies to the general public.
[8.250.500.2 NMAC - Rp, 8.250.500.2 NMAC, 1/1/2014]

8.250.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.250.500.3 NMAC - Rp, 8.250.500.3 NMAC, 1/1/2014 ; A, 7/1/2024]

8.250.500.4 DURATION: Permanent.
[8.250.500.4 NMAC - Rp, 8.250.500.4 NMAC, 1/1/2014]

8.250.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.250.500.5 NMAC - Rp, 8.250.500.5 NMAC, 1/1/2014]

8.250.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.250.500.6 NMAC - Rp, 8.250.500.6 NMAC, 1/1/2014]

8.250.500.7 DEFINITIONS: [RESERVED]

8.250.500.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.250.500.8 NMAC - Rp, 8.250.500.8 NMAC, 1/1/2014]

8.250.500.9 QUALIFIED INDIVIDUALS 1 (QI1s) - CATEGORY 042: Medical assistance division (MAD) pays the monthly medicare Part B insurance premium for qualified individuals (QI1s) with income between 120 percent and 135 percent of the federal poverty level and who are not otherwise eligible for another MAD category of eligibility. Eligible recipients will be served on a first come, first served basis, contingent upon availability of federal funds. Eligibility will be offered to individuals on a yearly basis. After 1998, eligible recipients currently enrolled in the program will get the first opportunity to continue to receive benefits.
[8.250.500.9 NMAC - N, 1/1/2014]

8.250.500.10 NEED DETERMINATION: An applicant or a re-determining recipient for the medical MAD eligibility Category 042 QI1s must apply for and take all necessary actions to obtain any resources to which they may be entitled. See 8.215.500 NMAC.
[8.250.500.10 NMAC - Rp, 8.250.500.9 NMAC, 1/1/2014]

8.250.500.11 RESOURCE STANDARDS: The value of an applicant or re-determining recipient's countable resources must not exceed the amount set forth in 8.200.510 NMAC. The resource limit for an applicant or re-determining recipient couple cannot exceed the amount for a couple set forth in 8.200.510 NMAC. An applicant or re-determining recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed the amount set forth in 8.200.510 NMAC, when resources are deemed. A resource determination is always made as of

the first moment of the first day of the month. An applicant or re-determining recipient is ineligible for any month in which the countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the amount of resources during a month do not affect eligibility for that month. See 8.215.500 NMAC for information on exclusions, disregards, and countable resources.
[8.250.500.11 NMAC - Rp, 8.250.500.10 NMAC, 1/1/2014]

8.250.500.12 RESOURCE TRANSFERS: The social security administration excluded transfer of resources as a factor of eligibility for a non-institutionalized recipient who receives supplemental security income (SSI) benefits. Transfer of resources is not a factor for consideration in categories that use SSI methodology in the eligibility determination.
[8.250.500.12 NMAC - Rp, 8.250.500.11 NMAC, 1/1/2014]

8.250.500.13 TRUSTS: See 8.281.510 NMAC.
[8.250.500.13 NMAC - Rp, 8.250.500.12 NMAC, 1/1/2014]

8.250.500.14 INCOME STANDARDS: Income standards for this category are at least one hundred and twenty percent but less than one hundred and thirty-five percent of the federal income poverty guidelines. The federal income poverty guidelines are adjusted annually, effective April 1. See 8.200.520 NMAC and 8.215.500 for information on exclusions, disregards and countable income. Verification of income must be documented in the case file.
[8.250.500.14 NMAC - Rp, 8.250.500.13 NMAC, 1/1/2014]

8.250.500.15 UNEARNED INCOME EXCLUSIONS: All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The ISD caseworker must disregard the COLA from January through March when determining or re-determining QI1s eligibility. For re-determinations made in January, February and March and for new QI1 applications registered in January, February or March, the ISD caseworker uses the December social security and railroad retirement benefit amounts. For QI1 applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April federal poverty levels. This exclusion does not apply to other types of income.
[8.250.500.15 NMAC - Rp, 8.250.500.14 NMAC, 1/1/2014]

8.250.500.16 DEEMED INCOME: If an applicant or re-determining recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered. If an applicant or re-determining recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500 NMAC for information on deemed income.
[8.250.500.16 NMAC - Rp, 8.250.500.15 NMAC, 1/1/2014]

HISTORY OF 8.250.500 NMAC:

History of Repealed Material:
8.250.500 NMAC, Income and Resource Standards, filed 11/16/2009 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 250 MEDICAID ELIGIBILITY - QUALIFIED INDIVIDUALS WHOSE INCOME EXCEEDS QMB AND SLIMB (CATEGORY 045)
PART 600 BENEFIT DESCRIPTION

8.250.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.250.600.1 NMAC - Rp, 8.250.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.250.600.2 SCOPE: The rule applies to the general public.
[8.250.600.2 NMAC - Rp, 8.250.600.2 NMAC, 1/1/2019]

8.250.600.3 STATUTORY AUTHORITY: Chapter 27, Articles 1 and 2 NMSA 1978 authorizes the state to administer the medicaid program. Section 4732 of the 1997 Balanced Budget Act creates a separate group of eligible individuals, to be known as qualified individuals 1 (QI1s), with income between one hundred twenty percent and one hundred thirty-five percent of the federal poverty level. The benefit is limited to the payment of the monthly medicare part B insurance premium. Funding is available under one hundred percent federal block grant money. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.250.600.3 NMAC - Rp, 8.250.600.3 NMAC, 1/1/2019 ; A, 7/1/2024]

8.250.600.4 DURATION: Permanent.
[8.250.600.4 NMAC - Rp, 8.250.600.4 NMAC, 1/1/2019]

8.250.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.250.600.5 NMAC - Rp, 8.250.600.5 NMAC, 1/1/2019]

8.250.600.6 OBJECTIVE: The objective of the qualified individuals 1 (QI1s) eligibility is for New Mexico medicaid to provide the payment of the monthly medicare part B insurance premium for individuals with income between one hundred twenty percent and one hundred thirty-five percent of the federal poverty level and who are not otherwise receiving medicaid under any other category of eligibility. Individuals will be served on a first come, first served basis, contingent upon availability of federal funds. Eligibility will be offered to individuals on a yearly basis. After 1998, individuals currently enrolled in the program will get the first opportunity to continue to receive benefits under this program.
[8.250.600.6 NMAC - Rp, 8.250.600.6 NMAC, 1/1/2019]

8.250.600.7 DEFINITIONS: [RESERVED]

8.250.600.8 [RESERVED]
[8.250.600.8 NMAC - Rp, 8.250.600.8 NMAC, 1/1/2019]

8.250.600.9 BENEFIT DESCRIPTION: Most individuals 65 or older receive free medicare part A. Those who do not receive free part A can voluntarily enroll for hospital insurance coverage and pay the monthly premium. Medicaid does not pay the medicare part A monthly premium for this category of recipients. Voluntary enrollees for premium/conditional medicare part A must enroll for supplementary medical insurance, medicare part B, and pay that premium also. After an application for QI benefits is approved, medicaid begins to pay the medicare part B premium. Applicants/recipients eligible for QI1 coverage under another medicaid category may not be eligible for QI1. QI1 eligibility is funded by limited block grant funding beginning in 1998 and ending when the congressional extension period expires. Since payment of the medicare part B premium is the only benefit, no medicaid card is issued.
[8.250.600.9 NMAC - Rp, 8.250.600.9 NMAC, 1/1/2019]

8.250.600.10 BENEFIT DETERMINATION: Application for QI1 is made on the assistance application form. Applications are acted on and notice of action taken is sent to the applicant within 45 days of the application.
[8.250.600.10 NMAC - Rp, 8.250.600.10 NMAC, 1/1/2019]

8.250.600.11 INITIAL BENEFITS: Eligibility begins the month the case is approved. When an eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, this notice includes the recipient's right to request a hearing.
[8.250.600.11 NMAC - Rp, 8.250.600.11 NMAC, 1/1/2019]

8.250.600.12 ONGOING BENEFITS: A redetermination of eligibility is made every 12 months.
[8.250.600.12 NMAC - Rp, 8.250.600.12 NMAC, 1/1/2019]

8.250.600.13 RETROACTIVE BENEFIT COVERAGE: Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.250.600.13 NMAC - Rp, 8.250.600.13 NMAC, 1/1/2019]

8.250.600.14 CHANGES IN ELIGIBILITY: A case is closed, with provision of advance notice, when the recipient becomes ineligible. If a recipient dies, the case is closed effective the following month.
[8.250.600.14 NMAC - Rp, 8.250.600.14 NMAC, 1/1/2019]

HISTORY OF 8.250.600 NMAC: [**RESERVED**]

History of Repealed Material:
8.250.600 NMAC - Benefit Description, filed 11/16/2009 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 252 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - BREAST AND CERVICAL CANCER PROGRAM
PART 500 INCOME AND RESOURCE STANDARDS

8.252.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.252.500.1 NMAC - Rp, 8.252.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.252.500.2 SCOPE: This rule applies to the general public.
[8.252.500.2 NMAC - Rp, 8.252.500.2 NMAC, 1/1/2014]

8.252.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.252.500.3 NMAC - Rp, 8.252.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.252.500.4 DURATION: Permanent.
[8.252.500.4 NMAC - Rp, 8.252.500.4 NMAC, 1/1/2014]

8.252.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.252.500.5 NMAC - Rp, 8.252.500.5 NMAC, 1/1/2014]

8.252.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.252.500.6 NMAC - Rp, 8.252.500.6 NMAC, 1/1/2014]

8.252.500.7 DEFINITIONS: [**RESERVED**]

8.252.500.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.252.500.8 NMAC - N, 1/1/2014]

8.252.500.9 RESOURCES: Resources are not an eligibility factor.
[8.252.500.9 NMAC - Rp, 8.252.500.9 NMAC, 1/1/2014]

8.252.500.10 INCOME: Income is not an eligibility factor.
[8.252.500.10 NMAC - Rp, 8.252.500.10 NMAC, 1/1/2014]

HISTORY OF 8.252.500 NMAC:

History of Repealed Material:
8.252.500 NMAC, Income and Resource Standards, filed 6-14-02 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 252 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - BREAST AND CERVICAL CANCER PROGRAM
PART 600 BENEFIT DESCRIPTION

8.252.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.252.600.1 NMAC - Rp, 8.252.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.252.600.2 SCOPE: This rule applies to the general public.
[8.252.600.2 NMAC - Rp, 8.252.600.2 NMAC, 1/1/2019]

8.252.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.252.600.3 NMAC - Rp, 8.252.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.252.600.4 DURATION: Permanent.
[8.252.600.4 NMAC - Rp, 8.252.600.4 NMAC, 1/1/2019]

8.252.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.252.600.5 NMAC - Rp, 8.252.600.5 NMAC, 1/1/2019]

8.252.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.252.600.6 NMAC - Rp, 8.252.600.6 NMAC, 1/1/2019]

8.252.600.7 DEFINITIONS: [**RESERVED**]

8.252.600.8 [RESERVED]
[8.252.600.8 NMAC – Rp, 8.252.600.8 NMAC, 1/1/2019]

8.252.600.9 GENERAL BENEFIT DESCRIPTION: A woman who is determined eligible for medicaid coverage under the breast and cervical cancer program (Category 052) can receive the full range of medicaid covered.
[8.252.600.9 NMAC - Rp, 8.252.600.9 NMAC, 1/1/2019]

8.252.600.10 BENEFIT DETERMINATION: Completed applications must be acted upon and notice of approval, denial, or delay sent out within 45 days of the date of application. The applicant will have time limits explained, and be informed of the date by which the application should be processed.
[8.252.600.10 NMAC - Rp, 8.252.600.10 NMAC, 1/1/2019]

8.252.600.11 INITIAL BENEFITS: Eligibility is always prospective and begins the month of application. When an eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, the notice shall include reason(s) for denial and the applicant's right to request a fair hearing.
[8.252.600.11 NMAC - Rp, 8.252.600.11 NMAC, 1/1/2019]

8.252.600.12 ONGOING BENEFITS: An eligible recipient is responsible to report changes affecting eligibility within 10 calendar days from the date on which the change took place. Changes in eligibility status will be effective the first day of the following month. A redetermination of eligibility is made every 12 months.

[8.252.600.12 NMAC - Rp, 8.252.600.12 NMAC, 1/1/2019]

8.252.600.13 RETROACTIVE BENEFIT COVERAGE: Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.252.600.13 NMAC - Rp, 8.252.600.13 NMAC, 1/1/2019]

8.252.600.14 CHANGES IN ELIGIBILITY: A recipient's eligibility ends when medical assistance division (MAD) receives information from the treating physician or from the recipient that her course of treatment is completed. A case is closed, with provision of advance notice, when the recipient becomes ineligible. The case is closed the month following the death of an eligible recipient.
[8.252.600.14 NMAC - Rp, 8.252.600.14 NMAC, 1/1/2019]

HISTORY OF 8.252.600 NMAC:

History of Repealed Material:
8.252.600 NMAC, Benefit Description, filed 6-14-02 - Repealed effective 1/1/2014.
8.252.600 NMAC, Benefit Description, filed 12/2/2013 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 259 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEES WITH SPEND DOWN PROVISION
PART 400 RECIPIENT REQUIREMENTS

8.259.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.259.400.1 NMAC - Rp, 8.259.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.259.400.2 SCOPE: The rule applies to the general public.
[8.259.400.2 NMAC - Rp, 8.259.400.2 NMAC, 1/1/2014]

8.259.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.259.400.3 NMAC - Rp, 8.259.400.3 NMAC, 1/1/2014 ; A, 7/1/2024]

8.259.400.4 DURATION: Permanent.
[8.259.400.4 NMAC - Rp, 8.259.400.4 NMAC, 1/1/2014]

8.259.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.259.400.5 NMAC - Rp, 8.259.400.5 NMAC, 1/1/2014]

8.259.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.259.400.6 NMAC - Rp, 8.259.400.6 NMAC, 1/1/2014]

8.259.400.7 DEFINITIONS: [RESERVED]

8.259.400.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.259.400.8 NMAC - N, 1/1/2014]

8.259.400.9 REFUGEE MEDICAL ASSISTANCE SPEND DOWN ONLY - CATEGORY 059: Refer to 8.249.400 NMAC.
[8.259.400.9 NMAC - Rp, 8.259.400.9 NMAC, 1/1/2014]

8.259.400.10 BASIS FOR DEFINING THE GROUP: Refer to 8.249.400 NMAC.
[8.259.400.10 NMAC - Rp, 8.259.400.10 NMAC, 1/1/2014]

8.259.400.11 GENERAL RECIPIENT REQUIREMENTS: Refer to 8.249.400 NMAC.
[8.259.400.11 NMAC - Rp, 8.259.400.11 NMAC, 1/1/2014]

8.259.400.12 ENUMERATION: Refer to 8.249.400 NMAC.
[8.259.400.12 NMAC - Rp, 8.259.400.12 NMAC, 1/1/2014]

8.259.400.13 CITIZENSHIP: Refer to 8.249.400 NMAC.
[8.259.400.13 NMAC - Rp, 8.259.400.13 NMAC, 1/1/2014]

8.259.400.14 RESIDENCE: Refer to 8.249.400 NMAC.
[8.259.400.14 NMAC - Rp, 8.259.400.14 NMAC, 1/1/2014]

8.259.400.15 SPECIAL RECIPIENT REQUIREMENTS: Refer to 8.249.400 NMAC.
[8.259.400.15 NMAC - Rp, 8.259.400.15 NMAC, 1/1/2014]

8.259.400.16 AGE: Refer to 8.249.400 NMAC.
[8.259.400.16 NMAC - Rp, 8.259.400.16 NMAC, 1/1/2014]

8.259.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: Refer to 8.249.400 NMAC.
[8.259.400.17 NMAC - Rp, 8.259.400.17 NMAC, 1/1/2014]

8.259.400.18 ASSIGNMENTS OF MEDICAL SUPPORT: Refer to 8.249.400 NMAC.
[8.259.400.18 NMAC - Rp, 8.259.400.18 NMAC, 1/1/2014]

HISTORY OF 8.259.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 822, Refugee Medical Assistance, filed 5/22/1992.

History of Repealed Material:
MAD Rule 822, Refugee Medical Assistance, filed 5/22/1992 - Repealed effective 2/1/1995.
8.259.400 NMAC, Recipient Requirements, filed 6/13/2003 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 259 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEES WITH SPEND DOWN PROVISION
PART 500 INCOME AND RESOURCE STANDARDS

8.259.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.259.500.1 NMAC - Rp, 8.259.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.259.500.2 SCOPE: The rule applies to the general public.
[8.259.500.2 NMAC - Rp, 8.259.500.2 NMAC, 1/1/2014]

8.259.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.259.500.3 NMAC - Rp, 8.259.500.3 NMAC, 1/1/2014 ; A, 7/1/2024]

8.259.500.4 DURATION: Permanent.
[8.259.500.4 NMAC - Rp, 8.259.500.4 NMAC, 1/1/2014]

8.259.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.259.500.5 NMAC - Rp, 8.259.500.5 NMAC, 1/1/2014]

8.259.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.259.500.6 NMAC - Rp, 8.259.500.6 NMAC, 1/1/2014]

8.259.500.7 DEFINITIONS: [RESERVED]

8.259.500.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.259.500.8 NMAC - N, 1/1/2014]

8.259.500.9 NEED DETERMINATION: Refer to 8.249.500 NMAC.
[8.259.500.9 NMAC - Rp, 8.259.500.9 NMAC, 1/1/2014]

8.259.500.10 RESOURCE STANDARDS: Refer to 8.249.500 NMAC.
[8.259.500.10 NMAC - Rp, 8.259.500.10 NMAC, 1/1/2014]

8.259.500.11 INCOME STANDARDS: Refer to 8.249.500 NMAC.
[8.259.500.11 NMAC - Rp, 8.259.500.11 NMAC, 1/1/2014]

HISTORY OF 8.259.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records: MAD Rule 822, Refugee Medical Assistance, filed 5/22/1992.

History of Repealed Material:
MAD Rule 822, Refugee Medical Assistance filed 5/22/1992 - Repealed effective 2/1/1995.
8.259.500 NMAC, Income and Resource Standards, filed 3/25/2010 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 259 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEES WITH SPEND DOWN PROVISION
PART 600 BENEFIT DESCRIPTION

8.259.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.259.600.1 NMAC - Rp, 8.259.600.1 NMAC, 1/1/2014; A, 7/1/2024]

8.259.600.2 SCOPE: The rule applies to the general public.
[8.259.600.2 NMAC - Rp, 8.259.600.2 NMAC, 1/1/2014]

8.259.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.259.600.3 NMAC - Rp, 8.259.600.3 NMAC, 1/1/2014 ; A, 7/1/2024]

8.259.600.4 DURATION: Permanent.
[8.259.600.4 NMAC - Rp, 8.259.600.4 NMAC, 1/1/2014]

8.259.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.259.600.5 NMAC - Rp, 8.259.600.5 NMAC, 1/1/2014]

8.259.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.259.600.6 NMAC - Rp, 8.259.600.6 NMAC, 1/1/2014]

8.259.600.7 DEFINITIONS: [RESERVED]

8.259.600.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.259.600.8 NMAC - N, 1/1/2014]

8.259.600.9 BENEFIT DESCRIPTION: Refer to 8.249.600 NMAC.
[8.259.600.9 NMAC - Rp, 8.259.600.9 NMAC, 1/1/2014]

8.259.600.10 BENEFIT DETERMINATION: Refer to 8.249.600 NMAC.
[8.259.600.10 NMAC - Rp, 8.259.600.10 NMAC, 1/1/2014]

HISTORY OF 8.259.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 822, Refugee Medical Assistance, filed 5/22/1992.

History of Repealed Material:
MAD Rule 822, Refugee Medical Assistance filed 5/22/1992 - Repealed effective 2/1/1995.
8.259.600 NMAC, Benefit Description, filed 9/3/2013 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 280 MEDICAID ELIGIBILITY - PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)
PART 400 RECIPIENT POLICIES

8.280.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.280.400.1 NMAC - Rp, 8.280.400.1 NMAC, 1/1/2019; A,7/1/2024; A, 7/1/2024]

8.280.400.2 SCOPE: The rule applies to the general public.
[8.280.400.2 NMAC - Rp, 8.280.400.2 NMAC, 1/1/2019]

8.280.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.280.400.3 NMAC - Rp, 8.280.400.3 NMAC, 1/1/2019; A,7/1/2024; A, 7/1/2024]

8.280.400.4 DURATION: Permanent.
[8.280.400.4 NMAC - Rp, 8.280.400.4 NMAC, 1/1/2019]

8.280.400.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.280.400.5 NMAC - Rp, 8.280.400.5 NMAC, 1/1/2019]

8.280.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.280.400.6 NMAC - Rp, 8.280.400.6 NMAC, 1/1/2019]

8.280.400.7 DEFINITIONS: [**RESERVED**]

8.280.400.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.280.400.8 NMAC - N, 2/1/2021]

8.280.400.9 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) - CATEGORIES 081, 083, AND 084: Certain populations meeting financial, non-financial, and medical criteria can receive acute and long-term care services in the community. These services are funded by medicaid on a capitated basis.
[8.280.400.9 NMAC - Rp, 8.280.400.9 NMAC, 1/1/2019]

8.280.400.10 BASIS FOR DEFINING THE GROUP: Recipients and eligible applicants must live in certain designated zip codes within New Mexico. A PACE recipient cannot concurrently receive other medicaid home and community-based services. A PACE recipient may be placed in a qualifying nursing facility upon a medical doctor's orders and continue to participate in PACE. Upon disenrollment from PACE, a former PACE recipient may receive institutional care (IC) medicaid services as long as the individual meets all IC medicaid eligibility requirements. PACE recipients can concurrently receive the qualified medicare beneficiaries program (QMB), the specified low income medicare beneficiaries program (SLIMB), or supplemental security income (SSI). For PACE applicants/recipients who receive SSI benefits no further verification of income, resources, citizenship, age, disability, or blindness is required.
[8.280.400.10 NMAC - Rp, 8.280.400.10 NMAC, 1/1/2019; A, 2/1/2021]

8.280.400.11 APPLICANT AND RECIPIENT REQUIREMENTS: Applicants must live within the designated PACE service area and meet all of the criteria listed below at the time of application and enrollment.

A. Applicants must be 55 years of age or older. Applicants/recipients must be determined blind or disabled if under the age of 65 years.

(1) To be considered blind, an applicant/recipient must have central visual acuity of 20/200 or less with corrective lenses or must be considered blind for practical purposes.

(2) To be considered disabled, an applicant/recipient must be unable to engage in any substantial gainful activity, because of any medically determinable physical, developmental, or mental impairment which has lasted, or is expected to last, for a continuous period of at least 12 months.

(3) If a determination of blindness or disability has not been made, the income support division worker will submit medical reports to the disability determination unit.

B. Level of care requirements must be met in addition to all other requirements. An applicant or recipient must be eligible for institutional nursing facility level of care as determined by the medical assistance division (MAD) utilization review contractor. An institutional level of care must be recommended for the applicant or recipient by a PACE physician licensed to practice medicine or osteopathy in the state of New Mexico. Institutions are defined as acute care hospitals, nursing facilities (either high NF or low NF as defined by medicaid regulations) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID). Level of care determinations are performed by the MAD utilization review contractor. Level of care for approved recipients will be determined on an annual basis.

C. An interview is not required in accordance with 8.281.400.11 NMAC.

D. Upon enrollment, applicants must be able to live in a community setting without jeopardizing their individual health and safety. The ability to live safely in the home and community is determined by the PACE organization's interdisciplinary team.

[8.280.400.11 NMAC - Rp, 8.280.400.11 NMAC, 1/1/2019; A, 2/1/2021, A, 1/1/2022]

8.280.400.12 RECIPIENT RIGHTS AND RESPONSIBILITIES: Applicants and recipients are responsible for establishing eligibility for medicaid. As part of this responsibility, the applicant or recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist.

[8.280.400.12 NMAC - Rp, 8.280.400.12 NMAC, 1/1/2019; A, 2/1/2021]

8.280.400.13 REPORTING REQUIREMENTS: All changes that may affect eligibility must be reported within 10 calendar days of the date of the change in accordance with 8.200.430.18 NMAC.

[8.280.400.13 NMAC - Rp, 8.280.400.13 NMAC, 1/1/2019]

HISTORY OF 8.280.400 NMAC:

History of Repealed Material:

8 NMAC 4.PAC.400, Recipient Policies, filed 1/20/1998 - Repealed effective 12/1/2006.

8.280.400 NMAC - Recipient Policies, filed 11/15/2006 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 280 MEDICAID ELIGIBILITY - PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)
PART 600 BENEFIT DESCRIPTION

8.280.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.280.600.1 NMAC - Rp, 8.280.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.280.600.2 SCOPE: The rule applies to the general public.
[8.280.600.2 NMAC - Rp, 8.280.600.2 NMAC, 1/1/2019]

8.280.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.280.600.3 NMAC - Rp, 8.280.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.280.600.4 DURATION: Permanent.
[8.280.600.4 NMAC - Rp, 8.280.600.4 NMAC, 1/1/2019]

8.280.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.280.600.5 NMAC - Rp, 8.280.600.5 NMAC, 1/1/2019]

8.280.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.280.600.6 NMAC - Rp, 8.280.600.6 NMAC, 1/1/2019]

8.280.600.7 DEFINITIONS: [**RESERVED**]

8.280.600.8 [**RESERVED**]

8.280.600.9 BENEFIT DESCRIPTION: An applicant/recipient who is eligible for PACE is eligible for specified services available under the program. See specific program policy sections for covered services.
[8.280.600.9 NMAC - Rp, 8.280.600.9 NMAC, 1/1/2019]

8.280.600.10 BENEFIT DETERMINATION: Application for PACE is made using the HCA 100 application. Applications must be acted upon and notice of approval, denial, or delay sent out within 45 days of the date of application. The applicant/recipient may complete the form themselves, or receive help from a relative, friend, guardian, or other designated representative. To avoid a conflict of interest, a PACE provider must not complete the application nor be a designated representative.
[8.280.600.10 NMAC - Rp, 8.280.600.10 NMAC, 1/1/2019]

8.280.600.11 INITIAL BENEFITS: An application for PACE can be approved when all factors of eligibility have been met and the individual is enrolled in the program. The effective date for PACE enrollment is the first day of the calendar month following the signing of the enrollment agreement (if all financial, non-financial, and medical eligibility criteria are met and an approved level of care (LOC) is in place). Applicants determined to be ineligible for PACE are notified of the reason for the denial and provided with an explanation of appeal rights. Applicants determined to be eligible for PACE are notified of the approval.
[8.280.600.11 NMAC - Rp, 8.280.600.11 NMAC, 1/1/2019]

8.280.600.12 ONGOING BENEFITS:
A. A complete redetermination of eligibility must be performed annually by the income support division worker for each open case.

B. Level of care reviews are required to be completed at least annually. Level of care determinations for PACE are made by the utilization review contractor.
[8.280.600.12 NMAC - Rp, 8.280.600.12 NMAC, 1/1/2019]

8.280.600.13 RETROACTIVE BENEFITS: Retroactive coverage is not available in the PACE program.
[8.280.600.13 NMAC - Rp, 8.280.600.13 NMAC, 1/1/2019]

8.280.600.14 CHANGES IN ELIGIBILITY: If the recipient ceases to meet any of the eligibility criteria, the case is closed following provision of advance notice as appropriate. See 8.200.430 NMAC for information about notices and hearing rights.

A. Non-provision of PACE services: To be eligible for PACE, an applicant/recipient must receive PACE services. If PACE services are no longer being provided and are not expected to be provided for at least a full calendar month, the recipient is ineligible for the program and the case must be closed after appropriate notice is provided, unless an exception has been prior authorized by MAD.

B. Admission to an acute care or nursing facility: If a PACE recipient enters an acute care or nursing facility, they still remain eligible. A PACE recipient may be disenrolled from the program either voluntarily or involuntarily. If disenrollment occurs, a new application for institutional care medicaid is not required in the following circumstances: the former PACE recipient is in an acute care or nursing facility; they continue to meet all eligibility criteria for institutional care medicaid; or the periodic review on the PACE case is not due in either the month of disenrollment or the following month.

C. Reporting changes in circumstances: The primary responsibility for reporting changes in the recipient's circumstances rests with the recipient or representative. At the initial eligibility determination and all on-going eligibility redeterminations, the income support division (ISD) must explain the reporting responsibilities requirement to the applicant/recipient or representative and document that such explanation was given. In the event that PACE services should cease, the PACE provider must immediately notify the income support division office by telephone of that fact. The telephone call is to be followed by a written notice to the ISD.

D. Disenrollment: A PACE recipient loses medicaid eligibility under this program when they are either voluntarily or involuntarily disenrolled. The PACE provider must inform the ISD office when disenrollment occurs. A **one time only** reinstatement will be allowed if the individual continues to meet all financial, non-financial and medical eligibility criteria. Reinstatement is subject to availability of positions and redetermination of medicaid eligibility. A PACE recipient may voluntarily disenroll at any time. Involuntary disenrollment occurs when any of the following situations exist:

(1) recipient moves out of PACE service area;

(2) recipient is a person with decision-making capacity who consistently does not comply with the individual plan of care and poses a significant risk to self or others;

(3) recipient experiences a breakdown in the physician or team relationship such that the PACE provider ability to furnish services to either the recipients or other recipients is seriously impaired;

(4) recipient refuses services or is unwilling to meet conditions of participation as they appear in the enrollment agreement;

(5) recipient refuses to provide accurate financial information, provides false information or illegally transfers assets;

(6) recipient is out of the PACE service area for more than one calendar month (unless other arrangements have been made);

(7) recipient is enrolled in PACE that loses its contract or licenses which enables it to cover health care services;

(8) recipient fails to meet the financial or non-financial criteria; or

(9) recipient ceases to meet the level of care at any time.

[8.280.600.14 NMAC - Rp, 8.280.600.14 NMAC, 1/1/2019]

HISTORY OF 8.280.600 NMAC:

History of Repealed Material:
8 NMAC 4.PAC.600, Benefit Description, filed 1-20-98 - Repealed effective 12/1/2006.
8.280.600 NMAC - Benefit Description, filed 11/15/2006 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 281 MEDICAID ELIGIBILITY - INSTITUTIONAL CARE (CATEGORIES 081, 083 and 084)
PART 400 RECIPIENT POLICIES

8.281.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.281.400.1 NMAC - Rp, 8.281.400.1 NMAC, 1/1/2019; A, 5/1/2021; A, 7/1/2024]

8.281.400.2 SCOPE: The rule applies to the general public.
[8.281.400.2 NMAC - Rp, 8.281.400.2 NMAC, 1/1/2019]

8.281.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See, Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.281.400.3 NMAC - Rp, 8.281.400.3 NMAC, 1/1/2019 ; A, 7/1/2024]

8.281.400.4 DURATION: Permanent.
[8.281.400.4 NMAC - Rp, 8.281.400.4 NMAC, 1/1/2019]

8.281.400.5 EFFECTIVE DATE: January 1, 2019 , unless a later date is cited at the end of a section.
[8.281.400.5 NMAC - Rp, 8.281.400.5 NMAC, 1/1/2019]

8.281.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.281.400.6 NMAC - Rp, 8.281.400.6 NMAC, 1/1/2019]

8.281.400.7 DEFINITIONS: [RESERVED]

8.281.400.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.281.400.8 NMAC - N, 5/1/2021]

8.281.400.9 INSTITUTIONAL CARE MEDICAID CATEGORIES 081, 083 AND 084: The New Mexico medicaid program (medicaid) pays for services furnished to individuals who require institutional care and who meet all supplemental security income (SSI) eligibility criteria and whose monthly gross countable income is less than the maximum allowed amount for institutional care.
[8.281.400.9 NMAC - Rp, 8.281.400.9 NMAC, 1/1/2019]

8.281.400.10 BASIS FOR DEFINING THE GROUP: An applicant or recipient must require institutional care as certified by a physician licensed to practice medicine or osteopathy. The applicant or recipient must be institutionalized in a medicaid qualifying bed in a New Mexico medicaid approved institution or in a hospital administered under the authority of the US department of veterans affairs (VA). Medicaid approved "Institutions" are defined as acute care hospitals (ACHs), nursing facilities (NFs) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID), swing beds and certified instate inpatient rehabilitation centers. Level of care (LOC) determinations for institutional care medicaid eligibility are made by the MAD utilization review (UR) contractor or a member's selected or assigned Managed Care Organization (MCO). Documentation of these determinations is provided to the institution by the UR contractor or MCO. For applicants or recipients in a hospital awaiting placement in NFs, confirmation letters are furnished by the MAD UR contractor for use by hospital staff. A level of care (LOC) is not required for acute care hospitals. Documentation of acute care hospitalization must be provided by the hospital to determine the eligibility period.
[8.281.400.10 NMAC - Rp, 8.281.400.10 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.11 INTERVIEW REQUIREMENTS:

An interview is not required for institutional care medicaid. An applicant or recipient can request an interview from the income support division (ISD).
[8.281.400.11 NMAC - Rp, 8.281.400.11 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.12 ENUMERATION: An applicant or recipient must furnish their social security number in accordance with 8.200.410.10 NMAC.
[8.281.400.12 NMAC - Rp, 8.281.400.12 NMAC, 1/1/2019; A, 5/1/2021; A, 12/1/2022]

8.281.400.13 CITIZENSHIP: Refer to medical assistance program manual Section 8.200.410.11 NMAC.
[8.281.400.13 NMAC - Rp, 8.281.400.13 NMAC, 1/1/2019]

8.281.400.14 RESIDENCE:

A. Residence in the United States: An applicant or recipient must be residing in the United States at the time of approval. An applicant or recipient who leaves the United States for an entire calendar month loses eligibility. The applicant or recipient must re-establish their residence in the United States for at least 30 consecutive days before becoming eligible for any SSI-related medicaid program.

B. Residence in New Mexico: To be eligible for institutional care medicaid, an applicant or recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have demonstrated intent to remain in the state. If the individual does not have the present mental capacity to declare intent, the parent, guardian or adult child may assume responsibility for a declaration of intent. If the individual does not have the present mental capacity to declare intent and there is no guardian or relative to assume responsibility for a declaration of intent, the state where the person is living is recognized as the state of residence. A temporary absence from the state does not preclude eligibility. A temporary absence exists if the applicant or recipient leaves the state for a specific purpose with a time-limited goal and intends to return to New Mexico when the goal is accomplished.
[8.281.400.14 NMAC - Rp, 8.281.400.14 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.15 SPECIAL RECIPIENT REQUIREMENTS:

A. Institutional care medicaid: To be eligible for institutional care medicaid an applicant or recipient must be aged, blind, or disabled as defined by the social security administration (SSA). Recipients of institutional care medicaid in New Mexico are terminated from assistance if they are transferred to, or choose to move to, a long term care facility out-of-state. New Mexico medicaid does not cover NF services furnished to applicants or recipients in out-of-state facilities with the exception of out-of-state long-term care facilities that are not available in the state of New Mexico in accordance with Subsection F of 8.302.4.12 NMAC.

B. Intermediate care facilities for individuals with intellectual disabilities (ICF/IID): To be eligible for an ICF/IID, applicants or recipients must obtain a match letter from the department of health to confirm that they meet the definition of an individual with a developmental disability as determined by the department of health/developmental disabilities supports division, in accordance with 8.290.400.10 NMAC.
[8.281.400.15 NMAC - Rp, 8.281.400.15 NMAC, 1/1/2019; A, 5/1/2021; A, 12/1/2022]

8.281.400.16 AGED: To be considered aged, an applicant or recipient must be 65 years of age or older. Age is verified by the following:

A. decision from SSA regarding age;

B. acceptable documentary evidence including:

- **(1)** birth certificate or delayed birth certificate;
- **(2)** World War II ration books;
- **(3)** baptismal records;
- **(4)** marriage license or certificate;
- **(5)** military discharge papers;
- **(6)** insurance policies;
- **(7)** Indian census records;
- **(8)** dated newspaper clippings;
- **(9)** voting registration;
- **(10)** World War I registration;
- **(11)** veterans administration records; or
- **(12)** school census.

[8.281.400.16 NMAC - Rp, 8.281.400.16 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.17 BLIND: To be considered blind, an applicant or recipient must have central visual acuity of 20/200 or less with corrective lenses.

A. Documentation of blindness: An applicant or recipient must meet the SSA's definition of blindness. If the applicant or recipient is receiving social security or supplemental security income (SSI) benefits based on the condition of blindness, verification of this factor can be accomplished through documents, such as award letters or benefit checks.

B. Status of SSA determination: If it has not been determined whether an applicant or recipient meets SSA's definition of blindness or if only a temporary determination was made, the ISD worker must request a determination from the disability determination unit (DDU). Eligibility based on blindness cannot be considered to exist without a DDS determination.

C. Redetermination of blindness: A redetermination of blindness by the DDU is not required on a re-application following an applicant or recipient's termination from SSI/SSA or medicaid, if a permanent condition of blindness was previously established or the termination was based on a condition unrelated to blindness and there was no indication of possible improvement in an applicant or recipient's vision.

D. Remedial treatment: If the DDU recommends remedial medical treatment that carries no more than the usual risk or a reasonable plan for vocational training, an applicant or recipient must comply with the recommendation unless good cause for not doing so exists.

[8.281.400.17 NMAC - Rp, 8.281.400.17 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.18 DISABILITY: To be considered disabled, an applicant or recipient under 65 years of age is considered to have a qualifying disability if they are unable to engage in any substantial gainful activity because of any medically determinable physical, developmental, or mental impairment which has lasted, or is expected to last, for a continuous period of at least 12 months.

A. Documentation of disability: An applicant or recipient must meet the social security administration (SSA)'s definition of disability. If the applicant or recipient is receiving social security or supplemental security income (SSI) benefits based on the condition of disability, verification of this factor can be accomplished through documents, such as award letters or benefit checks.

B. Status of SSA determination: If it has not been determined whether an applicant or recipient meets the SSA's definition of disability or if only a temporary determination was made, the ISS must request a determination from the DDU. Eligibility based on disability cannot be considered to exist without a DDS determination.

C. Redetermination of disability: A redetermination of disability by the DDU is not required on a re-application following an applicant or recipient's termination from SSI/SSA or medicaid, if a permanent condition of disability was previously established or the termination was based on a condition unrelated to disability and there was no indication of possible improvement in an applicant/recipient's physical condition.

D. Remedial treatment: If the DDU recommends remedial medical treatment that carries no more than the usual risk or a reasonable plan for vocational training, an applicant or recipient must comply with the recommendation unless good cause for not doing so exists.

[8.281.400.18 NMAC - Rp, 8.281.400.18 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.19 SSI STATUS: The ISD worker determines whether an applicant or recipient's SSI eligibility will continue while they are institutionalized.

A. Applicant/recipient currently eligible for SSI: If an applicant or recipient will not continue to be eligible for SSI while institutionalized, the ISD worker processes the application regardless of the fact that SSA will not terminate SSI benefits until the month following the month the applicant or recipient enters an institution.

B. Applicant not currently receiving SSI: If an applicant or recipient is not receiving SSI or has not applied for SSI before applying for medicaid and their gross income is less than $50, the ISD worker processes the application and refers the applicant to the SSA for determination of eligibility for SSI benefits. If an applicant's gross monthly income is $50 or more but not in excess of the maximum allowable income standard, the ISD worker determines eligibility for institutional care medicaid based on remaining financial and nonfinancial criteria.

[8.281.400.19 NMAC - Rp, 8.281.400.19 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.20 RECIPIENT RIGHTS AND RESPONSIBILITIES: An applicant or recipient is responsible for establishing their eligibility for medicaid. As part of this responsibility, the applicant or recipient must provide

required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant or recipient must also grant the HCA permission to contact other persons, agencies or sources of information, which are necessary to establish eligibility.
[8.281.400.20 NMAC - Rp, 8.281.400.20 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.21 RIGHT TO HEARING: An applicant or recipient residing in an institution can request an administrative hearing to dispute issues relating to the eligibility determination process at the time of the eligibility determination (see Section 8.200.430.12 NMAC, Right to Hearing).
[8.281.400.21 NMAC - Rp, 8.281.400.21 NMAC, 1/1/2019; A, 5/1/2021]

8.281.400.22 ASSIGNMENTS OF MEDICAL SUPPORT: Refer to medical assistance program manual Subsection F of Section 8.200.420.12 NMAC.
[8.281.400.22 NMAC - Rp, 8.281.400.22 NMAC, 1/1/2019]

8.281.400.23 REPORTING REQUIREMENTS: Medicaid recipients must report any change in circumstances, which may affect their eligibility to their local ISD office within 10 days of the change in accordance with 8.200.430.18 NMAC.
[8.281.400.23 NMAC - Rp, 8.281.400.23 NMAC, 1/1/2019; A, 5/1/2021]

HISTORY OF 8.281.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD Rule 380.0000, Medical Assistance For Persons Requiring Institutional Care, filed 12/29/1983.
ISD Rule 380.0000, Medical Assistance For Persons Requiring Institutional Care, filed 8/11/1987.
MAD Rule 380.0000, Medical Assistance For Persons Requiring Institutional Care, filed 2/5/1988.
MAD Rule 380.0000, Medical Assistance For Persons Requiring Institutional Care, filed 2/25/1988.
MAD Rule 380.0000, Medical Assistance For Persons Requiring Institutional Care, filed 6/1/1988.
MAD Rule 380.0000, Medical Assistance For Persons Requiring Institutional Care, filed 1/31/1989.
MAD Rule 380.0000, Medical Assistance For Persons Requiring Institutional Care, filed 6/21/1989.
MAD Rule 880.0000, Medical Assistance For Persons Requiring Institutional Care, filed 3/21/1990.
MAD Rule 880, Medical Assistance For Persons Requiring Institutional Care, filed 5/3/1991.
MAD Rule 880, Medical Assistance For Persons Requiring Institutional Care, filed 6/12/1992.
MAD Rule 880, Medical Assistance For Persons Requiring Institutional Care, filed 11/16/191994.
MAD Rule 882, Resources - Medical Assistance For Persons Requiring Institutional Care, filed 3/9/1993.
MAD Rule 882, Resources - Medical Assistance For Persons Requiring Institutional Care, filed 11/16/191994.
MAD Rule 882, Resources, filed 12/29/191994.
MAD Rule 883, Income - Medical Assistance For Persons Requiring Institutional Care, filed 3/18/1993.
MAD Rule 883, Income - Medical Assistance For Persons Requiring Institutional Care, filed 11/16/191994.
MAD Rule 883, Income, filed 12/29/1994.
MAD Rule 885, Medical Care Credit, filed 11/16/1994.
MAD Rule 888, Medicare Catastrophic Coverage Act of 1988 Regarding Transfers of Assets, filed 3/10/1994.
MAD Rule 888, Transfers of Assets, filed 12/27/1994.
MAD Rule 889, Spousal Impoverishment, filed 8/17/1992.
MAD Rule 889, Spousal Impoverishment, filed 2/17/1994.

History of Repealed Material:
MAD Rule 880, Medical Assistance For Persons Requiring Institutional Care, filed 11/16/1994 - Repealed effective 2/1/191995.
MAD Rule 882, Resources, filed 12/29/1994 - Repealed effective 2/1/1995.
MAD Rule 883, Income, filed 12/29/1994 - Repealed effective 2/1/1995.
MAD Rule 885, Medical Care Credit, filed 11/16/1994 - Repealed effective 2/1/1995.
MAD Rule 888, Transfers of Assets, filed 12/27/1994 - Repealed effective 2/1/1995.
MAD Rule 889, Spousal Impoverishment, filed 2/17/1994 - Repealed effective 2/1/1995.
8.281.400 NMAC - Recipient Policies, filed 6/13/2003 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 281 MEDICAID ELIGIBILITY - INSTITUTIONAL CARE (CATEGORIES 081, 083, 084)
PART 500 INCOME AND RESOURCE STANDARDS

8.281.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.281.500.1 NMAC - Rp, 8.281.500.1 NMAC, 8/15/2015; A, 7/1/2024]

8.281.500.2 SCOPE: The rule applies to the general public.
[8.281.500.2 NMAC - Rp, 8.281.500.2 NMAC, 8/15/2015]

8.281.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.281.500.3 NMAC - Rp, 8.281.500.3 NMAC, 8/15/2015 ; A, 7/1/2024]

8.281.500.4 DURATION: Permanent.
[8.281.500.4 NMAC - Rp, 8.281.500.4 NMAC, 8/15/2015]

8.281.500.5 EFFECTIVE DATE: August 15, 2015, unless a later date is cited at the end of a section.
[8.281.500.5 NMAC - Rp, 8.281.500.5 NMAC, 8/15/2015]

8.281.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs it administers. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) medical assistance programs (MAP) eligibility rules manual, specifically Section 8.200.400 NMAC. Processes for establishing and maintaining MAP eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC.
[8.281.500.6 NMAC - Rp, 8.281.500.6 NMAC, 8/15/2015]

8.281.500.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) Actuarially sound: With respect to an annuity or promissory note, the payments made to the beneficiary must not exceed their life expectancy and returns to the beneficiary an amount at least equal to the amount used to establish the contract.

(2) Annuity: A financial instrument, usually sold by a life insurance company, that pays out a regular income at fixed intervals for a certain period of time, often beginning at a certain age and continuing for the life of the owner.

(3) Asset limit: An applicant or recipient may be eligible for a MAP category of institutional care on the factor of resources if countable resources do not exceed $2,000.

(4) Assets: All income and resources of an applicant or recipient and their spouse, if applicable.

(5) Authorized representative: The individual designated to represent and act on the applicant's or recipient's behalf during the eligibility process. The applicant or recipient or their authorized representative must provide formal 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 claimant.

B. Definitions beginning with "B": Bona fide: A bona fide agreement is made in good faith and is legally valid.

C. Definitions beginning with "C":

(1) Community spouse: The spouse of an institutionalized applicant or eligible recipient who is residing in the community and is not in an institution.

(2) Community spouse resource allowance (CSRA): An amount of a married couple's resources that is set aside for the community spouse when the eligible recipient is institutionalized. There is a MAD

minimum and a federal maximum amount of resources that can be set aside for the community spouse.

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

E. Definitions beginning with "E": Encumbrance: A general term for any claim or lien on a parcel of real property, including mortgages, deeds of trust and abstracts of judgments.

F. Definitions beginning with "F": Fair market value: An estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in appraising the value of assets for the purpose of determining a MAP category of eligibility.

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

H. Definitions beginning with "H": Home equity: (Also known as equity value.) The value of a home minus the total amount owed on it in mortgages, liens and other encumbrances.

I. Definitions beginning with "I":

(1) Income: Anything that an applicant or recipient receives in cash or in kind that [he or she] they can use to meet their needs for food and shelter. In-kind income is not cash, but is actual food or shelter, or something that the applicant or recipient can use to get one of these.

(2) Institutionalized spouse: An applicant or recipient who is in an acute care hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), swing bed or certified in-state inpatient rehabilitation center.

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

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

L. Definitions beginning with "L":

(1) Life estate: An interest in property that exists for the life of a person. For example, an individual gives a life estate in a house to person A and the remainder to person B. Person A has a life estate and person B has a remainder interest until person A dies.

(2) Liquid resource: Cash or something that can easily be converted to cash within 20 business days.

(3) Loan: A transaction in which one party advances money to, or on behalf of another party, who promises to repay the lender in full, with or without interest.

(4) Long-term Care Insurance Policy: A type of insurance developed specifically to cover the costs of nursing homes, assisted living, home health care and other long-term care services as specified in the individual's policy.

(5) Lookback period: A period of time in the past through which the ISD caseworker may examine all financial transactions for asset transfers.

M. Definitions beginning with "M": Minimum monthly maintenance needs allowance: A minimum level of income that the federal government allows to be set aside for the support of the community spouse when the other spouse is in an institution.

N. Definitions beginning with "N":

(1) Negotiable agreement: An agreement (i.e., a loan) in which the ownership of the agreement and the whole amount of money can be transferred from one person to another.

(2) Non-liquid resource: An asset such as real property, which cannot be easily converted to cash within 20 days.

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

P. Definitions beginning with "P":

(1) Promissory note: A promissory note is a written, unconditional agreement in which one person promises to pay a specified sum of money at a specified time to another person.

(2) Protected Asset Limit: Protected assets up to the amount of qualified long-term care insurance partnership (QLTCPI) benefit payments made to or on the behalf of individual. This is the applicant's or recipient's protected asset limit (PAL).

Q. Definitions beginning with "Q": Qualified state long-term care insurance partnership (QSLTCIP) program: A partnership program that joins MAD with private insurance companies that offer long-term care insurance policies. The MAP eligibility requirements are adjusted to provide financial incentives for eligible recipients to purchase private QSLTCIP coverage.

R. Definitions beginning with "R":

(1) Relative: Relative is defined as a spouse, son or daughter; grandson or granddaughter; step-son or step-daughter; in-laws; mother or father; step-mother or step-father; half-sister or half-brother; grandmother or grandfather; aunt or uncle; sister or brother; step-brother or step-sister; and niece or nephew.

(2) Remainder/remainder man: An interest in property that occurs after a life estate. For

example, an individual gives a life estate in a house to person A and the remainder to person B. Person A has a life estate and Person B has a remainder interest until person A dies. Person B is also called the remainderman.

(3) Resources: Cash or other liquid assets and any real or personal property that applicant or recipient (or spouse if any) owns and could convert to be used for their support and maintenance.

(4) Restricted coverage: An eligible recipient who has restricted coverage may access medically necessary MAD benefits except for long-term care services in a nursing facility.

(5) Reverse mortgage: A loan against home equity providing cash advances to a borrower and requiring no repayment until a future date.

S. Definitions beginning with "S":

(1) Sole benefit of: A transfer is considered for the sole benefit of a spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind, or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

(2) Spouse: For purposes of this rule, a spouse is an individual who is legally married under the laws of a state, a territory, or a foreign jurisdiction in which the marriage was celebrated.

T. Definitions beginning with "T": Transfer: To change over the possession, control or ownership of something.

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

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

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

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

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

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

[8.281.500.7 NMAC - Rp, 8.281.500.7 NMAC, 8/15/2015; A, 3/1/2018; A, 12/1/2022]

8.281.500.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.281.500.10 NMAC - N, 12/1/2022]

8.281.500.9 NEED DETERMINATION: Applicants for and recipients of institutional care must apply for and take all necessary steps to obtain any income or resources to which they may be entitled. When an applicant or recipient is given notification by HCA to apply for and obtain specific income and resources they must take steps to do so within 30 calendar days.

A. Failure to apply for and take steps to determine eligibility for other benefits: Failure or refusal to apply for and take all necessary steps to determine eligibility for other benefits after notice is received results in an applicant or recipient becoming ineligible for a MAP category of eligibility for institutional care.

B. Exceptions to general requirement: Applicants or recipients who have elected a lower veterans administration (VA) payment do not need to reapply for veterans administration improved pension (VAIP) benefits. Crime victims are not required to accept victims compensation payments from a state-administered fund as a condition of MAP eligibility.

[8.281.500.9 NMAC - Rp, 8.281.500.9 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.10 RESOURCE STANDARDS: A "resource" is defined as cash or liquid assets and real or personal property which is owned and can be used either directly, or by sale or conversion, for the applicant's or recipient's support and maintenance. Resources may be liquid or non-liquid and may be excluded from the eligibility determination process under certain conditions. A liquid resource is an asset which can readily be converted to cash. A non-liquid resource is an asset or property which cannot readily be converted to cash.

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

B. Distinguishing between resources and income: Resources must be distinguished from income to avoid counting a single asset twice. As a general rule, ownership of a resource precedes the current month while income is received in the current month. Income held by an applicant or recipient until the following month

becomes a resource.
[8.281.500.10 NMAC - Rp, 8.281.500.10 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.11 APPLICABLE RESOURCE STANDARDS: The resource criteria and eligibility standards of this section apply to all applicants for and recipients of a MAP category of eligibility for institutional care. An applicant or recipient is eligible for a MAP category of eligibility for institutional care on the factor of resources if countable resources do not exceed $2,000. Some of an applicant's or recipient's resources are counted in the eligibility determination and some resources are excluded. Any resource which is not specifically excluded in Section 8.281.500.13 NMAC is considered a countable resource for the purpose of determining a MAP category of eligibility for institutional care.

A. Liquid resources: A liquid resource is cash or something that can easily be converted to cash within 20 business days. The face or surrender value of liquid resources such as cash, savings or checking accounts, and other financial instruments are considered in determining a MAP category of eligibility. The countable value of liquid resources is based on their current fair market value.

(1) An applicant or recipient must provide verification of the value of all liquid resources. The resource value of a bank account is customarily verified by a statement from the bank showing the account balance as of the first moment of the first day of the month in question. If an applicant or recipient cannot provide this verification, the ISD worker provides the applicant or recipient with a detailed request of all documents needed to determine a MAP category of eligibility.

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

B. Non-liquid resources: A non-liquid resource is something such as real property that cannot easily be converted to cash within 20 business days. The value of non-liquid resources is computed at current market value minus encumbrances or financial penalties for early withdrawal.
[8.281.500.11 NMAC - Rp, 8.281.500.11 NMAC, 8/15/2015]

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

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

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

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

(2) Unrestricted use of resource: An applicant or recipient is considered to have free access to the unrestricted use of a resource even if they can take those actions only through an agent, such as a representative payee, guardian, conservator, trustee, or another authorized representative. If there is a legal bar to the sale of a resource, the resource is not countable. However, if a co-owner of real property can bring an action to partition and sell the property, their interest in the property is a countable resource.

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

D. Joint ownership of resources: If an applicant or recipient owns either liquid or non-liquid resources jointly with others, they have 30 calendar days from the date requested by the ISD worker to submit all documentation required to verify their claims regarding ownership of, access to, and legal ability to use the resource for personal support and maintenance. Failure to do so results in the presumption that the resource is countable and belongs to the applicant or recipient.

(1) Jointly held property: If jointly held property is identified during review of an active case, the ISD worker must:

(a) determine whether the property is a countable resource;

(b) determine whether the value of the jointly held property plus the value of other countable resources exceeds the allowable resource maximum; and

(c) if the value of countable resources exceeds the allowable maximum, advance notice is furnished to the applicant or recipient of the intent to close their case and their right to verify claims regarding ownership of, access to, and legal ability to use the property for personal support and maintenance.

(i) If the applicant or recipient fails to provide required information or respond within the advance notice period, their case is closed.

(ii) If, after expiration of the advance notice period but prior to the end of the month in which the advance notice expires, the applicant or recipient provides the required evidence to show the property is not a countable resource, or is countable in an amount which, when added to the value of other countable resources, does not exceed the maximum allowable limit, and eligibility continues to exist on all other factors, the case is reinstated for the next month.

(2) Joint bank accounts: If liquid resources are in a joint bank account of any type, the applicant's or recipient's ownership interest, while the parties to the account are alive, is presumed to be proportionate to the applicant's or recipient's contributions to the total resources on deposit.

(a) The applicant or recipient is presumed to own a proportionate share of the funds on deposit unless they present clear and convincing evidence that the parties to the account intended the applicant or recipient to have a different ownership interest.

(b) To establish the applicant's or recipient's ownership interest in a joint account, the following are required:

(i) statement by the applicant or recipient regarding contributions to the account; reasons for establishing the account; who owns the funds in the account; and any supporting documentation; plus

(ii) corroborating statements from the other account holder(s);

(iii) if either the applicant or recipient or the other account holder is not capable of making a statement, the applicant or recipient or an authorized representative must obtain a statement from a third party who has knowledge of the circumstances surrounding the establishment of the joint account.

(c) Failure to provide required documentation within 30 calendar days of the date requested by the ISD worker results in a determination that the entire account amount belongs to the applicant or recipient.

(d) If the existence of a jointly held bank account is identified during the review of an active case, the ISD worker requests evidence of ownership and accessibility. If the evidence is not furnished within 30 calendar days of the request, their case is closed.

(3) Life estate: A life estate interest in the applicant's or recipient's own home will count as a resource if the applicant or recipient has not resided on the property continuously for at least 12 months from the date of the life estate purchase. For a purchase of a life estate in the home of another, see Subsection D of 8.281.500.14 NMAC.

(a) The "unisex life estate and remainder interest tables" are used to determine the value of a life estate. See 8.200.520 NMAC. The value is computed by multiplying the current fair market value by the percentage reduction on the unisex table under the column for the applicant's or recipient's age.

(b) If an applicant or recipient feels the value calculated based on this method is overstated, they can obtain a valuation of the life estate in the area for use as documentation of lesser value.

E. The home as a countable resource: If the applicant or recipient or their authorized representative states the applicant or recipient does not intend to return to the home and it is not the residence of applicant's or recipient's spouse or dependent relative, the home is considered a countable resource. If the applicant or recipient or their authorized representative puts the home up for sale and it is not the primary residence of the applicant's or recipient's spouse or a dependent relative, the home is considered a countable resource. A dependent relative is a minor child or adult disabled child of the applicant, recipient, or community spouse.

F. Value of property: The applicant or recipient must supply HCA with written documentation regarding the fair market value of the property from a real estate agent, title company or mortgage insurance company familiar with the area in which the property is located in addition to any encumbrances against the property. The ISD worker determines the equity value of the property by subtracting the amount of the encumbrances from the fair market value of the property.

G. Hardship: Applicants or recipients who are on restricted coverage due to excess equity in their homes may request an undue hardship waiver based on the criteria specified in 8.281.500.24 NMAC.

H. Real property:

(1) If an applicant or recipient is the sole owner of real property, other than the applicant's or recipient's or their primary residence and has the right to dispose of it, the entire equity value is included as a

countable resource.

(2) If an applicant or recipient owns property with one or more individuals and the applicant or recipient has the right, authority or power to liquidate the property or their pro-rata share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource to applicant or recipient. The applicant or recipient must provide a copy of the legal document which indicates their interest in the property.

I. Vehicles: One automobile is totally excluded regardless of value if it is used for transportation for the applicant or recipient or a member of applicant's or recipient's household. Any other automobiles are considered to be non-liquid resources. Recreational vehicles and boats are considered household goods and personal effects rather than vehicles.

J. Household goods and personal effects: Household goods and personal effects are considered countable resources if the items were acquired or are held for their value or are held as an investment. Such items can include but are not limited to gems and jewelry that is not worn or held for family significance, or collectibles.

K. Promissory notes: If an applicant or recipient holds or owns a promissory note and the note is negotiable, it is a countable resource. The value is the outstanding principal balance due at the time of the applicant's or recipient's MAP application, unless the applicant or recipient proves that it has a lower value.

(1) A promissory note held by the applicant or recipient must be a bona fide loan. This means that it must be legally valid and made in good faith. The ISD worker must evaluate the note and determine whether or not it is a bona fide loan. In order to determine if the note is a bona fide loan, the ISD worker should obtain documentation of the applicant's or recipient's receipt of payments on the note at the time of application and at re-certification. If the applicant or recipient sells or transfers the promissory note, then [he or she] they may be subject to a penalty for a transfer of assets for less than fair market value.

(2) If the promissory note is non-negotiable, and the applicant or recipient receives payments on the note that could be used for food or shelter, then the amount of the payment retained in the month following receipt is a resource to the applicant or recipient.

(3) If an applicant or recipient purchases a promissory note, loan or mortgage, the repayment terms must be actuarially sound, provide for equal payment amounts with no deferral or balloon payments, and it must contain a provision that prohibits cancellation of the balance upon the death of the lender. A promissory note not meeting these requirements shall be treated as a transfer of assets for less than fair market value. If a promissory note does not meet these requirements, the value of the note, loan or mortgage is the outstanding balance due on the date of the applicant's or recipient's MAP application.

L. Pension funds: A pension fund, if accessible to the applicant or recipient, is a countable resource. Any fees for withdrawal of the funds are subtracted from the balance and the remainder is a countable resource.

M. Individual retirement accounts (IRA): An IRA is a tax-deductible savings account that sets aside money for retirement. Funds in an IRA are counted as an asset in their entirety less the amount of penalty for early withdrawal.

N. Keogh plan: A Keogh plan is a retirement plan established by a self-employed applicant or recipient alone or for the self-employed applicant or recipient and their employees. If the Keogh plan was established for the self-employed applicant or recipient alone, the funds in the plan are counted as an asset in their entirety less the amount of penalty for early withdrawal. If the Keogh plan was established for employees other than the spouse of the applicant or recipient, the funds do not count as an asset.

O. Loans: In some circumstances a loan may be a countable resource.

(1) Negotiable loan. If an applicant or recipient owns a loan agreement or is a lender and the agreement is a negotiable, bona fide loan:

(a) the outstanding principal balance is a resource of the applicant or recipient;

(b) the cash provided to the borrower is no longer the applicant or recipient lender's resource because they cannot access it for their own use; the loan agreement replaces the cash as the applicant or recipient lender's resource;

(c) payments that the applicant or recipient lender receives from the borrower against the loan principal are conversions of a resource, not income; if retained, the payments are counted as the applicant or recipient lender's resource starting in the month following the month of receipt; and

(d) interest income received by the applicant or recipient lender is unearned income.

(2) Non-negotiable loan. If the applicant or recipient owns a loan agreement or is a lender and the loan agreement is not a bona fide loan or is not negotiable:

(a) the agreement is not a resource of the applicant or recipient lender;

(b) payments against the principal are income to the applicant or recipient lender,

not conversion of a resource;

(c) the cash specified in the agreement may be a resource if the applicant or recipient lender can access it for their own use; and

(d) interest income received by the applicant or recipient lender is unearned income.

(3) Bona fide loan. If the applicant or recipient is the borrower and the agreement is a bona fide loan:

(a) the loan agreement itself is not a resource for the applicant or recipient; and

(b) the cash provided by the applicant or recipient lender is not income, but is the borrower's resource if retained in the month following the month of receipt.

(4) Not a bona fide loan. If the applicant or recipient is the borrower and the agreement is not a bona fide loan:

(a) the loan agreement itself is not a resource of the applicant or recipient; and

(b) the cash provided by the applicant or recipient lender is income in the month received and is a resource if retained in the month following the month it was received.

(5) Informal loan. If the agreement is an agreement between applicants or recipients who are not in the business of lending money or providing credit, it is an informal loan. An informal loan is bona fide if it meets all of the following criteria:

(a) the agreement is enforceable under state law;

(b) the agreement is in effect at the time that the cash is provided to the borrower; money given to an applicant or recipient with no obligation to repay cannot become a loan at a later date;

(c) the obligation to repay the loan must be acknowledged by both the applicant or recipient lender and the borrower; when money or property is given and accepted based on any understanding other than it is to be repaid by the receiver, there is no loan;

(d) the agreement must include a plan or schedule for repayment, and the borrower's express intent to repay by pledging real or personal property or anticipated future income (such as social security insurance (SSI) benefits);

(e) the repayment plan or schedule must be feasible; in determining the plan's feasibility, consider the amount of the loan, the applicant's or recipient's resources and income and the applicant's or recipient's living expenses;

(f) if the applicant or recipient is the borrower, the loan proceeds are a resource if they are retained in the month following the month of receipt; the resource value is the amount of the proceeds that the applicant or recipient still holds in the month following the month of receipt;

(g) if the applicant or recipient is the lender, the agreement is a countable resource starting in the month after the month that the applicant or recipient lender provides the proceeds to the borrower; and

(h) the agreement's resource value is the outstanding principal balance unless the applicant or recipient lender provides evidence that the loan has a lower value.

P. Other financial instruments: Other financial instruments will be evaluated by HCA to determine if they are a countable resource.

Q. Continuing care retirement community, assisted living, life care community or like living arrangement: The portion of initial fees paid upon signing a contract for housing and care that has a potential to be refunded to the applicant or recipient is countable.

R. Other countable resources: Other liquid or non-liquid resources must be considered in the calculation of total countable resources. The following non-liquid resources may be included in the calculation of countable resources if they cannot be excluded pursuant to 8.281.500.13 NMAC:

(1) burial funds;

(2) burial spaces;

(3) life insurance and other insurance products such as annuities;

(4) income-producing property; and

(5) other financial investment products.

[8.281.500.12 NMAC - Rp, 8.281.500.12 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.13 RESOURCE EXCLUSIONS: Some types of resources can be excluded from the calculation of countable resources if they meet the specific criteria listed below.

A. Burial fund exclusion: Up to $1,500 can be excluded from the countable liquid resources of an applicant or recipient if designated as their burial fund. An additional amount of up to $1,500 can be excluded from countable liquid resources if designated as burial funds for the spouse of the applicant or recipient. The burial fund

exclusion is separate from the burial space exclusion.

(1) Retroactive designation of burial funds: An applicant or recipient can retroactively designate funds for burial back to the first day of the month in which the applicant or recipient intended the funds to be set aside for burial. The applicant or recipient must sign a statement indicating the month the funds were set aside for burial.

(2) Limit on exclusion: An applicant or recipient can designate as much of their liquid resources as they wish for burial purposes. However, only one burial fund allowance of up to $1,500 each for the applicant or recipient and their spouse can be excluded from countable resources. A burial fund exclusion does not continue from one period of eligibility to another (i.e., across a period of ineligibility). For each new period of eligibility, any exclusion of burial funds must be developed as for an initial application.

(3) Removal of designation: An applicant or recipient cannot "un-designate" burial funds, unless one of the following occurs:

(a) eligibility terminates;

(b) part, or all, of the funds can no longer be excluded because the applicant or recipient purchased excluded life insurance or an irrevocable burial contract which partially or totally offsets the available burial fund exclusion; or

(c) the applicant or recipient uses the funds or any portion of the funds for another purpose; this action makes the funds countable; any designated burial funds used for another purpose will be counted as income in the month withdrawn and as a resource thereafter.

(4) Reduction of burial fund exclusion: The $1,500 burial fund exclusion is reduced by the following:

(a) the face value of excluded life insurance policies;

(b) assets held in irrevocable burial trusts; irrevocable means the value paid cannot be returned to the applicant or recipient;

(c) assets that are not burial space items held in irrevocable burial contracts;

(d) assets held in other irrevocable burial arrangements; and

(e) assets held in an irrevocable trust available to meet burial expenses.

(5) Interest from burial fund: Interest derived from a burial fund is not considered a countable resource or income if all the following conditions exist:

(a) the original amount is excluded;

(b) the excluded burial fund is not commingled with non-excluded burial funds;

(c) the interest earned remains with the excluded burial funds.

(6) Commingling of burial funds: Burial funds cannot be commingled with non-burial funds. If only part of the funds in an account are designated for burial, the burial fund exclusion cannot be applied until the funds designated for burial expenses are separated from the non-burial funds. Countable and excluded burial funds can be commingled.

(7) Life insurance policy designated as burial fund: An applicant or recipient can designate a life insurance policy as a burial fund at the time of application. The ISD caseworker must first analyze Subsection H of 8.281.500.13 NMAC [of this rule].

(8) Burial contracts: If an applicant or recipient has a prepaid burial contract, the ISD caseworker determines whether it is revocable or irrevocable and whether it is paid for. Until all payments are made on a burial contract, the amounts paid are considered burial funds and no burial space exclusions apply.

(a) An applicant or recipient may have a burial contract which is funded by a life insurance policy. The life insurance may be either revocably or irrevocably assigned to a funeral director or mortuary.

(b) A revocable contract exists if the value can be returned to the applicant or recipient. An irrevocable contract exists when the value cannot be returned. If the contract or insurance policy assignment is revocable, the following apply.

(i) If the burial contract is funded by a life insurance policy, the policy is the resource which must be evaluated. The burial contract itself has no value. It exists only to explain the applicant's or recipient's burial arrangements.

(ii) No exclusions can be made for burial space items because the applicant or recipient does not have a right to them if the contract is not paid for or the policy is not paid up.

(c) If the assignment is irrevocable, the life insurance or burial contract is not a countable resource, because the applicant or recipient does not own it.

(i) The burial space exclusions can apply if the applicant or recipient has

the right to the burial space items.

(ii) The value of the irrevocable burial arrangement is applied against the $1,500 burial fund exclusion only if the applicant or recipient has other liquid resources to designate for burial.

B. Burial space exclusion: A burial space or an agreement which represents the purchase of a burial space held for the burial of an applicant or recipient, their spouse, or any other member of their immediate family is an excluded resource regardless of value. Interest and accruals on the value of a burial space are excluded from consideration as countable income or resources.

(1) When calculating the value of resources to be deemed to an applicant or recipient from their parent(s) or spouse, the value of spaces held by the parent(s) or spouse which are to be used for the burial of the applicant or recipient, or any member of the applicant's or recipient's immediate family, including the deemer parent or spouse, must be excluded.

(2) The burial space exclusion is separate from, and in addition to, the burial fund exclusion.

(3) Burial space definitions: "Burial space" is defined as a burial plot, gravesite, crypt, mausoleum, casket, urn, niche, or other repository customarily used for the deceased's bodily remains.

(a) A burial space also includes necessary and reasonable improvements or additions, such as vaults, headstones, markers, plaques, burial containers (e.g., caskets), arrangements for the opening and closing of a gravesite, and contracts for care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care.

(b) Items that serve the same purpose are excluded once per applicant or recipient, such as excluding a cemetery lot and a casket, but not a casket and an urn.

(4) Burial space contract: An agreement which represents the purchase of a burial space is defined as a contract with a burial provider for a burial space held for the eligible applicant or recipient or a member of their immediate family.

(a) Until all payments are made on the contract, the amounts paid are considered burial funds and no burial space exclusions apply.

(b) An applicant's or recipient's immediate family includes:

(i) spouse;

(ii) natural or adoptive parents;

(iii) minor or adult children, including adoptive and stepchildren;

(iv) siblings, including adoptive and stepsiblings; and

(v) spouse of any of the above relatives.

(c) If a relative's relationship to an applicant or recipient is by marriage only, the relationship ceases to exist upon the dissolution of the marriage.

(5) Burial space "held" for an applicant or recipient: A burial space is considered held for an applicant or recipient if:

(a) someone has title to or possesses a burial space intended for the use of the applicant or recipient or a member of their immediate family; or

(b) someone has a contract with a funeral service company for a specified burial space for the applicant or recipient or a member of their immediate family, such as an agreement which represents the applicant's or recipient's current right to the use of the items at the amount shown.

(6) Until the purchase price is paid in full, a burial space is not considered "held for" an applicant or recipient under an installment sales contract or similar device if:

(a) the applicant or recipient does not currently own the space;

(b) the applicant or recipient does not currently have the right to use the space; and

(c) the seller is not currently obligated to provide the space.

C. Life estate exclusion: The value of a life estate interest in the applicant's or recipient's own home or in the home of another is excluded if the applicant or recipient has continuously resided in the home for a period of 12 months or more from the date of the life estate purchase. The value of the remainderman's interest when a life estate is retained in one's own home is considered a transfer of resources to be evaluated in accordance with 8.281.500.14 NMAC.

D. Settlement exclusions: Agent orange settlement payments made to applicant or recipient veterans or their survivors are excluded from consideration as resources.

(1) Payments made under the Radiation Exposure Compensation Act are excluded from consideration as resources.

(2) Payments received from a state-administered fund established to aid victims of crime are excluded for nine months beginning the month after the month of receipt.

(3) Payments under the foundation called 'remembrance, responsibility and the future', excluded from consideration as resources.

E. Exclusions for real property and home: A home is any shelter used by an applicant or recipient, or their spouse, as the principal place of residence. The home is not considered a countable resource while in use by the applicant, recipient, or their spouse as a principal place of residence. If an applicant's or recipient's home equity value exceeds the amount allowed under 8.200.510 NMAC, then the entire valued amount of their home is a countable resource. An applicant or recipient with home equity of more than the amount specified shall be placed on restricted coverage for as long as they own the home. The home includes any buildings and contiguous land used in the operation of the home. If the amount is equal to or less than allowed under 8.200.510 NMAC, then their home is excluded during the periods when they reside in an acute care or long-term care medical facility when the applicant or recipient, or their authorized representative, states that the applicant or recipient intends to return to their home.

F. Exclusion of home: If the applicant or recipient or their authorized representative states the applicant or recipient does not intend to return to the home, but the home is the residence of the applicant's or recipient's spouse or dependent minor child or adult disabled child, the home is an excluded resource.

G. Income-producing property exclusion: To be excluded from consideration as a countable resource, income-producing property that does not qualify as a bona fide business (e.g., rental property or mineral rights) must have an equity value of no more than $6,000 and an annual rate of return of at least six percent of the equity value. See Subsection F of 8.281.500.13 NMAC if the equity value exceeds $6,000 but the rate of return is at least six percent annually. The $6,000 and six percent limitation does not apply to property used in a trade or bona fide business, or to property used by an applicant or recipient as an employee which is essential to the applicant's or recipient's self-support (e.g., tools used in employment as a mechanic, property owned or being purchased in conjunction with operating a business). Existence of a bona fide business can be established by documentation such as business tax returns.

(1) Determination of rate of return: To calculate the annual rate of return for income producing property when the $6,000 and six percent limits apply, the previous year's income tax statement, or at least three months earnings is used to project the rate of return for the year.

(a) If the income is sporadic or has decreased from that needed to maintain a six percent rate of return for the coming year, the property is reevaluated at appropriate intervals.

(b) If the annual rate of return is at least six percent of the equity value but the equity value exceeds $6,000, only the excess equity is a countable resource.

(c) If the annual rate of return is less than six percent but the usual rate of return is more, the property is excluded as a countable resource if all the following conditions are met:

(i) unforeseeable circumstances, such as a fire, cause a temporary reduction in the rate of return;

(ii) the previous year's rate of return, as documented by the income tax statement or several months receipts, is at least six percent; and

(iii) the property is expected to produce a rate of return of at least six percent within 18 months of the end of the year in which the adverse circumstances occurred; the ISD caseworker records in the case narrative the plan of action which is expected to increase the rate of return.

(d) The ISD caseworker notifies the applicant or recipient in writing that the property is excluded based on its expected increase in return and that it will be reevaluated at the end of the 18 month grace period. When this period ends, the property must be producing an annual rate of at least six percent to continue to be excluded as a countable resource.

(2) Types of income-producing property: Income-producing property includes:

(a) a business, such as a farm or store, including necessary capital and operating assets such as land and buildings, inventory or livestock; the property must be in current use or have been used with a reasonable expectation of resumed use within a year of its most recent use; the ISD caseworker must account for the cash actually required to operate the business; liquid business assets of any amount are excluded;

(b) non-business property includes rental property, leased property, land leased for its mineral rights, and property producing items for home consumption; property which produces items solely for home use is assumed to be producing an annual rate of return of at least six percent;

(c) employment-related property, such as tools or equipment; the applicant or recipient must provide a statement from their employer to establish that tools or equipment are required for continued employment when the applicant or recipient leaves the institution; if the applicant or recipient is self-employed, only those tools normally required to perform the job adequately are excluded; the applicant or recipient

must obtain a statement from someone in the same line of self-employment to establish what is excludable.

H. Vehicle exclusion: The term "vehicle" includes any mode of transportation such as a passenger car, truck or special vehicle. Included in this definition are vehicles which are unregistered, inoperable, or in need of repair. Vehicles used solely for purposes other than transportation, such as disassembly to resell parts, racing or as an antique, are not included in this definition. Recreational vehicles and boats are classified as personal effects and are evaluated under the household goods and personal effects exclusion. One vehicle is totally excluded if regardless of value if it is used for transportation for the applicant or recipient or a member of their household. Any other automobiles are considered to be non-liquid resources. Equity in the other automobiles is counted as a resource.

I. Life insurance exclusion: The value of life insurance policies is not considered a countable resource if the total cumulative face value of all policies owned by the applicant or recipient does not exceed $1,500. A policy is considered to be "owned" by the applicant or recipient if the applicant or recipient is the only one who can surrender the policy for cash.

(1) Consideration of burial insurance and term insurance: Burial insurance and term insurance are not considered when computing the cumulative face value because this insurance is redeemable only upon death.

(2) Calculation when value exceeds limit: If the total cumulative face value of all countable life insurance policies owned by the applicant or recipient exceeds $1,500, the ISD caseworker:

(a) verifies the total cash surrender value of all policies and considers the total amount a countable resource;

(b) informs the applicant or recipient that the insurance policies can be converted to term insurance or ordinary life insurance of lower face value at their option, if the cash surrender value, alone or in combination with other countable resources, exceeds the resource standard.

J. Qualified State Long-term Care Insurance Partnership (QSLTCIP) program: A resource exclusion equal to the amount of the qualified long-term care insurance benefit payments is made to or on the behalf of the applicant or recipient as determined during their eligibility process.

(1) In order to be considered a QSLTCIP policy it must meet the requirements set forth in 1917(a) of the Social Security Act.

(2) The applicant or recipient:

(a) must have been a beneficiary of a QSLTCIP that was purchased on or after August 15, 2015; or

(b) must have a QSLTCIP policy established in another state with a CMS approved state plan for state long-term care insurance partnerships and the beneficiary must have been a resident of such a state on the date the policy was purchased; or

(c) must be a current New Mexico resident and after August 14, 2015 have purchased a long-term care policy that was converted to a QSLTCIP through an endorsement, exchange, or rider.

(3) Long-term care insurance does not qualify as a QSLTCIP.

(4) Resources excluded in the amount of benefits paid out are also excluded in the estate recovery process.

(5) Resources can be designated for protection when a MAP category of eligibility for either institutional care services or home and community based services is established, while receiving MAD benefits provided through institutional care or home and community based waiver programs, or during the estate recovery process after a recipient dies.

(6) An applicant or recipient may protect assets up to the amount of QSLTCIP benefit payments made to or on the behalf of an applicant or recipient; this is the eligible applicant or recipient's protected asset limit (PAL). If the value of protected assets exceeds the PAL, the excess value is counted against the asset limit and is not protected in estate recovery.

(7) The following conditions may apply to assets protected under a QSLTCIP:

(a) an applicant or recipient may keep protected resources;

(b) the value of protected assets is updated each year at the MAP eligibility review; the updated value is the counted towards the PAL;

(c) an applicant or recipient may transfer a protected asset to another person without a transfer penalty; a transferred asset is counted against the PAL based on the value of the asset on the day it was transferred;

(d) an applicant or recipient may use a protected asset to obtain another protected asset, which then becomes the protected asset;

(e) an applicant or recipient can spend or deplete a protected asset; the asset continues to be protected and is counted against the PAL even though the applicant or recipient no longer has it;

(f) once an asset is officially designated for protection, it cannot be undesignated in favor of designating another asset;

(g) changes in the status of protected assets must be reported at the recipient's annual re-determination for MAP eligibility; some examples of changes are transferring, spending, depleting, or replacing an asset; and

(h) new countable assets that are reported in-between MAP eligibility renewals must be evaluated when reported to determine if they can be protected under the QSLTCIP program's PAL;

(i) the following assets cannot be protected under the QSLTCIP program and must be made available after the death of the recipient to reimburse HCA up to the amount of the paid MAD benefits on the deceased recipient behalf;

(i) special and or supplemental needs, pooled charitable trusts, irrevocable trusts with a reversionary state interest, or income diversion trusts; and

(ii) annuity interest where HCA has been named a reminder beneficiary.

(8) Unused asset protection may result because all available asset protection was not used at the time of designation or when an applicant or recipient PAL has increased because the applicant or recipient continues to receive benefits from a QSLTCIP while receiving MAD benefits.

(9) Unused asset protection will automatically apply to protect assets already officially indicated for protection when the value of the asset has increased and there is unused asset protection.

(10) Unused asset protection may also be used to more fully cover an asset that is only partially protected, protect additional assets that have become available during a recipient's lifetime, or to protect assets in a recipient's estate after they die.

K. Produce for home consumption exclusion: The value of produce for home consumption is totally excluded.

L. Exclusion of settlement payments from the federal department of housing and urban development: Payments from the department of housing and urban development (HUD) as defined in *Underwood v. Harris* are excluded as income and resources. These one-time payments were made in the spring of 1980 to certain eligible tenants of subsidized housing (Section 236 of the National Housing Act).

(1) Segregation of payment: To be excluded as a resource, payments retained by an applicant or recipient must be kept separate; these payments must not be combined with any other countable resources.

(2) Income from segregated funds: Interest or dividend income received from segregated payment funds is not excluded from income, or, if retained, is not an excluded resource; this interest or dividend income must be kept separate from excludable payment funds.

M. Lump sum payments exclusion: SSI and social security lump sum payments for retroactive periods are excluded as countable resources for nine months after the month in which they are received. See Subsection B of 8.281.500.15 NMAC for instructions regarding SSI and social security lump sums which are placed into the ownership of a MAD qualifying trust. Social security lump sum payments are considered infrequent income. See Subsection C of 8.281.500.19 NMAC.

N. Home replacement exclusion: The proceeds from a reverse mortgage from the sale of an excluded home is excluded. Additionally, the value of a promissory note or similar installment sales contract which constitutes proceeds from the sale of an excluded home is excluded from countable resources if all of the following conditions are met:

(1) the note results from the sale of the applicant's or recipient's home as described in Subsection E of 8.281.500.13 NMAC;

(2) within three months of receipt (execution) of the note, the applicant or recipient purchases a replacement home which meets the definition of a home in Subsection E of 8.281.500.13 NMAC;

(3) all note-generated proceeds are reinvested in the replacement home within three months of receipt;

(4) additional exclusions: in addition to excluding the value of the note itself, the down payment received from the sale of the former home, as well as that portion of any installment amount constituting payment on the principal are also excluded from countable resources;

(5) failure to purchase another excluded home timely: if the applicant or recipient does not purchase another home which can be excluded under the provisions of Subsection E of 8.281.500.13 NMAC and the following paragraphs within three months, the value of the promissory note or similar sales contract received

from the sale of an excluded home becomes a countable resource as of the first moment of the first day of the month following the month the note is executed; if the applicant or recipient purchases a replacement home after the expiration of the three month period, the value of the promissory note or similar installment sales contract becomes an excluded resource effective the month following the month of purchase of the replacement home provided that all other proceeds are fully and timely reinvested;

(6) **failure to reinvest proceeds timely:** if the proceeds from the sale of an excluded home under a promissory note or similar installment sales contract are not reinvested fully within three months of receipt in a replacement home, the following resources become countable as of the first moment of the first day of the month following receipt of the payment:

(a) the fair market value of the note;

(b) the portion of the proceeds, retained by the applicant or recipient which was not timely reinvested;

(c) the fair market value of the note remains a countable resource until the first moment of the first day of the month following the receipt of proceeds that are fully and timely reinvested in the replacement home; failure to reinvest proceeds for a period of time does not permanently preclude exclusion of the promissory note or installment sales contract; however, previously received proceeds that were not timely reinvested remain countable resources to the extent they are retained;

(7) **interest payments:** if interest is received as part of an installment payment resulting from the sale of an excluded home under a promissory note or similar installment sales contract, the interest payments are considered countable unearned income in accordance with Subsection A of 8.281.500.19 NMAC;

(8) **when the home replacement exclusion does not apply:** if the home replacement exclusion does not apply, the market value of a promissory note or sales contract as well as the portion of the payment received on the principal are considered countable resources.

O. **Household goods and personal effects exclusion:** Household goods and personal effects are excluded if they meet one of the following four criteria:

(1) items of personal property, found in or near the home, which are used on a regular basis; items may include but are not limited to furniture, appliances, recreational vehicles (i.e. boats and RVs), electronic equipment (i.e. computers and television sets), and carpeting;

(2) items needed by the householder for maintenance, use and occupancy of the premises as a home; items may include but are not limited to cooking and eating utensils, dishes, appliances, tools, and furniture;

(3) items of personal property ordinarily worn or carried by the applicant or recipient; items may include but are not limited to clothing, shoes, bags, luggage, personal jewelry including wedding and engagement rings, and personal care items;

(4) items otherwise having an intimate relation to the applicant or recipient; items may include but are not limited to prosthetic devices, educational or recreational items such as books or musical instruments, items of cultural or religious significance to an applicant or recipient; or items required because of an applicant or recipient impairment.

[8.281.500.13 NMAC - Rp, 8.281.500.13 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.14 **ASSET TRANSFERS:** The ISD caseworker must determine whether an applicant or recipient or their spouse transferred assets within a specified period of time (lookback period) before applying for a MAP category of eligibility for institutional care or at any time after approval of the applicant's or recipient's application. Then the ISD caseworker must determine if the applicant or recipient or their spouse received fair market value for the asset. If the applicant or recipient or their spouse did not receive fair market value for the asset, then the applicant or recipient may be subject to a penalty. In the case of an asset held by the applicant or recipient in common with another individual or individuals in a joint tenancy, tenancy in common, or similar arrangement including life estate or remainderman relation, the asset (or the affected portion of such asset) is considered to be transferred by the applicant or recipient when any action is taken, either by the applicant or recipient or by any other individual, acting on behalf of the applicant or recipient (including but not limited to a spouse, representative payee, trustee, guardian, conservator, or another authorized representative), that reduces or eliminates the applicant's or recipient's ownership or control of such asset. Any asset transferred to a community spouse in excess of the community spouse resource allowance (CSRA) is considered to be totally available to the institutionalized spouse and must be spent down before eligibility can be established.

A. **Lookback period:** Any transfer of assets made prior to February 8, 2006, is subject to a 36-month lookback period prior to the date of the applicant's or recipient's application or at any time subsequent to the approval of an application for a MAP category of eligible for institutional care. Transfers made on or after February

8, 2006, are subject to a 60-month lookback period.

(1) The lookback period is 60 months if the transfer occurred as the result of payments from a trust or portions of a trust that are treated as assets disposed of by the applicant or recipient.

(2) The lookback period starts on the date the applicant or recipient applies for a MAP category of institutional care and is in an institution.

B. Transfer of assets for less than fair market value: If a transfer of assets occurred within the applicable lookback period, or at any time after approval of the applicant's or recipient's application, the ISD caseworker must determine whether the applicant or recipient or their spouse received fair market value for the transferred asset(s).

(1) Documentation requirement: The applicant or recipient or their spouse must provide documentation of the transfer, the fair market value of the asset(s) transferred, the circumstances surrounding the transfer and the amount, if any, received as compensation for the transferred asset.

(2) If the applicant or recipient fails to provide this information without good cause within 30 calendar days from the date requested by the ISD caseworker, the ISD caseworker denies the application or closes the applicant's or recipient's case, as appropriate.

(a) Good cause is considered to exist if the applicant or recipient or their authorized representative can show that they were effectively precluded from timely reporting because of legal, financial, or other reasons, or because of the existence of a health related problem including death of a family member within the specific degree of relationship during the period of time in which the applicant or recipient, or authorized representative has to report the required information. The health or other problem must have been of such severity and duration as to have effectively precluded the applicant or recipient or their authorized representative from reporting in a timely manner. See 8.291.410 NMAC for a detailed description of degree of relationships.

(b) To document the good cause claim, the applicant or recipient or authorized representative must provide proof of the existence of the health or other problem and must explain the circumstances which precluded provision of the required information.

(c) The ISD caseworker makes the determination of good cause subject to review and approval by the county director or designee.

(3) Restricted coverage: If a transfer of assets occurred within the applicable lookback period, or at any time subsequent to approval for a MAP category of institutional care eligibility, for which the applicant or recipient or their spouse did not receive fair market value, the ISD caseworker determines if a penalty period must be calculated. The penalty for transfers of assets for less than fair market value in a MAP category of eligibility for institutional care is restricted coverage. "Restricted coverage" means that the applicant or recipient is eligible for all MAD services except services furnished in a nursing facility or services considered to be long-term care services.

(a) Determine the current average monthly cost of nursing facilities for private patients. See 8.281.500.13 NMAC.

(b) Divide the total uncompensated value (amount) of the resources transferred for less than fair market value by the current average monthly cost of nursing facilities for private patients.

(c) The result is the number of months and partial months for which the applicant or recipient will be on restricted coverage.

(4) Calculating restricted coverage when the transferred asset is income: If income has been transferred as a lump sum, the period of restricted coverage is calculated based on the lump sum value. For transfers of the right to an income stream, the period of restricted coverage is calculated using the actuarial value of all payments transferred. See 8.200.520 NMAC.

C. Transfer rules based on date of transfer: Two sets of rules govern the calculation of penalty periods if a transfer of assets for less than fair market value has occurred. The date of transfer and approval date for the MAP category of institutional care medicaid applicant or recipient institutional care governs which set of rules is used to calculate the penalty period.

(1) For transfers made on or after August 11, 1993: Periods of restricted coverage are calculated as follows (Omnibus Budget Reconciliation Act of 1993):

(a) the period of restricted coverage begins the month the resources were transferred; the total uncompensated value of the transferred assets divided by the average cost to a private patient for nursing facility services in the state at the time of the applicant's or recipient's application is the methodology used to calculate a period of restricted coverage;

(b) transfers for less than fair market value made by an institutionalized SSI applicant or recipient, or a community spouse of institutionalized applicant or recipient may subject the

institutionalized applicant or recipient to a period of restricted coverage;

(c) penalty periods are now consecutive rather than concurrent; if multiple transfers occur in different months, the periods of restricted coverage begin with the month of the initial transfer and run consecutively; for example, if an applicant or recipient transfers an asset for less than fair market value in February causing four months of restricted coverage (i.e., February through May) and transfers another asset in April causing three months of restricted coverage, the second period of restricted coverage begins in June and lasts through August; and

(d) if an institutionalized applicant or recipient with a community spouse is placed on restricted coverage as the result of a transfer of assets for less than fair market value and the community spouse subsequently becomes eligible for a MAP category of eligibility for institutional care, any remaining months in the restricted coverage period must be divided equally between the spouses.

(2) For transfers made on or after February 8, 2006: Pursuant to the Deficit Reduction Act of 2005, otherwise eligible institutionalized recipients who transfer assets for less than fair market value after this date are penalized as follows:

(a) the period of restricted coverage begins the first day of the month in which the resources were transferred, or the date on which the individual applicant or recipient meets a MAP category of eligibility, and would otherwise be receiving institutional level of care but for the application of the penalty period, whichever is later, and does not occur during any other period of ineligibility as a result of an asset transfer; see Subsection B of 8.281.500.14 NMAC for the methodology used to calculate a period of restricted coverage;

(b) once eligibility has been determined and a penalty period has begun to run, it continues until expiration, whether or not there is a break in the institutionalized recipient's eligibility;

(c) the beginning date of restricted coverage is the first day of the month in which the resources were transferred provided the applicant or recipient is institutionalized and retains their MAP category of eligibility for institutional care; for current recipients who fail to report a transfer, the recipients will continue to receive benefits until the adverse action notice date, but HCA may seek to recover any MAD benefits paid for long-term care services during what should have been a period of restricted coverage; federal law does not provide a basis to impose a transfer penalty based on date of discovery;

(d) for a non-institutionalized applicant or recipient, the date restricted coverage begins is the month in which the applicant or recipient becomes institutionalized;

(e) transfers for less than fair market value made by an institutionalized SSI applicant or recipient, or a community spouse of the institutionalized applicant or recipient may subject the institutionalized applicant or recipient to a period of restricted coverage; and

(f) multiple transfers occurring in different months are added together and calculated as a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

D. Non-excludable transfers: Certain financial instruments must be evaluated before they can be considered a transfer of assets.

(1) Annuities: Annuities belonging to the applicant or recipient or to the spouse of the applicant or recipient must be declared. Annuities must be actuarially sound with no deferral and no balloon payments. Annuities purchased or issued after February 8, 2006, must meet the following additional requirements for exclusion as a transfer of assets:

(a) HCA is named as the remainder beneficiary in the first position for at least the total amount of MAD benefits paid on behalf of the institutionalized applicant or recipient; HCA may be named the remainder beneficiary in the second position if there is a community spouse, or a minor, or a disabled child and is named in the first position if the community spouse or an authorized representative of the child disposes of any such remainder for less than fair market value;

(b) when HCA is a beneficiary of an annuity, issuers of annuities are required to notify MAD of any changes in the disbursement of income or principal from the annuity as well as any changes to HCA's position as remainder beneficiary; and

(c) it is non-assignable and irrevocable.

(2) Life estates: If an applicant or recipient purchases a life estate in another individual's home, the applicant or recipient must live in that home for a period of at least 12 months after the date of purchase or the transaction will be treated as a transfer of assets for less than fair market value.

(3) Promissory notes: If an applicant or recipient uses funds to purchase a promissory note, the repayment terms must be actuarially sound, provide for equal payment amounts with no deferral or balloon payments, and it must contain a provision that prohibits cancellation of the balance upon the death of the applicant

or recipient lender. A promissory note not meeting these requirements shall be treated as a transfer of assets for less than fair market value.

E. Excludable transfers: If certain conditions are met, an applicant or recipient is not placed on restricted coverage for transferring assets for less than fair market value.

(1) Transferred asset was home: The asset transferred was a home and title to the home was transferred to:

(a) the spouse of the applicant or recipient;

(b) the son or daughter of the applicant or recipient who is under 21 years of age or who meets the social security administration's definition of disability or blindness; if the child is receiving benefits based on disability or blindness from a program other than social security or SSI, or is not receiving benefits based on disability or blindness from any program, the ISD caseworker must request a determination of disability or blindness from disability determination services;

(c) sibling of the applicant or recipient who has an equity interest in the home and who was residing in the home for a period of at least one year immediately before the applicant or recipient was institutionalized; or

(d) son or daughter of the applicant or recipient who was residing in the home for a period of at least two years immediately before the applicant or recipient was institutionalized; for this exclusion to apply, the ISD caseworker must determine that the son or daughter provided care to the applicant or recipient which permitted the applicant or recipient to reside at home rather than in a medical facility or nursing home.

(2) Other asset transfers: Sufficient information must be given to the ISD caseworker to establish that either:

(a) the applicant or recipient intended to dispose of the asset at fair market value; or

(b) at the time of the transfer the applicant or recipient had no expectation of applying for a MAP category of eligibility and the resources were transferred exclusively for a purpose other than to qualify for a MAP category of eligibility as demonstrated by a preponderance of evidence; unless these conditions are met, the transfer is presumed to have been for the purpose of qualifying for a MAP category of eligibility; or

(c) HCA determines that the denial of eligibility would work an undue hardship.

(3) Asset transferred to or for the sole benefit of the community spouse: No transfer penalty is assessed when assets are transferred from one spouse to another (e.g., assets are transferred from an institutionalized spouse to a community spouse). Any asset transferred to a community spouse or to another individual for the sole benefit of the community spouse in excess of the CSRA is considered to be totally available to the institutionalized spouse and must be spent down before eligibility can be established. No transfer penalty is assessed when assets are transferred to another for the sole benefit of the community spouse if all of the conditions listed in Subparagraphs (a) through (c) below are met.

(a) a transfer is considered to be for the sole benefit of the community spouse if it is arranged in such a way that no individual or entity except the community spouse can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future;

(b) a transfer, or transfer instrument, that provides for funds or property to pass to a beneficiary who is not the community spouse is not considered to be established for the sole benefit of the community spouse; for a transfer to be considered to be for the sole benefit of the community spouse, the instrument or document must provide for the spending of the funds involved for the benefit of the community spouse on a basis that is actuarially sound based on the life expectancy of the community spouse or when the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void;

(c) to determine whether an asset was transferred for the sole benefit of the community spouse, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer; a transfer without such a document cannot be said to have been made for the sole benefit of the community spouse since there is no way to establish, without a document, that only the community spouse will benefit from the transfer.

(4) Asset transfers to or for the sole benefit of a blind or disabled child of the institutionalized individual: No transfer penalty is assessed when assets are transferred to a blind or disabled child of the institutionalized applicant or recipient, or to a trust established solely for the benefit of a blind or disabled child of the institutionalized applicant or recipient. For this exemption to apply, the child must meet the social security administration's definition of blindness or disability. The transfer must either meet the criteria set forth in 8.281.500.11 NMAC or meets all of the conditions listed in this section, Subparagraphs (a) through (c) below to be excluded in the eligibility determination process.

(a) A transfer to such a blind or disabled child is considered to be for the sole benefit of that child if the transfer is arranged in such a way that no individual or entity, except the blind or disabled child, can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

(b) A transfer, or transfer instrument, that provides for funds or property to pass to a beneficiary who is not the blind or disabled child of the institutionalized applicant or recipient is not considered to be established for the sole benefit of the blind or disabled child. For a transfer or trust to be considered to be for the sole benefit of a blind or disabled child, the instrument or document must provide for the spending of the funds involved for the benefit of the blind or disabled child on a basis that is actuarially sound based on the life expectancy of the child. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.

(c) To determine whether an asset was transferred for the sole benefit of the blind or disabled child of the institutionalized applicant or recipient, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the blind or disabled child since there is no way to establish, without a document, that only the blind or disabled child will benefit from the transfer.

(5) Asset transfers to a trust for the sole benefit of a disabled individual under age 65: No transfer penalty is assessed when assets are transferred to a trust established for the sole benefit of an individual under age 65 who meets the social security administration's definition of disability. The transfer must either meet the criteria set forth in 8.281.500.11 NMAC or meet all of the conditions listed in Subparagraphs (a) through (c) below to be excluded in the eligibility determination process.

(a) A transfer is considered to be for the sole benefit of a disabled individual under age 65 as described above if the transfer is arranged in such a way that no individual or entity except the disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

(b) A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not a disabled individual under age 65 as described above, is not considered to be established for the sole benefit of the disabled individual. For a transfer or trust to be considered to be for the sole benefit of the disabled individual, the instrument or document must provide for the spending of the funds involved for the benefit of the disabled individual on a basis that is actuarially sound based on the life expectancy of the disabled individual. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.

(c) To determine whether an asset was transferred for the sole benefit of the disabled individual, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the disabled individual since there is no way to establish, without a document, that only the disabled individual will benefit from the transfer.

(6) Assets transfers and qualified state long-term care insurance partnerships (QSLTCIP) protected asset limits (PAL):

(a) No transfer penalty is assessed if at initial determination the applicant or recipient has indicated protection of the transferred asset and there is enough of the PAL to cover the value of the resource at the time of the transfer.

(b) No transfer of assets penalty is assessed if the applicant or recipient has previously indicated an asset for protection and there was enough of the applicant's or recipient's PAL to cover the value of the resource at the time of the transfer.

(c) No transfer penalty is assessed for the portion of a resource which has been partially protected. The unprotected portion of the resource is subject to all assets transfer provisions outlined in 8.281.500.14 NMAC.

F. Re-establishing eligibility: If an asset is transferred for less than fair market value and the applicant or recipient is placed on restricted coverage, they have options to re-establish their past MAP category of eligibility.

(1) Reimbursement by transferee: The individual to whom the asset was transferred can reimburse the applicant or recipient for the asset at fair market value or liquidate or sell the asset and spend an

amount equal to the uncompensated fair market value on the applicant's or recipient's care or other exempt assets as listed in 8.281.500.13 NMAC.

(2) **Return asset to applicant:** The asset can be transferred back to the applicant or recipient, liquated or sold. The applicant or recipient must determine the use of the asset; such use may include spending down the resource limit on the applicant's or recipient's care, classifying the resource as exempt as listed in 8.281.500.13 NMAC, or having the asset become a countable resource.

(3) If the transferred asset is restored to an applicant or recipient, they may become totally ineligible for a MAP category of institutional care eligibility due to excess resources. The ISD caseworker must verify that the applicant's or recipient's countable assets do not exceed the standard for a MAP category of institutional care eligibility. If the transferred asset is restored to an applicant or recipient, they may no longer be eligible for a MAP category of institutional care due to the excess resources. The ISD caseworker must verify that the applicant's or recipient's countable assets meet the requirements to have a MAP category of institutional care eligibility.

[8.281.500.14 NMAC - Rp, 8.281.500.14 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.15 RESOURCE STANDARDS FOR MARRIED COUPLES:

A. **Community property resource determination methodology:** Community property resource determination methodology is used in the eligibility determination for a married applicant or recipient who began institutionalization for a continuous period prior to September 30, 1989.

(1) To determine the countable value of resources, the ISD worker must:

(a) add the total value of all resources owned by both spouses;

(b) exclude the separate property of the non- applicant or recipient spouse; and

(c) attribute one-half of the total value of the community property to the applicant or recipient spouse plus the value of their separate property;

(d) the resulting figure must be less than $2,000.

(2) **Application of community property rules:** Under community property rules, all property held by either spouse is presumed to be community property unless successfully rebutted by the applicant or recipient, or representative. To rebut community property status, the applicant or recipient, or representative must document that the property was:

(a) acquired before marriage or after a divorce or legal separation;

(b) designated as separate property by a judgment or decree of any court;

(c) acquired by either spouse as a gift or inheritance; or

(d) designated as separate property by a written agreement between the spouses, including a deed or other written agreement concerning property held by either or both spouses in which the property is designated as separate property.

(i) If one of the parties to this written agreement is incompetent, legal counsel must execute the agreement on behalf of the incompetent spouse.

(ii) Property designated as separate by written agreement is evaluated according to current rules regarding transfer of resources.

(iii) Income cannot be designated as separate by an agreement between spouses; income is considered separate only if it is derived from a resource that has been determined separate.

B. **Spousal impoverishment:** Spousal impoverishment provisions apply if one spouse of a married couple is institutionalized for a continuous period of at least 30 consecutive days beginning on or after September 30, 1989. See spousal impoverishment provisions of the Medicare Catastrophic Coverage Act of 1988 (MCCA). No comparable treatment of resources and income is required for non-institutionalized applicants or recipients who do not have a spouse remaining in the community. These provisions cease to apply as of the month following the month an applicant or recipient is no longer institutionalized or no longer has a community spouse. If a community spouse or other dependents apply for a MAP category of eligibility they are subject to the rules governing treatment of income and resources for the individual applicant or recipient.

(1) **Resource assessment:** A resource assessment must be completed to evaluate a couple's resources as of the first moment of the first day of the month one member of the married couple is institutionalized for a continuous period of at least 30 consecutive days beginning on or after September 30, 1989. This process is used to determine the amount of resources which may be protected for the community spouse. See Subparagraph (f) below for resources which must be included in the resource assessment. The resource assessment and computation of spousal shares occurs only once, at the beginning of the first continuous period of institutionalization beginning on or after September 30, 1989. A new resource assessment may be completed if it is later determined that the

original resource assessment was inaccurate. Upon the death of the community spouse, the ISD worker may review the applicant's or recipient's resources.

(a) A MAP application does not need to be submitted at the time the assessment is requested. A reasonable fee may be charged for completing assessments which are not made in conjunction with the applications. Applications for assessments are available at the ISD offices which determine eligibility for a MAP category of institutional care. Either member of the couple or their authorized representative may request an assessment application.

(b) The ISD worker must complete a resource assessment using the following criteria:

(i) one member of a married couple became institutionalized on or after September 30, 1989 in an acute care hospital or nursing facility for a continuous period of at least 30 consecutive days;

(ii) the institutionalized applicant or recipient has a spouse who remains in the community in a non-institutionalized setting; and

(iii) the institutionalized spouse remains, or is likely to remain, institutionalized for a period of at least 30 consecutive days based on a written statement from their physician and supporting medical documentation; the institutionalized applicant or recipient is considered "likely to remain" even if they do not actually remain in an institution for 30 consecutive days if they met this condition at the beginning of the period of institutionalization.

(c) The ISD worker explains exactly what verification is required to complete the assessment. If the ISD worker requires further information, the individual requesting the assessment is notified in writing and given a reasonable time period of at least 10 working days to provide the additional information.

(d) The institutionalized individual or their spouse or an authorized representative is responsible for providing all verification necessary to complete the assessment.

(e) The ISD worker completes the resource assessment within 45 calendar days of the date of receipt of the completed and signed assessment application unless verification is still pending by the 45th day. In that case, the assessment is not completed until all necessary information is provided by the institutionalized individual or their spouse or authorized representative.

(f) Assessments include the total value of the couple's countable resources held jointly or separately as of the first moment of the first day of the month one spouse became institutionalized for a continuous period of at least 30 consecutive days beginning on or after September 30, 1989. The assessment form identifies the spousal shares and the CSRA. The couple is entitled to all resource exclusions allowed in 8.281.500.13 NMAC except that value limits for the exempt vehicle and household goods of the community spouse do not apply. Assets excluded under the QSLTCIP program are counted in the spousal resource assessment. The disregarded assets are included in determining the amount of the CSRA. The disregarded asset is not counted in determining the applicant's or recipient's eligibility.

(g) When the assessment is complete, the ISD worker copies all documentation used to make the determination of countable resources and retains the documents in the case record. The ISD worker also provides complete copies of the assessment forms to the following parties:

(i) institutionalized applicant or recipient;

(ii) community spouse; and

(iii) authorized representative(s) if any.

(h) When the amount of the couple's total countable resources has been determined, the resulting amount is divided by two to determine the spousal shares. The community spouse is entitled to their spousal share or the MAD minimum resource allowance, whichever is greater, up to the applicable federal maximum standard or an amount determined at a HCA administrative hearing or an amount transferred pursuant to a district court order. The CSRA is the amount by which the greatest of the spousal shares or state minimum resource allowance exceeds the amount of resources otherwise available to the community spouse without regard to such an allowance. The CSRA remains in effect until one of the spouses dies. The remainder of the couple's total countable resources in excess of the CSRA is considered available to the institutionalized spouse. If either the institutionalized spouse or the community spouse is dissatisfied with the computation of the spousal share of the resources, the attribution of resources or the determination of the community spouse resource allowance, they can request a HCA administrative hearing pursuant to 8.352.2 NMAC. Refer to 8.352.2 NMAC for a detailed description of the HCA administrative hearing process.

(2) **CSRA standards:** The state minimum resource allowance and the federal maximum standards vary based on when the applicant or recipient became institutionalized for a continuous period of at least

30 consecutive days. See 8.281.500.10 NMAC for the applicable standards.

(3) **CSRA revision:** The CSRA can be revised if either of the following occurs:

(a) a different amount is determined by a HCA administrative hearing final decision or district court decision; or

(b) inaccurate information was provided to the ISD worker at the time the spousal share was calculated.

(4) **Resource availability after computation of CSRA:** Resources of a couple remaining after the computation of the CSRA are considered available to the institutionalized spouse. These remaining resources are compared to the resource limit.

(a) From the time of the initial determination of eligibility until the first regularly scheduled redetermination, the CSRA is not considered available to the institutionalized spouse.

(b) The CSRA may be applied retroactively for the three months prior to the month of application and is not considered available to the institutionalized spouse until the first periodic review following initial approval.

(5) **Resource transfer after computation of the CSRA:** When eligibility has been approved for an institutionalized spouse, resources equal to the amount of the CSRA may be transferred to the community spouse. This transfer is intended to assist the community spouse in meeting their needs in the community. Couples should transfer resources in the amount of the CSRA to the community spouse as soon as possible after approval for a MAP category of institutional care eligibility. The institutionalized spouse or authorized representative can complete this transfer at any time between the date of the assessment and the first periodic review 12 months after approval.

(6) **Resource transfers which exceed the CSRA:** Resources transferred to a community spouse at less than fair market value are not subject to transfer penalties. Resources transferred to the community spouse in excess of the computed CSRA are considered available to the institutionalized spouse and must be spent down to below the resource standard before eligibility can be established. Resources transferred to the community spouse may exceed the CSRA if an increased amount is ordered by any court having jurisdiction or by the MAD director as part of a HCA administrative hearing final decision.

(7) **Transfer deadlines:** If the resource transfer is not completed by the institutionalized spouse by the end of the initial period of eligibility, the resources are considered completely available to the institutionalized spouse beginning with the first periodic review after the initial determination of eligibility.

(8) **Newly acquired assets:** After a continuous period of institutionalization begins, newly acquired resources or increases in the value of resources owned by the institutionalized spouse are countable. Recalculations of eligibility for the institutionalized spouse based on countable resources are effective at the beginning of the month following the month in which new resources were received or an increase occurred in the value of resources already owned.

(a) The institutionalized spouse may transfer newly acquired resources to the community spouse without a penalty up to the difference between the CSRA and the state minimum resource standard in effect as of the date of institutionalization.

(b) After a continuous period begins, new resources acquired by the community spouse or increases in the value of resources which are part of the CSRA are not considered available to the institutionalized spouse.

[8.281.500.15 NMAC - Rp, 8.281.500.16 NMAC, 8/15/2015; A, 3/1/2018; A, 12/1/2022]

8.281.500.16 **DEEMING RESOURCES:** Deeming of resources applies only during periods when an eligible applicant/recipient under 18 years of age lives at home and during the month the eligible applicant or recipient enters an institution. After the initial month of entry into the institution, only those resources directly attributable to or available to the applicant or recipient are counted and compared to the $2,000 resource limit.

A. **Deeming of resources for children who are blind or have a disability:** If an applicant or recipient under 18 years of age who is blind or disabled enters an institution, the resources of the parent(s) are deemed to the applicant or recipient if the parent(s) live in the same household. If an ineligible parent receives temporary assistance to needy families (TANF), resources are not deemed to the applicant or recipient.

B. To determine the amount of resources deemed to the applicant or recipient, the following computation is made:

(1) determine parent(s) resources;

(2) allow parent(s) all the resource exclusions that an eligible applicant or recipient would receive;

(3) the remaining resources in excess of $2,000 for one parent or $3,000 for two parents are deemed to the applicant or recipient child; if there is more than one applicant or recipient child, the deemed resources are divided equally; and

(4) the deemed resources are added to whatever countable resources the applicant or recipient child has in their own right; the applicant or recipient child is eligible for a MAP category of institutional care eligibility on the factor of resources if countable resources do not exceed $2,000.

[8.281.500.16 NMAC - Rp, 8.281.500.17 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.17 INCOME: An applicant's or recipient's gross countable monthly income must be less than the maximum allowable monthly income standard. If an applicant's or recipient's monthly gross countable income is below $50, the application can still be processed; however, the applicant or the recipient must be referred to the social security administration to apply for SSI. Income may be in the form of cash, checks, and money orders, or in-kind, including personal property or food. If income is not received in the form of cash, the cash value of the item is determined and counted as income. The ISD worker verifies all income and obtains appropriate documentation. Income is counted in the month received. Income is considered available throughout the month regardless of the date received.

A. Types of income: Countable income is the sum of unearned income or earned income, less disregards or exclusions, plus deemed income.

B. Earned income: Earned income consists of the total gross income received by an applicant or recipient for services performed as an employee or as a result of self-employment.

(1) Royalties earned in connection with the publication of an applicant's or recipient's work and any honorarium or fee received for services rendered are considered earned income.

(2) The self-employed applicant or recipient must provide an estimate of their current income based on the tax return filed for the previous year or current records maintained in the regular course of business. The estimate of net earnings for the entire previous taxable year is prorated equally among all months of the current year, even if the business is seasonal.

(a) Consideration is given to the applicant's or recipient's explanation as to why they believe the estimated net earnings for the current year vary substantially from the information shown on their tax return for past years.

(b) A satisfactory explanation is that the business suffered heavy loss or damage from fire, flood, burglary, serious illness or disability of the owner, or other such catastrophic events. Documentation must include copies of newspaper accounts or medical reports and must be filed in the case record to substantiate the need for a reduced estimate of current self-employment income.

C. Unearned income: Unearned income consists of all other income (minus exclusions and disregards) that is not earned in the course of employment or self-employment.

D. Deemed income: Deemed income is income considered available to a minor applicant or recipient from their parents.

E. Community property income methodology: If an applicant or recipient is married, community property income methodology shall be used in the eligibility determination, regardless of the living arrangements, if the one spouse has less income than the other spouse or if using the community property methodology would benefit both spouses. Under this methodology, one-half of the community property income is attributed to each spouse. Income is considered separate if it is earned in and is paid from a non-community property state. Proof of separate income is the burden of the applicant or recipient, spouse, or authorized representative.

[8.281.500.17 NMAC - Rp, 8.281.500.18 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.18 INCOME STANDARDS: The applicable income standard used in the determination of a MAP category of institutional care eligibility for an applicant or recipient who has not been institutionalized for a period of 30 consecutive days is the SSI federal benefit rate (FBR) for a non-institutionalized individual. Participation in the medicaid home and community based waiver program is considered institutionalization and counts toward the calculation of the 30-day period. All income, whether in cash or in-kind, shall be considered in the eligibility determination, unless such income is specifically excluded or disregarded.

A. Institutionalization period of 30 consecutive days: After the applicant or recipient has been institutionalized for 30 consecutive days, the application can be approved as of the first day of the 30-day period. Once an applicant or recipient has been institutionalized for 30 consecutive days, the higher income maximum as specified in 8.200.520 NMAC is used.

B. Institutionalization period less than 30 consecutive days: If the applicant or recipient leaves

the facility before 30 consecutive days, the lower income standard (SSI FBR) is used to establish eligibility.

C. Transfer or death: If an applicant or recipient transfers to another institution or dies prior to completing 30 consecutive days of institutionalization, the higher income maximum is used. See 8.200.520 NMAC.

(1) Income exclusions: Income exclusions are applied before income disregards. Exclusions are applied in determining eligibility whether the income belongs to the applicant or recipient or to an individual from whom income is deemed.

(2) Infrequent or irregular income: Exclude the first $30 per calendar quarter of earned income; and the first $60 per calendar quarter of unearned income. The following definitions apply:

(a) "Irregular income" is income received on an unscheduled or unpredictable basis.

(b) "Infrequent income" is income received only once during a calendar quarter from a single source and includes:

(i) proceeds of life insurance policies;
(ii) prizes and awards;
(iii) gifts;
(iv) support and alimony;
(v) inheritances;
(vi) interest and royalties; and
(vii) one-time lump sum payments, such as social security.

(c) "Frequency" is evaluated for the calendar quarter (i.e. January - March, April - June, July - September, October - December) but the dollar amount is considered in the month received.

(3) Foster care: Foster care payments are totally excluded if:

(a) the foster child is not eligible for SSI; and

(b) the child was placed in the applicant's or recipient's home by a public or private nonprofit child placement or child care agency.

(4) Domestic volunteer services exclusions: Payments to volunteers under domestic volunteer services (ACTION) programs are excluded from consideration as income in the eligibility determination process. These programs include the following:

(a) volunteers in service to America (VISTA);
(b) university year for action (UYA);
(c) special demonstration and volunteer programs;
(d) retired senior volunteer program (RSVP);
(e) foster grandparent program; and
(f) senior companion program.

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

[8.281.500.18 NMAC - Rp, 8.281.500.19 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.19 UNEARNED INCOME: Unearned income includes all income not earned in the course of employment or self-employment. If payment is made in the name of either or both spouses and another party, only the applicant's or recipient's proportionate share is considered available to them. If income is derived from property for which ownership is not established, such as unprobated property, one-half of the income is considered available to each member of a married couple.

A. Standards for unearned income: Unearned income is computed on a monthly basis. If there are no expenses incurred with the receipt of unearned income, such as annuities, pensions, retirement payments or disability benefits, the gross amount is considered countable unearned income.

(1) Social security overpayments: If the social security administration withholds an amount because of an overpayment, the gross social security payment amount is used to determine eligibility. See Subsection B of 8.281.500.22 NMAC for instructions regarding calculation of the medical care credit.

(2) Rental income: If an applicant or recipient has rental property, the ISD worker allows the cost of real estate taxes, maintenance and repairs, advertising, mortgage insurance and interest payments on the mortgage as deductions from the amount received as rent.

(3) Interest on promissory note or sales contract: The portion of the payment representing interest received from a promissory note or sales contract is considered unearned income. The market value of promissory notes or sales contracts and the portion of the payment representing payment of the principal are considered resources. See also Subsection L of 8.281.500.13 NMAC.

(4) Income from annuities, pensions and other periodic payments: Payments from annuities, pensions, social security benefits, disability, veterans benefits, worker compensation, railroad retirement annuities and unemployment insurance benefits and other periodic payments are counted as unearned income.

B. Unearned income exclusions:

(1) Interest from an excluded burial fund: Interest from an excluded burial fund is not considered unearned income if the interest is applied toward the fund balance. If the interest is paid to the applicant or recipient, it is considered unearned income.

(2) Tax refunds and earned income tax credit: Tax refunds from any public agency for property taxes or taxes on food purchases are totally excluded. Any portion of a federal income tax return which constitutes an earned income tax credit is excluded.

(3) Grants, scholarships and fellowships: All grants, scholarships and fellowships used to pay tuition and fees at an educational institution, including vocational and technical schools, are totally excluded. Any portion of a grant, scholarship or fellowship used to pay any other expenses, such as food, clothing or shelter, is not excluded.

(4) Veteran's pensions: Allowances for aid and attendance (A&A) and unusual medical expenses (UME) are excluded from unearned income for determination of eligibility. If an applicant or recipient receives an augmented VA pension as a veteran or veteran's widow or widower, the pension amount may include an increment for a dependent. If so, the VA must be contacted to provide documentation of the portion of the pension which represents the dependent's increment. When verified, this amount of the VA pension is considered the dependent's income.

(5) Payments by a third party: Third party payments are excluded as income if made directly to the applicant's or recipient's creditor.

(a) Third party payments may include mortgage payments by credit life or credit disability insurance and installment payments by a family member on a burial plot or prepaid burial contract.

(b) Interest from a burial contract that is automatically applied to the outstanding balance is excluded from unearned income. If the payment or interest is sent to the applicant or recipient, it is counted as unearned income regardless of the sender's (third party's) intentions. This applies even if the sender specifies the purpose of the payment on the check. This provision does not apply if the signature of the creditor and the applicant or recipient must both be present in order to negotiate the check (two-party check).

(6) Indian tribe per capita payments: Funds held in trust by the secretary of the interior for an Indian tribe and distributed on a per capita basis and any interest and investment income from these funds, are excluded as income and resources in the eligibility determination process and the computation of the medical care credit.

(7) Plans for achieving self-support: Income derived from, or necessary to, an approved plan for achieving self-support for a blind or disabled applicant or recipient under 65 years of age is excluded.

(a) For an applicant or recipient who is blind or disabled and over 65 years of age, this exclusion applies only if they received MAD services for the month preceding their 65th birthday.

(b) The self-support plan must be in writing and contain the following:

(i) designated occupational objective;

(ii) specification of any savings (resource) or earnings needed to complete the plan, such as amounts needed for purchase of equipment or for financial independence;

(iii) identification and segregation of any income saved to meet the occupational goal;

(iv) designation of a time period for completing the plan and achieving the occupational goal.

(c) Plans for achieving self-support are developed by vocational rehabilitation counselors. If a self-support plan is not in place, the ISD worker makes a referral to the division of vocational rehabilitation (DVR).

(d) The ISD worker forwards the written plan and documentation to the MAD eligibility unit. The plan must be approved by that unit.

(e) An approved plan is valid for the following specified time periods:

(i) initial period of no more than 18 months;

(ii) extension period of no more than 18 months;

(iii) final period of no more than 12 months; and

(iv) total period of no more than 48 months.

(8) Agent orange settlement payments: Agent orange settlement payments made to

applicant or recipient veterans or their survivors are excluded from consideration as income in determining eligibility.

(9) Radiation Exposure Compensation Act payments: Payments made under the Radiation Exposure Compensation Act are excluded from consideration as income in determining eligibility.

(10) Victims compensation payments: Payments made by a state-administered fund established to aid victims of crime are excluded from consideration as income in determining eligibility. These payments are included as countable income when calculating the medical care credit.

(11) Lump sums for retroactive periods: SSI lump sum payments for retroactive periods are excluded from consideration as countable income in the month received.

(12) Life insurance and other burial benefits: Life insurance and other burial benefits are unearned income to the beneficiary (not the owner). The ISD worker must subtract the amount spent on the insured recipient's last illness or burial up to $1,500. Any excess is counted as unearned income.

(13) One hundred percent state funded assistance payment: Any one hundred percent-state-funded assistance payment based on need, such as general assistance (GA) is excluded. Any interim payments made by a state or municipality from all state or local funds while an SSI application is pending are excluded.

(14) National vaccine injury compensation program (NVICP) payment: The NVICP funds are excluded as income or a resource until they are actually disbursed by the issuing agent. However, they are counted as income in the month in which they are received and counted as a resource in the following months, provided that the funds in question are not specifically earmarked for medical expenses. If the payment is designated for both living expenses and medical care, a determination must be made to identify how much of the payment is for living expenses, and how much is for medical care. The only portion actually counted then is that amount which is for living expenses. Therefore, a determination must be made as to how the payment is apportioned before making an eligibility determination.

(15) Remembrance, responsibility and the future payments: Payments by the remembrance, responsibility and the future foundation to individual survivors forced into slave labor by the Nazis are excluded as income in determining eligibility.

[8.281.500.19 NMAC - Rp, 8.281.500.20 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.20 DEEMED INCOME:

A. Availability: Deemed income is income considered available to a minor applicant or recipient from their parents. Deeming of resources and income applies only during periods when an applicant or recipient under 18 years of age is living with their parents and during the month of entry into an institution.

B. Situations in which deeming occurs: Deeming of income occurs:

(1) from ineligible parent to eligible child; or

(2) if there is both a MAP eligible parent and a MAP eligible child in the home.

C. Computing deemed income: The ISD worker computes the total monthly amount of parental unearned and earned income and then computes the deemed income available to the applicant or recipient child. If the deemed income plus the child's separate income exceeds the applicable maximum, the child will not have a MAP category of institutional care eligibility for that month.

(1) Parents and children receiving aid: If one of the applicant or recipient child's parents is receiving any benefit or assistance paid by a governmental agency on the basis of economic need, that benefit plus all the income of that parent is excluded from the deeming process. This exclusion applies only to the income of the parent who receives the benefit. Even if the income of one parent is excluded, that parent is still considered a member of the household for purposes of determining the parental allocation. Provisions for deeming income do not apply to benefits under temporary assistance to needy families (TANF). No income is deemed to a parent or child(ren) if that parent or child(ren) is (are) receiving TANF assistance.

(2) Applicant or recipient parent and their child(ren): If a household is composed of an applicant or recipient parent and an applicant or recipient child(ren), the parent's income is determined according to the methodology appropriate to the MAP category of eligibility which they receive.

(a) If there is enough income to make the applicant or recipient parent ineligible, the remainder of the income is carried over to be deemed to the child(ren).

(b) If there is more than one potentially eligible child, the deemed income is divided equally among them. If total countable income is less than the applicable maximum, the applicant or recipient has a MAP category of institutional care eligibility on the factor of income.

(c) If an applicant or recipient is determined to meet the MAP category of institutional care eligibility, the ISD worker must recompute available income for the following month based on

separate income to establish the correct medical care credit. See 8.281.500.23 NMAC, *post-eligibility/medical care credit*.
[8.281.500.20 NMAC - Rp, 8.281.500.21 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.21 DISREGARDS: Income disregards are determined on an individual basis. Disregards may be applied to any appropriate month of assistance, regardless of which income maximum is used.

A. $20 disregard: The first $20 of unearned or earned income received in a month is disregarded. This disregard is applied first to unearned income and, if any amount remains, to earned income. If there is no unearned income, the entire $20 disregard is applied to earned income. This disregard is not applied to any payment made to the applicant or recipient through government assistance programs or private charitable organizations, where payments are based on need. These payments include financial assistance, TANF, assistance from catholic charities, salvation army, bureau of Indian affairs, and VA pension (not compensation) payments.

B. Additional earned income disregard: After applying the $20 disregard as specified in Subsection A of 8.281.500.21 NMAC if appropriate, the first $65 of monthly earned income plus one-half of the remainder is also disregarded.

C. Work-related expenses of the blind: Work-related expenses of an employed applicant or recipient or couple who are legally blind are disregarded. The dollar amount of expenses which may be disregarded must be reasonable. Expenses are disregarded when paid and must be verified.

(1) This disregard does not apply to an applicant or recipient who is blind and is 65 years or age or older, unless they were receiving SSI payments due to blindness in the month before turning 65 or received payments under a state aid to the blind program.

(2) Types of work-related expenses which may be disregarded include:

(a) federal, state, and local income taxes;

(b) social security contributions;

(c) union dues;

(d) transportation costs, including actual cost of bus/taxi cab fare, or $0.15 per mile for private automobile;

(e) lunches;

(f) child care costs, if not otherwise provided;

(g) uniforms, tools and other necessary equipment; and

(h) special expenses necessary to enable an applicant or recipient who is blind to engage in employment, such as a seeing-eye dog or Braille instructions.

D. Student earned income disregard: Up to $1,200 per quarter or a maximum of $1,620 per calendar year of the earned income of certain students may be disregarded. To qualify for this disregard, the applicant or recipient must meet all of the following requirements:

(1) under 22 years of age;

(2) unmarried;

(3) not head of a household; and

(4) in regular attendance at a college or university, for at least 12 semester hours or vocational or technical training course for at least 20 hours per a calendar week.

(a) This disregard applies only to a student's own earned income and includes all payments made as compensation for services, such as wages from employment or self-employment, or payments from programs such as neighborhood youth corps or work-study.

(b) This disregard is available in addition to any exclusions applied to grants, scholarships or fellowships and in addition to any other allowable disregards.

E. Child support payments: One-third of the amount of child support payments made to a child applying for a MAP category of institutional care eligibility is disregarded. The remainder is considered unearned income, subject to the appropriate disregards outlined below.
[8.281.500.21 NMAC - Rp, 8.281.500.22 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.22 POST ELIGIBILITY/MEDICAL CARE CREDIT: Once financial eligibility for a MAP category of institutional care has been established, the ISD worker must determine the following.

A. Medical care credit: The medical care credit is the amount of the applicant's or recipient's income used to reduce the MAD payment to the institution where they reside. An applicant or recipient must make this payment directly to the institution. Applicants or recipients eligible for a MAP category of institutional care due to institutionalization in an acute care hospital or an in-state in-patient rehabilitation center are not charged a medical

care credit. The amount of the medical care credit is always determined prospectively. The ISD worker computes a medical care credit starting with the first full month of institutional care. No medical care credit is required for the month the recipient enters the institution if they are admitted after the first moment of the first day of the month.

(1) No medical care credit for the month of discharge or death: An applicant or recipient is not required to pay a medical care credit for the month of discharge from the institution. The medical care credit must be paid if the applicant or recipient is transferred to another institution or makes a short visit outside the institution. No medical care credit is charged for the month in which a recipient who received MAD institutional care services dies. This will prevent a deficit for the institution when a benefit, such as social security, must be returned due to the death of a beneficiary.

(2) Application delay: If there is a delay between application and approval, an applicant or recipient incurs a liability for a medical care credit. The ISD worker notifies the applicant or recipient of this liability during the application process and informs them of the amount of the medical care credit they should pay. The applicant or recipient is encouraged to pay the medical care credit to the institution before approval of the application.

(3) Medical care credit during retroactive months: No medical care credits are applied for any period of retroactive eligibility under this provision.

B. Computing the medical care credit: The current personal needs amount (PNA) of an applicant or recipient monthly income is protected for their personal use in a nursing facility. Each year thereafter, the amount of an applicant's or recipient's monthly income shall be adjusted according to the consumer price index as indicated in 8.200.510 NMAC. The excess over the amount protected, subject to other deductions, is applied toward payment for care in the nursing facility as a medical care credit.

(1) See Paragraph (6) of Subsection B of 8.281.500.22 NMAC for personal needs allowance for veterans or surviving spouses.

(2) An applicant's or recipient's total income, including amounts disregarded in determining eligibility, is used to compute the medical care credit with the following exceptions:

(a) Indian tribe per capita payments (see Subsection B of 8.281.500.19 NMAC);

(b) German reparation payments; and

(c) social security administration overpayments.

(i) When the social security administration withholds an amount due to an overpayment, the social security gross payment amount is used to determine eligibility per Subsection A of 8.281.500.19 NMAC. To determine the amount used in calculating the medical care credit, the ISD worker ascertains whether a social security (Title II) overpayment is being recouped or whether an SSI overpayment is being recouped from a social security benefit check (a cross-program recoupment). Cross-program recoupments are at the recipient's option so the gross benefit amount is used to calculate the medical care credit.

(ii) Recoupment of a social security overpayment from a social security benefit check is mandatory. In such cases, the net social security benefit amount is used to calculate the medical care credit.

(d) payments from the Radiation Exposure Compensation Act.

(e) 'remembrance, responsibility and the future' payments.

(3) Dependent children at home: If an institutionalized applicant or recipient with no spouse has dependent children at home who are ineligible for TANF or assistance from any other program, or are eligible for an amount less than the TANF need standard, an allowance for each child of up to the current TANF standard of need may be deducted from the institutionalized applicant's or recipient's income which is in excess of the applicant's or recipient's personal allowance.

(4) Expenses not subject to third party payment 42 CFR 435.725(4): Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including:

(a) medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(b) necessary medical or remedial care recognized under state law but not covered under the state medicaid plan, subject to reasonable limits on amounts of these expenses. HCA has the following reasonable limits on amounts for necessary medical or remedial care not covered under medicaid:

(i) For expenses not covered under the state plan or expenses covered under the state plan, but not paid for by medicaid, the amount of the deduction is the billed amount not to exceed the provider's usual and customary charges except for unpaid nursing facility expenses.

(ii) To be deducted, an expense must be for medically necessary medical or remedial care rendered to the applicant or beneficiary and prescribed by a health care practitioner acting within their

scope of practice who meet the qualifications of an eligible medicaid provider as listed in the New Mexico Administrative Code (NMAC) 8.310.3.9 NMAC, even if such practitioner is not a medicaid provider.

(iii) A deduction for incurred medically necessary non-covered medical or remedial care expenses will be allowed when the bill is incurred during a period which is no more than three months prior to the month of the current application. For each month of unpaid nursing facility services incurred during this period, deductions are allowed at an amount not to exceed the average monthly private rate of nursing facility services, as used to calculate asset transfer penalties and which is updated annually in 8.200.510.13 NMAC (or a prorated amount of this figure, for unpaid nursing facility services that are for less than a full month.

(iv) The deduction for medical and remedial care expenses that were incurred as the result of a transfer penalty period is limited to zero.

(v) Expenses for cosmetic/elective procedures (e.g., face lifts or liposuction etc.) are not allowed as deductions except when prescribed by a health care practitioner.

(vi) Expenses from medical or remedial procedures that were denied coverage by an insurer, including medicaid, on the basis of a lack of medical necessity are not allowed.

(5) Court-ordered support: A deduction for the full amount of court-ordered child or spousal support is also allowed for the applicant or recipient.

(6) Personal needs allowance for recipients in an ICF-IID: If an applicant or recipient who is institutionalized in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) has a monthly income from employment in a sheltered workshop or other work activity program, up to the first $100 of this earned income is protected for the applicant's or recipient's personal needs. This amount is in addition to the applicant's or recipient's personal needs allowance protected from income from any source. If the applicant's or recipient's income is from any other source, the personal needs allowance is set at the amount as set forth in 8.281.500.12 NMAC.

(7) Veterans administration (VA) benefits: The ISD worker must contact the VA on each veteran's case to verify how much of the benefit is for pension, aid and attendance (A&A) or unusual medical expenses (UME).

(a) For MAP eligible veterans with no spouse or dependent children, and for surviving spouses of veterans without dependent children who do not reside in a state veteran's home (Fort Bayard or Truth or Consequences):

(i) exclude the A&A and UME in the medical care credit computation;

(ii) allow the personal needs allowance as set forth in 8.281.500.12 NMAC;

(iii) the benefit for applicant or recipient will be reduced to $90 per month effective the latest of the following;

(iv) the last day of the calendar month in which medicaid coverage begins;

(v) the last date of the month following 60 calendar days after issuance of a reduction notice;

(vi) the earliest date on which payment may be reduced without creating an overpayment;

(vii) when the benefit is reduced to $90, recomputed the medical care credit to allow $90 for personal needs.

(b) For MAP eligible veterans with no spouse or dependent children, and for surviving spouses of veterans without dependent children who do reside in a state veteran's home (Fort Bayard or Truth or Consequences):

(i) include the A&A and UME in the medical care credit computation;

(ii) allow $90 for their personal needs;

(iii) the benefit for the applicant or recipient is not reduced to $90.

(c) Benefits for the following applicants or recipients are not reduced to $90 a month, regardless of whether or not they reside in a state veteran's home:

(i) veterans who have a spouse or dependent child(ren);

(ii) surviving spouses of veterans who have dependent child(ren).

(d) The ISD worker allows these applicants or recipients the allowance as set forth in 8.281.500.12 NMAC, for personal needs.

C. Computing medical care credits for married institutionalized applicants or recipients: To calculate the medical care credit for a married institutionalized applicant or recipient, the "name-on-the-check" rule applies. The ISD worker uses only the income belonging to the institutionalized applicant or recipient to compute

their medical care credit. Total gross income before any deductions is used in this process.

(1) Treatment of VA aid and attendance (A&A) and unusual medical expenses (UME): Allowances for A&A and UME are considered when computing the medical credit in accordance with Subsection B of 8.281.500.22 NMAC.

(2) Court-ordered support: A deduction for the full amount of court-ordered child or spousal support is also allowed for the applicant or recipient.

D. Computing medical care credits for an institutionalized couple: To compute medical care credits for each of an eligible institutionalized couple, the ISD worker totals the couple's gross income and divides by two. The personal needs allowance as set forth in Subsection B of 8.281.500.22 NMAC is subtracted from each amount for each applicant's or recipient's personal needs and added to any allowable amount(s) paid by that applicant or recipient for noncovered medical expenses.

E. Medical care credit deductions: The ISD worker applies the deductions listed below in the following order when determining the medical care credit:

(1) institutionalized spouse's personal needs allowance as set forth in 8.281.500.12 NMAC;

(2) community spouse monthly income allowance (CSMIA); the CSMIA deduction is permitted only to the extent that the income is available and is actually contributed to and accepted by the community spouse or other dependent family members:

(a) the CSMIA is calculated by starting with the minimum monthly maintenance needs allowance (MMMNA) and subtracting the community spouse's total gross income;

(b) both spouses shall be given notice of the amount of the CSMIA;

(c) if either spouse is dissatisfied with the amount of the CSMIA, [he or she] they can request a HCA administrative hearing pursuant to 8.352.2 NMAC, to establish that the community spouse needs income above the minimum monthly maintenance needs allowance; the spouse must demonstrate that the community spouse needs the additional income above the level otherwise provided by the minimum monthly maintenance needs allowance due to exceptional circumstances resulting in significant financial duress; if the spouse establishes that the community spouse needs additional income due to exceptional circumstances resulting in significant financial duress, there shall be substituted for the CSMIA such amount as is necessary to alleviate the financial duress and for so long as the exceptional circumstances exist; if as a result of a HCA administrative hearing final decision or district court hearing, additional income is granted to the community spouse for a specified period of time, when that time expires, the original CSMIA, as calculated by the ISD worker is reinstated; the exceptional circumstances can include medical, remedial or other support expenses that jeopardize the ability of the community spouse to remain self-sufficient in the community;

(d) if as a result of a district court hearing or a HCA administrative hearing final decision, a request for a revision of the CSMIA is granted, the revised amount shall be substituted for the CSMIA calculated by the ISD worker; and

(e) when the institutionalized applicant's or recipient's income is insufficient to provide the minimum authorized deduction for the community spouse, either spouse can request a HCA administrative hearing pursuant to 8.352.2.NMAC if either spouse establishes that the CSRA (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the MMMNA, there shall be substituted, for the CSRA, an amount adequate to provide the MMMNA.

(3) an excess shelter allowance for allowable expenses of the community spouse which exceed thirty percent of the MMMNA standard up to a specified maximum; the following expenses are allowed for the primary residence of the community spouse:

(a) rent or mortgage payment, including interest or principal;

(b) home taxes and insurance;

(c) maintenance charges for a condominium or cooperative; and

(d) amount equal to the standard utility allowance used by the food stamp program if the community spouse incurs a heating or cooling expense; utility expenses included in the rent or the basic maintenance fee for a condominium or cooperative, are not allowed.

(4) The total CSMIA and excess shelter allowance combined may not exceed the standard amount per month, unless the MAD director or a district court orders the institutionalized spouse to pay an increased amount.

(5) An allowance for each eligible family member equal to one-third of the balance obtained after deducting the family member's gross income from the MMMNA. Family members include the couple's minor child(ren) under the age of 18 years, disabled adult child(ren) of the couple who meet the social security administration's definition of disability and dependent sibling(s) or parent(s) of the couple. These family members

must reside with the community spouse. The dependency requirements are met if either member of the couple could claim the family member as a dependent for tax purposes.

(6) The deductions for the community spouse and dependent family members apply only so long as there is a community spouse. Deductions for the community spouse and other family members shall cease in the first full calendar month after the community spouse dies, becomes divorced, or is institutionalized.

(7) Health insurance premiums and non-covered medical expense deduction.

F. **Reporting requirements:** An applicant or recipient, spouse, or authorized representative is required to report to the ISD worker any change in circumstances which may affect eligibility or the medical care credit amount within 10 working days after the date the change occurs. Changes which cause adjustments in an applicant's or recipient's medical care credit amount are effective the month after the change occurs. Family members receiving allowances must also report all changes of gross income and residence within 10 working days after the date the change occurs. Changes must be reported when the institutionalized spouse stops making all or part of a maintenance allowance available to the community spouse or other family member(s), or when the recipient of a maintenance allowance begins to refuse all or part of the income.

G. **Changes in income and recipient medical care credit:** Payments received by an applicant or recipient, such as social security, VA, retirement or other benefits, are applied to billing for services for the same month in which the payment is received. If the income increases, the institution must continue to collect the amount indicated on the medical care credit report in the eligible recipient's file and immediately advise the ISD worker of the change. The ISD worker processes the change, notifies the institution and the eligible recipient of the new medical care credit amount and indicates the month in which the higher amount is to be collected. The difference between the medical care credit amounts is deposited in the eligible recipient's personal fund account until the change is effective.

[8.281.500.22 NMAC - Rp, 8.281.500.23 NMAC, 8/15/2015; A, 12/1/2022]

8.281.500.23 **UNDUE HARDSHIP:** An applicant or recipient subject to a penalty for transfer of assets for less than fair market value may apply for a waiver of the regulation regarding transfer of assets as constituting an undue hardship. The facility where an institutionalized applicant or recipient resides may file an application for waiver of the requirement on behalf of the applicant or recipient with the applicant's or recipient's or authorized representative's consent.

A. The transfer must have been made to someone other than a family member. "Family member" includes son, daughter, grandson, granddaughter, step-son, step-daughter, in-laws, mother, father, step-mother, step-father, half-brother, half-sister, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, step-sister, step-brother.

B. The applicant or recipient must demonstrate that the application of the transfer of assets regulation would deprive the applicant or recipient of:

(1) medical care such that the applicant's or recipient's health or life would be endangered; or

(2) food, clothing, shelter or other necessities of life.

C. The applicant or recipient or the facility where the applicant or recipient resides must submit any documentation to support the claim that application of the transfer of assets requirement would constitute an undue hardship within 30 calendar days of the date of the notice regarding the penalty to the ISD county office.

D. Undue hardship does not exist when the application of a transfer penalty causes an applicant or recipient or their family members inconvenience or restricts their lifestyle.

E. The county director of the ISD office will make a decision regarding an application for waiver of the transfer of assets requirements within 30 calendar days of receipt of the application.

(1) Notice of the decision shall be mailed to the applicant or recipient or their authorized representative.

(2) MAD may make payments to the nursing facility for an applicant or recipient who is a resident of the facility while an application for waiver of the requirement is pending to hold the bed for the applicant or recipient. HCA may make payments for no more than 30 calendar days.

F. If the applicant's or recipient's application for waiver of the transfer of assets requirement is granted, MAD shall pay for long-term care services prospective from the date of the application. MAD shall pay for long-term care services as long as the circumstances constituting the basis for waiver of the application of the requirement exist. If the applicant's or recipient's application for waiver of the transfer of assets requirement is denied, the applicant or recipient can request a HCA administrative hearing pursuant to 8.352.2 NMAC within 90 calendar days of the date of the notice of denial.

G. The applicant or recipient or their authorized representative must notify the ISD worker of any change in circumstances which affects the application of the undue hardship waiver exception within 10 working days of the change in circumstances. MAD will review the change of circumstances and determine the next appropriate action, which may include withdrawal of the waiver.
[8.281.500.23 NMAC - Rp, 8.281.500.24 NMAC, 8/15/2015; A, 12/1/2022]

HISTORY OF 8.281.500 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
ISD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, 12/29/1983.
ISD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, 8/11/1987.
MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, 2/5/1988.
MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, 2/25/1988.
MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, 6/1/1988.
MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, 1/31/1989.
MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, 6/21/1989.
MAD Rule 880.0000, Medical Assistance for Persons Requiring Institutional Care, 3/21/1990.
MAD Rule 880, Medical Assistance for Persons Requiring Institutional Care, 5/3/1991.
MAD Rule 880, Medical Assistance for Persons Requiring Institutional Care, 6/12/1992.
MAD Rule 880, Medical Assistance for Persons Requiring Institutional Care, 11/16/1994.
MAD Rule 889, Spousal Impoverishment, 8/17/1992.
MAD Rule 889, Spousal Impoverishment, 2/17/1994.
MAD Rule 882, Resources - Medical Assistance for Persons Requiring Institutional Care, 3/9/1993.
MAD Rule 882, Medical Assistance for Persons Requiring Institutional Care, 11/16/1994.
MAD Rule 882, Resources, 12/29/1994.
MAD Rule 883, Income - Medical Assistance for Persons Requiring Institutional Care, 3/18/1993.
MAD Rule 883, Income - Medical Assistance for Persons Requiring Institutional Care, 11/16/1994.
MAD Rule 883, Income, 12/29/1994.
MAD Rule 888, Medicare Catastrophic Coverage Act of 1988 Regarding Transfers of Assets, 3/10/1994.
MAD Rule 888, Transfers of Assets, 12/27/1994.
MAD Rule 885, Medical Care Credit, 11/16/1994.

History of Repealed Material: 8.281.500 NMAC, Income and Resource Standards, filed 2/15/2001 - Repealed effective 8/15/2015.

TITLE 8 SOCIAL SERVICES
CHAPTER 281 MEDICAID ELIGIBILIY - INSTITUTIONAL CARE (CATEGORIES 081, 083, AND 084)
PART 510 TRUST STANDARDS

8.281.510.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.281.510.1 NMAC - N, 10/1/2012; A, 7/1/2024]

8.281.510.2 SCOPE: The rule applies to the general public.
[8.281.510.2 NMAC - N, 10/1/2012]

8.281.510.3 STATUTORY AUTHORITY: STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the health care authority pursuant to state statute. See Sections 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.281.510.3 NMAC - N, 10/1/2012; A, 7/1/2024]

8.281.510.4 DURATION: Permanent.
[8.281.510.4 NMAC - N, 10/1/2012]

8.281.510.5 EFFECTIVE DATE: October 1, 2012, unless a later date is cited at the end of a section.
[8.281.510.5 NMAC - N, 10/1/2012]

8.281.510.6 OBJECTIVE: The objective of this rule is to provide eligibility criteria and procedures for the medicaid programs.
[8.281.510.6 NMAC - N, 10/1/2012]

8.281.510.7 DEFINITIONS:

A. **"Assets"** include all income and resources as described in Section 8.281.500 NMAC of an applicant/recipient and their spouse. Assets not in a trust are considered under the applicable rule to determine if they are countable or excludable for the purposes of medicaid eligibility.

B. **"Beneficiary"** is the individual(s) for whose benefit the assets are held by the trustee.

C. **"Benefit"** is something to the advantage of or profit to the recipient.

D. **"Community spouse"** is an individual as described in Subsection E of Section 8.281.500.7 NMAC, *definitions*.

E. **"Corporate trustee"** means a bank, trust company, or company whose primary business is trust services. A corporate trustee may not have any affiliation with the beneficiary either through relatives working for the corporate trustee or investments by the beneficiary with the company other than for administrative fees.

F. **"Corpus"** is the body of the trust or the original asset used to establish the trust (to include principal, interest, and subsequent additions), such as a sum of money or real property.

G. **"Grantor"** is the owner of or has legal control over the assets placed into a trust. A grantor may also be referred to as a settlor or trustor.

H. **"Institutionalized individual"** is an individual as described in Subsection K of 8.281.500.7 NMAC.

I. **"Irrevocable trust"** is created when the grantor does not reserve any right to cancel or revoke any provision of the trust.

(1) Although termed irrevocable, a trust which provides that the trust can only be modified or terminated by a court is a revocable trust because the applicant/recipient (or their responsible party) or the trustee can petition the court to amend or terminate the trust.

(2) Although termed irrevocable, a trust that will terminate if a certain circumstance occurs during the lifetime of the applicant/recipient, such as the applicant/recipient leaving the nursing facility and returning home, is a revocable trust.

(3) Although termed irrevocable, a trust that can be revoked or terminated upon the agreement of any or all beneficiaries (including residual beneficiaries) is a revocable trust.

J. **"Payment"** means any disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as non-cash or property disbursements, such as the right to use and occupy real property.

K. **"Residual beneficiary"** is a person or entity that receives the remaining trust principal upon the death of the original trust beneficiary.

L. **"Revocable trust"** is created when the grantor reserves any right to cancel any provision of the trust.

M. **"Sole benefit of"** means that no individual or entity, except the person for whom the trust was established, may benefit from the assets in any way whether at the time the trust is created or at any time in the future except after medicaid is reimbursed.

N. **"Trust"** includes any legal instrument, device or arrangement, that is reduced to writing, signed and executed, which may not be called a trust under state law, or which is similar to a trust. A trust is a legal device in which property (real or personal) or other assets are held by one or more individuals for the benefit of others. A trust is usually created by a transfer of assets from the owner (grantor) to the trustee. Assets are not part of a trust and are considered outside of the trust until the date they are actually transferred into the trust, as demonstrated by verifiable documentation, regardless of the effective date of the trust. The transfer may be made while the grantor is alive or it may be made by will. The transfer of assets into a trust divests the original owner of legal title or restricts access to those assets. Trusts may also include structured settlements meeting the requirements stated above.

O. **"Trust records"** include, but are not limited to verifiable documentation of all transactions paid by or paid into a trust. Minimal documentation of distributions includes date of transaction, amount of payment (or if not paid by cash or other legal tender, type of asset distributed), person or entity receiving distribution, purpose of distribution, if distribution was made to acquire a non-consumable good, the location of that non-consumable good, and person or entity authorizing the distribution. Minimal documentation of additions to the trust includes the date of the transaction and a description of or amount of the asset transferred into the trust. The HCA shall not pay any costs or fees for obtaining trust records from the applicant/recipient or the trustee.

P. **"Trustee"** is a person or entity who holds and controls the assets in the trust. The trustee usually has legal title to the assets held in the trust and is considered the owner of the trust assets in most dealings with third parties.

[8.281.510.7 NMAC - N, 10/1/2012]

8.281.510.8 [RESERVED]

8.281.510.9 MEDICAID QUALIFYING TRUSTS (MQT): An MQT is a trust created prior to August 11, 1993. An MQT is a trust, or similar legal device, established (other than by will) by an applicant/recipient or an applicant/recipient's spouse, under which the applicant/recipient may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the applicant/recipient. A trust established by an applicant/recipient or an applicant/recipient's spouse includes trusts created or approved by a representative of the applicant/recipient (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the applicant/recipient or the applicant/recipient's spouse. This includes trust accounts or similar devices established for a minor child. In addition, a trust established jointly by at least one of the applicant/recipients who can establish an MQT and another party or parties (who do not qualify as one of these applicant/recipients) is an MQT as long as it meets the other MQT criteria. The provisions regarding MQTs apply even though an MQT is irrevocable or is established for purposes other than enabling an applicant/recipient to qualify for medicaid; and, whether or not discretion is actually exercised.

A. **Similar legal device:** MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. The determination whether a given document or arrangement constitutes a "similar legal device" shall be made by the HCA.

B. **MQT resource treatment:** For revocable MQTs, the entire principal is an available resource to the applicant/recipient. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the applicant/recipient, using their full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the applicant/recipient (or to use it for the applicant/recipient's benefit), the entire principal is an available resource to the applicant/recipient. Placement of an asset excluded by Section 8.281.500.13 NMAC, *resource exclusions*, into a trust does not change the nature of the asset. The asset remains excluded, except for the

home of an institutionalized individual. If the home of an institutionalized individual is placed in a trust, it becomes a countable resource. The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the applicant/recipient (or to be used for their benefit), but those distributions are not made, the applicant/recipient's countable resources increase cumulatively by the undistributed amount.

C. Income treatment: Amounts of MQT income distributed to the applicant/recipient or to third parties for the applicant/recipient's benefit are countable income when distributed.

D. Transfer of resources: If the MQT is irrevocable, a transfer of resources has occurred to the extent that the applicant/ recipient or grantor's access to the principal is restricted (e.g., if the trust states that the trustee cannot access the principal, but must distribute the income produced by that principal to the applicant/recipient, the principal is not an available resource and has, therefore, been transferred). See 8.281.500.14 NMAC.

E. Beneficiary of trust lives in an ICF-MR: If the beneficiary of a trust is an applicant/recipient who is mentally retarded and resides in an intermediate care facility for the mentally retarded (ICF-MR), that applicant/recipient's trust is not considered an MQT if the trust or trust decree was established prior to April 7, 1986, and is solely for the benefit of that applicant/recipient.

F. Treatment of SSI or social security lump sum payments: SSI or social security lump sum payments for retroactive periods which are placed in an MQT do not qualify for the nine-month exclusion from countable resources. The trust is evaluated as an MQT for purposes of medicaid eligibility.

G. Trust records shall be open at all reasonable times to inspection by the HCA and copies shall be provided upon the request of an authorized representative of the HCA.

[8.281.510.9 NMAC - Rp, 8.281.510.15 NMAC, 10/1/2012]

8.281.510.10 TRUSTS ESTABLISHED ON OR AFTER AUGUST 11, 1993: Trusts established on or after August 11, 1993 are evaluated using the provisions of OBRA 93. The term "medicaid qualifying trust" or MQT is no longer used after that date. Any trust which meets the basic definition of a trust can be counted in determining eligibility for medicaid. No clause or requirement in a trust, no matter how specifically it applies to medicaid or other federal or state programs (i.e. exculpatory clauses) precludes a trust from being considered under 8.281.500 NMAC. Depending on how the trust is structured, the amounts in the trust may count as resources, income, or a transfer of assets. All trusts submitted for review by the HCA must be in writing, signed, and fully executed. Trusts that are not signed and executed will not be considered as effective trusts until they are signed and executed. Assets are not part of a trust and are considered outside of the trust until the date they are actually transferred into the trust, as demonstrated by verifiable documentation, regardless of the effective date of the trust.

A. The standards set forth in this section shall apply to trusts or similar legal devices without regard to:

(1) the purposes for which the trust is established;

(2) whether the trustee(s) has discretion or exercises such discretion under the trust;

(3) any restrictions on when or whether distributions can be made from the trust; and

(4) or any restrictions on the use of distributions from the trust.

B. Trust establishment: An applicant/recipient is considered to have established a trust and that trust is considered to belong to that applicant/recipient if their assets were used to form all or part of the corpus of the trust. Applicants/recipients to whom the trust provisions apply shall include any applicant/recipient who establishes a trust and who is an applicant/recipient for medicaid services. An applicant/recipient shall be considered to have established a trust if any of their assets, regardless of the amount, were used to form part or all of the corpus of the trust.

(1) The trust must have been established, other than by will, by any of the following individuals:

(a) applicant/recipient;

(b) applicant/recipient's spouse;

(c) an individual, including a court or administrative body, with legal authority to act in place of, or on behalf of, the applicant/recipient or their spouse; or

(d) an individual, including a court or administrative body, acting at the direction of, or upon the request of, the applicant/recipient or their spouse.

(2) When the corpus of a trust includes assets of another person or persons not described in Subparagraphs (a) through (d) above, as well as assets of the applicant/recipient, the rules apply only to the portion of the trust attributable to the assets of the applicant/recipient. Thus, in determining countable income and resources

in the trust for eligibility and post-eligibility purposes, the ISD caseworker shall prorate any amounts of income and resources, based on the proportion of the applicant/recipient's assets in the trust to those of other persons. (For example: if the applicant/recipient and their two sisters create a trust and each sister contributes a total value of $50,000 and the applicant contributes $25,000, the applicant's prorated share is twenty percent of the entire value of the trust.)

C. Treatment of trusts: For purposes of determining medicaid eligibility, the treatment of trusts shall be dependent on the characteristics of the trust.

D. Revocable trusts:

(1) the entire corpus of the trust shall be counted as a resource available to the applicant/recipient; and

(2) any payments from the trust made to or for the benefit of the applicant/recipient shall be counted as income (unless otherwise excludable, see Section 8.281.500.20 NMAC, *unearned income*, and Section 8.281.500.21 NMAC, *deemed income*); and

(3) any payments from the trust which are not made to or for the benefit of the applicant/recipient shall be considered as assets transferred for less than fair market value (see Section 8.281.500.14 NMAC, *asset transfers*).

E. Irrevocable trusts: In an irrevocable trust from which payment can be made under the terms of the trust to or for the benefit of the applicant/recipient from all or a portion of the trust.

(1) The following shall apply to that trust or that portion of the trust:

(a) payments from income or from the corpus made to or for the benefit of the applicant/recipient shall be treated as income to the applicant/recipient unless otherwise excludable (see Section 8.281.500.20 NMAC and Section 8.281.500.21 NMAC);

(b) income on the corpus of the trust which could be paid to or for the benefit of the applicant/recipient shall be counted as a resource available to the applicant/recipient;

(c) the portion of the corpus that could be paid to or for the benefit of the applicant/recipient shall be treated as a resource available to the applicant/recipient; and

(d) payments from income or from the corpus that are made, but not to or for the benefit of the applicant/recipient, shall be treated as a transfer of assets for less than fair market value (see Section 8.281.500.14 NMAC).

(2) In the case of an irrevocable trust from which payments from all or a portion of the trust cannot, under any circumstances, be made to or for the benefit of the applicant/recipient, all of the trust, or any such portion or income thereof, shall be treated as a transfer of assets for less than fair market value (see Section 8.281.500.14 NMAC).

(a) In treating these portions as a transfer of assets, the date of transfer shall be considered to be the date the trust was established, or, if later, the date on which the applicant/recipient no longer had a right of payment.

(b) For transfer of assets purposes, in determining the value of the portion of the trust which cannot be paid to the applicant/recipient, amounts that have been paid, for whatever purpose, shall not be subtracted from the value of the trust on the date the trust was created or, if later, the date that payment could no longer be made. The value of the transferred amount shall be no less than the value on the date the trust is established or, if later, on the date that payment could no longer be made. If additional funds are added to this portion of the trust, those funds shall be treated as a new transfer of assets for less than fair market value, as of the date the additional funds were added to the trust (See Section 8.281.500.14 NMAC).

F. Payments are considered countable to the applicant/recipient when made from a revocable or irrevocable trust to or on behalf of the applicant/recipient including payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the applicant/recipient derives some benefit from the payment.

G. In determining whether payments can or cannot be made from a trust to or for an applicant/recipient, the HCA shall take into account any restrictions on payments, such as use restrictions, exculpatory clauses, or limits on trustee discretion that may be included in the trust. Any amount in a trust for which payment can be made, no matter how unlikely the circumstance of payment might be or how distant in the future, shall be considered a payment that can be made under some circumstances. For example, if an irrevocable trust provides that the trustee can disburse only $1,000 to or for the applicant/recipient out of $10,000 trust, only the $1,000 is treated as a payment that could be made. The remaining $9,000 is treated as an amount which cannot, under any circumstances, be paid to or for the benefit of the applicant/recipient and may be subject to a transfer penalty. On the other hand, if a trust contains $25,000 that the trustee can pay to the applicant/recipient only in the

event that the applicant/recipient needs, for example, a heart transplant, this full amount is considered as a payment that could be made under some circumstance, even though the likelihood of payment is remote. Similarly, if a payment cannot be made until some point in the distant future, it is still payment that can be made under some circumstances and the funds are counted as a resource.

H. Institutionalized individuals with a community spouse: A transfer to a trust (or similar instrument) for the sole benefit of a community spouse shall be treated in accordance with the provisions above. If the trust is established by either spouse (using at least some of the couple's assets) the trust shall be reviewed by the HCA for availability of resources, in accordance with the provisions above. If the payment from such a trust shall be considered an available resource to either spouse, the trust shall be included as a countable resource in determining medicaid eligibility for the institutionalized spouse.

I. Trust records shall be open at all reasonable times to inspection by the HCA and copies shall be provided upon the request of an authorized representative of the HCA. The HCA shall not be charged any fees or costs associated with providing trust records to the HCA.

[8.281.510.10 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012]

8.281.510.11 RECOGNIZED MEDICAID TRUSTS: The trust provisions set forth in 8.281.510.9 NMAC and 8.281.510.10 NMAC shall not apply to the following trusts so long as the trust document meets all the requirements set forth in this section.

A. The recognized medicaid trusts described in this section (special needs trusts and non-profit trusts for certain disabled individuals) are subject to the following.

(1) Only income and resources distributed directly to the applicant/recipient or to a third party on the applicant/recipient's behalf by the trustee are considered available to the applicant/recipient in determining medicaid eligibility if the applicant/recipient could use the payment for food or shelter for themselves.

(2) The trusts are reversionary trusts meaning the trust must provide that, upon the death of the applicant/recipient, any funds remaining in the trust revert to the state medicaid agency, up to the amount paid in medicaid benefits on the applicant/recipient's behalf. If the applicant/recipient has resided in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the applicant/recipient received medicaid, based on the state's proportionate share of the total amount of medicaid benefits paid by all of the states on the applicant/recipient's behalf.

(3) All trusts submitted for review to the HCA must be in writing, signed, and fully executed. Trusts that are not signed and executed will not be considered as effective trusts until they are signed and executed. Trusts must also be funded as demonstrated by verifiable documentation prior to review by the HCA.

(4) Assets are not part of a trust and are considered outside of the trust until the date they are actually transferred into the trust, as demonstrated by verifiable documentation, regardless of the effective date of the trust. Assets outside of a trust will be evaluated according to the applicable regulations regarding the counting of resources.

(5) Since the HCA is a reversionary beneficiary for all of the trusts described in the rest of this section, any legal action concerning one of these trusts must name the HCA as an interested party and the HCA must be notified by service of process in accordance with the New Mexico Rules of Civil Procedure.

(6) The applicant/recipient may not be the trustee and may not have any ability, access, or authority to manage or control the trust account.

(7) Each trust document must identify the person or organization that drafted the trust document.

(8) If the HCA approves or previously approved a recognized medicaid trust, the trust and administration of the trust are subject to review by the HCA, at least annually, and more frequently upon the request of the HCA, to determine if the trust remains a valid trust for the purposes of meeting the requirements of a recognized medicaid trust.

(9) If the HCA determines that a trust is invalid under Paragraph (8) above, the HCA will evaluate the applicant/recipient's medicaid eligibility, applying the provisions of Section 8.281.500 NMAC to the corpus of any existing trust. If the corpus of the trust is not disclosed or cannot be identified by the HCA due to a lack of documentation, the HCA will presume that the corpus of the trust is a countable resource in excess and will be counted toward the allowable resource limit in 8.281.500.11 NMAC, *applicable resource standards*.

(10) The trustee and any alternate trustees shall be specifically identified by name and address.

(11) The HCA shall not be charged any fees or costs for obtaining trust records or documents.

(12) The trust may not under any circumstances provide a loan to the beneficiary or any other individual or entity.

(13) The trust must be in compliance with all applicable criteria as set forth in 8.281.510.11 NMAC.

(14) All trusts under Subsection B below must terminate upon the death of the beneficiary and provision made to immediately disburse the remaining corpus in accordance with the terms of the trust.

B. Special needs trusts: A special needs trust is a trust containing the assets of a disabled applicant/recipient established and funded prior to the time the disabled applicant/recipient reaches the age of 65 and which is established for the sole benefit of the disabled applicant/recipient by a parent, grandparent, legal guardian of the disabled applicant/recipient, or a court. A trust established on or after December 13, 2016, by an individual (i.e. the trust beneficiary) with a disability under age 65 for their own benefit can qualify as a special needs trust, conferring the same benefits as a special needs trust set up by a parent, grandparent, legal guardian, or court. To qualify as a special needs trust, the trust shall contain the following provisions.

(1) The trust shall be identified as an OBRA '93 trust established pursuant to 42 U.S.C. Section 1396p(d)(4)(A).

(2) The trust shall not contain any provisions to automatically alter the form of the trust from an individual trust to a "pooled trust" under 42 U.S.C. Section 1396p(d)(4)(C). The special needs trust should be properly dissolved and a pooled trust should be created in accordance with federal and state laws.

(3) The trust shall specifically state that the trust is for the sole benefit of the trust beneficiary. Only trusts which are intended for the sole benefit of the disabled applicant/recipient are special needs trusts. Any trust which provides benefits to other persons is not for the sole benefit of the trust beneficiary and shall not be considered a special needs trust. The trust may provide for reasonable compensation to a trustee and shall provide for the reimbursement to the HCA on the death of the trust beneficiary.

(4) The trust shall specifically state that its purpose is to permit the use of trust assets to supplement, and not to supplant, impair or diminish, any benefits or assistance of any federal, state or other governmental entity for which the beneficiary may otherwise be eligible or for which the beneficiary may be receiving.

(5) Parents shall not be relieved of their duty to support a minor child. A minor's funds in a trust shall not be expended on routine support that should be provided by the parents.

(6) The trust shall specifically state the age of the trust beneficiary, whether the trust beneficiary is disabled within the definition of 42 U.S.C. Section 1382c(a)(3), and whether the trust beneficiary is competent at the time the trust is established.

(7) If the trust beneficiary is a minor, the trustee shall execute a bond to protect the child's funds or shall get a court's written order exempting them from the bond requirement.

(8) If there is some question about the trust beneficiary's disability, independent proof may be required.

(9) If the trust beneficiary is a minor, the trust shall state whether the trust beneficiary is expected to be competent at their majority.

(10) The trust shall specifically identify, in an attached schedule, the source of the initial trust property and all assets of the trust. If the trust is being established with funds from the proceeds of a settlement or judgment subsequent to the bringing of a legal cause of action, medicaid's claim for its expenditures that are related to the cause of action shall be repaid immediately upon the receipt of such proceeds and prior to the establishment of the trust.

(11) Subsequent additions made to the trust corpus shall be reported to the ISD caseworker upon application and recertification. Subsequent additions to the trust (other than interest on the corpus) after the applicant/recipient reaches age 65 may be subject to transfer of asset provisions (unless an exception to transfer of asset provisions applies).

(12) If subsequent additions are to be made to the trust corpus with funds not belonging to the trust beneficiary, it shall be understood that those funds are a gift to the trust beneficiary and cannot be reclaimed by the donor.

(13) If the trust makes provisions which are intended to limit invasion by creditors or to insulate the trust from liens or encumbrances, the trust shall state that such provisions are not intended to limit the state's right to reimbursement or to recoup incorrectly paid benefits.

(14) The special needs trust shall identify the grantor by name, indicate their relationship to the primary beneficiary, and state that it is established by a parent, grandparent, or legal guardian of the trust beneficiary, or by a court. A court can be named as the grantor, if the trust is established pursuant to a settlement of a case before it, or if the court is otherwise involved in the creation of the trust.

(15) The trust may pay administration fees and legal bills incurred by the beneficiary related

to the trust administration.

(16) The trust shall specifically state that it is irrevocable. Neither the grantor, nor the beneficiary, or any remainder beneficiaries shall have any right or power, whether alone or in conjunction with others, in whatever capacity, to revoke or terminate the trust or to designate the persons who shall possess or enjoy the trust estate during their lifetime. However, the trustee may seek an amendment for the limited purpose of ensuring that the trust complies with any changes to the laws governing the trust, per the agreement of all interested parties, to include the HCA. All such amendments shall be reviewed, consented to, and approved in writing by the HCA or its successor agency prior to finalizing the amendments. Any amendments not agreed to in writing by the HCA are void. Trust records shall be open at all reasonable times to inspection by the HCA and copies shall be provided, at no cost to the HCA, upon the request of an authorized representative of the HCA.

(17) The trustee shall be specifically identified by name and address. The trust shall state that the original trust beneficiary cannot be the trustee. The trust shall make provisions for naming a successor trustee in the event that any trustee is unable or unwilling to serve. The HCA as well as the trust beneficiary or guardian (if applicable), shall be given prior notice if there is a change in the trustee.

(18) The trust shall specifically state that the trustee shall fully comply with all state laws and regulations, including prudent administration per, Section 46A-8-804 (2003) NMSA 1978. The trust shall provide that the trustee cannot take any actions not authorized by, or without regard to, state laws and regulations.

(19) The trust shall specifically state that the trustee shall be compensated only as provided by law. The costs of administration must comply with Section 46A-8-805 (2003) NMSA 1978. If the trust identifies a guardian, the trust shall specifically identify the guardian by name. A guardian shall be compensated only as provided by law. The parent of a minor child shall not be compensated from the trust as the child's guardian.

(20) The trust shall specifically name the HCA as a remainder beneficiary with priority over any other beneficiaries except the primary beneficiary for whom the trust was created. The trust shall specifically state that, upon the death of the primary beneficiary, the HCA will be immediately notified by the trustee in writing, and shall be paid all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of the primary beneficiary. The trustee shall comply fully with this obligation to first repay the HCA, without requiring the HCA to take any action except to establish the amount to be repaid. Repayment shall be made by the trustee to the HCA or to any successor agency within 30 days after receiving written notification by the HCA of the amounts expended on behalf of the primary beneficiary.

(a) Allowable administrative expenses: The following types of administrative expenses may be paid from the trust prior to reimbursement to the HCA for medical assistance paid: taxes due from the trust to the state or federal government because of the death of the beneficiary, and reasonable fees for administration of the trust estate such as an accounting of the trust to a court, completion and filing of documents, or other required actions associated with termination and wrapping up of the trust. Payment of such expenses must be fully documented and copies of the documentation provided to the HCA within seven calendar days of making such payments.

(b) Prohibited expenses and payments: Examples of some types of expenses that are not permitted prior to reimbursement to the HCA for medical assistance, include but are not limited to: taxes due from the estate of the beneficiary other than those arising from inclusion of the trust in the estate, inheritance taxes due for residual beneficiaries, payment of debts owed to third parties other than the HCA, funeral expenses, and payments to residual beneficiaries.

(21) If there is a provision for repayment of other assistance programs, the trust shall specifically state that the medicaid program shall be repaid prior to making repayment to any other assistance programs.

(22) The trust shall specifically state that if the beneficiary has received medicaid benefits in more than one state, each state that provided medicaid benefits shall be repaid. If there is an insufficient amount left to cover all benefits paid, then each state shall be paid its proportionate share of the amount left in the trust, based upon the amount of support provided by each state to the beneficiary.

(23) No provisions in the trust shall permit the trustee or the estate's representative to first repay other persons or creditors at the death of the beneficiary. Only what remains in the trust after the repayments specified in Paragraphs (20) through (22) above have been made shall be considered available for other expenses or beneficiaries of the estate.

(24) The trust shall specify that an accounting of all additions and expenditures made by or into the trust shall be submitted to the HCA on an annual basis, or more frequently upon the request of the HCA. The HCA shall not be charged any fees or costs for obtaining these records.

(25) The trust shall not create other trusts within it.

(26) If the trust is funded, in whole or in part, with an annuity or other periodic payment arrangement, the HCA must be named in the controlling documents as the primary remainder beneficiary up to the total amount of medical assistance paid on behalf of the individual.

(27) Distributions from the trust made to or for the benefit of a third party that are not for the sole primary benefit of the disabled individual are treated as a transfer of assets for less than fair market value and may create a period of ineligibility for certain medicaid services.

C. Income diversion trusts: An applicant/recipient whose income exceeds the income standard may be eligible to receive medicaid through the creation and funding of an income diversion trust. The trust terminates upon the death of the beneficiary. An income diversion trust must meet all of the following requirements.

(1) The trust is composed only of pension, social security, and other income to the applicant/recipient, including accumulated income in the trust.

(2) Only income distributed directly to the applicant/recipient or to a third party on the applicant/recipient's behalf by the trustee are considered available to the applicant/recipient in determining medicaid eligibility if the applicant/recipient could use the payment for food or shelter for themselves.

(3) An income diversion trust is a reversionary trust meaning the trust must provide that, upon the death of the applicant/recipient, any funds remaining in the trust revert to the state medicaid agency, up to the amount paid in medicaid benefits on the applicant/recipient's behalf.

(4) If the applicant/recipient has resided in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the applicant/recipient received medicaid, based on the state's proportionate share of the total amount of medicaid benefits paid by all the states on the applicant/recipient's behalf.

(5) The trustee may, upon the death of the beneficiary, pay the expenses of the beneficiary's burial or cremation up to the amount then authorized for burial expenses under federal and state medicaid law and regulations, to the extent other resources are not so designated.

(6) The trusts described in this section are also known in New Mexico as Maxwell v. Heim income diversion trusts; those trusts executed on or after August 11, 1993, no longer have to be court ordered or approved.

D. Non-profit trusts for certain disabled individuals: Trusts containing the assets of applicants/recipients who meet the social security administration's definition of disability.

(1) The trust must meet all the following criteria to be considered a non-profit trust for certain disabled individuals:

(a) the trust is established and managed by a non-profit association;

(b) a separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools these accounts;

(c) accounts in the trust are established solely for the benefit of applicants/recipients who meet the social security administration's definition of disability and are established by the parent, grandparent, or legal guardian of such applicants/recipients, by such applicants/recipients themselves, or by a court;

(d) to the extent that any amounts remaining in the applicant/recipient's trust account upon their death are not retained by the trust, the trust pays to the HCA an amount equal to the total amount of medicaid benefits paid on behalf of the applicant/recipient;

(i) allowable administrative expenses: the following types of administrative expenses may be paid from the trust prior to reimbursement to the HCA for medical assistance paid: taxes due from the trust to the state or federal government because of the death of the beneficiary, and reasonable fees for administration of the trust estate such as an accounting of the trust to a court, completion and filing of documents, or other required actions associated with termination and wrapping up of the trust; payment of such expenses must be fully documented and copies of the documentation provided to the HCA within seven calendar days of making such payments;

(ii) prohibited expenses and payments: examples of some types of expenses that are not permitted prior to reimbursement to the HCA for medical assistance, include but are not limited to: taxes due from the estate of the beneficiary other than those arising from inclusion of the trust in the estate, inheritance taxes due for residual beneficiaries, payment of debts owed to third parties, funeral expenses, and payments to residual beneficiaries; and

(iii) any income or resources added to the trust after the applicant/recipient reaches 65 years of age may subject them to a transfer of assets penalty.

(2) A trustee of a non-profit trust, in order to fulfill their fiduciary obligations with respect to the state's remainder interest in the trust, must:

(a) notify the HCA, in writing, of the creation or funding of the trust for the benefit of an applicant/recipient; and

(b) notify the HCA, in writing, of the death of the beneficiary of the trust; and

(c) notify the HCA, in writing, in advance of any transactions involving transfers from the trust principal for less than fair market value.

(3) Trust records shall be open at all reasonable times to inspection by the HCA and copies shall be provided, at no cost to the HCA, upon the request of an authorized representative of the HCA.

[8.281.510.11 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012; A, 3/1/2018]

8.281.510.12 OTHER TRUSTS:

A. Limited partnerships: A limited partnership is a "similar legal device" to a trust. Trust provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) direct that the term "trust" includes any legal device similar to a trust. Therefore, OBRA 93 trust provisions of this section apply to limited partnerships. The general partners act as trustee, and the limited partners are the equivalent of beneficiaries of an irrevocable trust. To the extent that the general partners can make each limited partner's ownership interest available to them, that interest is a countable resource and not a transfer of assets. However, a transfer of assets has occurred to the extent that:

(1) the value of the share of ownership purchased by the limited partner is less than the amount they invested;

(2) the general partners cannot make the limited partner's share available to them;

(3) if transfer-of-assets provisions apply, the look-back period is 60 months.

B. Trusts created by will: Trusts that are created by will, but are not in effect (i.e., the testator is not deceased) are not considered as countable resources. Once a trust created by will is in effect and funded (i.e., the testator is deceased), the trust will be reviewed according to Subsection C, below.

C. Third party trusts:

(1) Third party trusts are trusts which are established with assets contributed by individuals other than the applicant/recipient or the applicant/recipient's spouse for the benefit of an applicant/recipient.

(2) The terms of the trust will determine whether the trust fund is countable as a resource or income for medicaid eligibility.

(a) Trusts which limit distributions to non-support or supplemental needs will not be considered as a countable resource in their entirety.

(b) If the applicant/recipient has the right to demand a distribution, the amount that may be demanded is countable, whether or not it is actually distributed.

(c) If the trustee may exercise discretion in distributing income or resources to the applicant/recipient or on behalf of the applicant/recipient, only the actual distributions of income or resources are countable in determining eligibility.

(d) If the applicant/recipient as the beneficiary of the trust may revoke or direct distributions from the trust, the trust is considered a countable resource.

(3) Trust records shall be open at all reasonable times to inspection by the HCA and copies shall be provided, at no cost to the HCA, upon the request of an authorized representative of the HCA.

[8.281.510.12 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012]

8.281.510.13 UNDUE HARDSHIP: An applicant/recipient who has excess resources and is unable to access resources from an existing trust will not be found ineligible for medicaid where the HCA determines, on a case by case basis, that denial of eligibility on the basis of excess resources would work an undue hardship.

A. The applicant/recipient must demonstrate that the application of the trust regulation would deprive the applicant/recipient or their spouse of:

(1) medical care such that the applicant/recipient's health or life would be endangered; or

(2) food, clothing, shelter or other necessities of life.

B. The applicant/recipient must submit any documentation to support the claim that application of the trust regulation would constitute an undue hardship within 30 days of the date of the notice regarding eligibility for medicaid.

C. Undue hardship does not exist when the application of the trust regulation causes an applicant/recipient or their family members inconvenience or restricts their lifestyle.

D. The county director of the ISD office will make a decision regarding an application for waiver of the trust regulation within 30 days of receipt of the application. The decision to grant a waiver shall be reviewed at

every re-certification to determine if the circumstances justifying a waiver are still applicable.

E. Notice of the decision shall be mailed to the applicant/recipient or their representative.

F. The applicant/recipient or their representative must notify the ISD caseworker of any change in circumstances which affects the application of the undue hardship waiver exception within 10 days of the change in circumstances. The HCA will review the change of circumstances and determine the next appropriate action, which may include withdrawal of the waiver.

[8.281.510.13 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012]

8.281.510.14 USE OF TRUST V. TRANSFER RULES FOR ASSETS PLACED IN TRUST: When a non-excluded asset is placed in a trust, a transfer of assets for less than fair market value generally takes place. An applicant/recipient (or someone acting on behalf of the applicant/recipient) placing an asset in a trust generally gives up ownership of the asset to the trust. If the applicant/recipient does not receive fair compensation in return, a penalty is imposed under the transfer of assets provisions. However, the trust provisions contain specific requirements for treatment of assets placed in trusts. These requirements indicate when assets are considered countable as income or resources, and as a transfer of assets depending on the specific circumstances of the particular trust. Application of the trust regulations, along with the imposition of a penalty for the transfer of the assets into the trust, could result in the applicant/recipient being penalized twice for actions involving the same asset. If an asset is subject to the trust regulations and a transfer of asset penalty, the requirements of the trust regulations take precedence over a transfer of assets penalty for the same asset.

[8.281.510.14 NMAC - N, 10/1/2012]

8.281.510.15 EXCLUDED ASSETS PLACED IN A TRUST: Placement of excluded assets in a trust, with the exception of a home, shall not result in a penalty of ineligibility because the transferred asset is not an asset for transfer purposes. However, a home, whether excluded or not, when transferred into a trust shall be considered a resource unless:

A. the trust is for the sole benefit for the applicant/recipient's spouse; or

B. was transferred to a trust that is in compliance with Subsection B or D of Section 8.281.510.11 NMAC that is established for the sole benefit of the applicant/recipient's disabled child, or

C. was transferred to a trust that is in compliance with Subsection B or D of Section 8.281.510.11 NMAC that is established solely for the benefit of an individual who is under 65 years of age and who is disabled.

[8.281.510.15 NMAC - N, 10/1/2012]

8.281.510.16 DOCUMENTATION OF TRUSTS AND TRUST RECORDS: Applicants/recipients shall disclose the existence of any trust to which they have contributed income, resources, or are a beneficiary. Upon learning of the existence of a trust, the ISD caseworker must obtain a copy of the trust document, including all attachments, and forward it to the MAD eligibility unit so that it may be reviewed by MAD for a determination on how the trust may affect medicaid eligibility. Trust records shall be open at all reasonable times to inspection by the HCA and copies shall be provided upon the request of an authorized representative of the HCA. The HCA shall not be charged any fees or costs associated with providing trust records to the HCA. Any records relating to a trust that are sealed by a court order or settlement agreement shall be produced to the HCA by the applicant/recipient or trustee upon request. Failure to provide such records will result in the presumption that the applicant/recipient's trust is a countable resource that exceeds the resource limitation at 8.281.500 NMAC.

[8.281.510.16 NMAC - N, 10/1/2012]

8.281.510.17 COMMENCEMENT OF PROCEEDINGS: The HCA may commence a proceeding against the trustee of a trust, if the HCA considers any acts, omissions, or failures of the trustee to be inconsistent with the terms of the trust, contrary to applicable laws or regulations, or contrary to the fiduciary obligations of the trustee.

[8.281.510.17 NMAC - N, 10/1/2012]

8.281.510.18 NON-COMPLIANCE WITH TERMS OF TRUST: If the HCA suspects or determines that the trustee is not complying with the terms of a trust that has been approved by the HCA, the HCA will send a letter to the recipient of services or their representative requesting more information or describing the specific actions that are not in compliance with the trust which may include but is not limited to proper management of the funds in the trust. The recipient will have 15 days to provide the requested information or demonstrate, through documentation, that the actions of the trustee are not in violation of the terms of the trust. Failure to respond or to adequately demonstrate that the terms of the trust have not been violated may result in a transfer of assets penalty,

disqualification from eligibility to receive benefits, and legal action, as appropriate. If the HCA identifies that the violation of the terms of the trust has been to inadequately fund the trust, the recipient shall immediately obtain a corporate trustee and amend the trust to be managed by that corporate trustee.
[8.281.510.18 NMAC - N, 10/1/2012]

8.281.510.19 AMENDMENTS TO CERTAIN TRUSTS: A special needs trust, income diversion trust, or pooled charitable trust that was created prior to the effective date of these regulations must fully comply with these regulations as part of any subsequent amendments made to those trusts on or after the effective date of these regulations.
[8.281.510.19 NMAC - N, 10/1/2012]

HISTORY OF 8.281.510 NMAC:
NMAC History:
8 NMAC 4.ICM.500, Eligibility Policy, Income and Resource Standards, filed 12/30/1994.
8 NMAC 4.ICM.500, Eligibility Policy, Income and Resource Standards, filed 7/17/1997.
8.281.500 NMAC, Income and Resource Standards, filed 2/15/2001.
8.281.500.15 NMAC, Trusts, filed 2/15/2001- Replaced by 8.281.510 NMAC, Trust Standards, effective 10/1/2012.

TITLE 8 SOCIAL SERVICES
CHAPTER 281 MEDICAID ELIGIBILITY - INSTITUTIONAL CARE (CATEGORIES 081, 083 and 084)
PART 600 BENEFIT DESCRIPTION

8.281.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.281.600.1 NMAC - Rp, 8.281.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.281.600.2 SCOPE: The rule applies to the general public.
[8.281.600.2 NMAC - Rp, 8.281.600.2 NMAC, 1/1/2019]

8.281.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.281.600.3 NMAC - Rp, 8.281.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.281.600.4 DURATION: Permanent.
[8.281.600.4 NMAC - Rp, 8.281.600.4 NMAC, 1/1/2019]

8.281.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.281.600.5 NMAC - Rp, 8.281.600.5 NMAC, 1/1/2019]

8.281.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.281.600.6 NMAC - Rp, 8.281.600.6 NMAC, 1/1/2019]

8.281.600.7 DEFINITIONS: [**RESERVED**]

8.281.600.8 [**RESERVED**]

8.281.600.9 BENEFIT DESCRIPTION: Applicant/recipient who is eligible for institutional care medicaid is eligible to receive the full range of medicaid-covered services, unless coverage is restricted due to transfer of asset penalties.
[8.281.600.9 NMAC - Rp, 8.281.600.9 NMAC, 1/1/2019]

8.281.600.10 BENEFIT DETERMINATION:

A. Application for institutional care medicaid is made using the HCA 100 application. Completed applications must be acted upon and notice of approval, denial, or delay sent out within 45 days from the date of registration. The income support division (ISD) worker explains time limits to the applicant and informs them of the date by which the application should be processed.

B. Representatives applying on behalf of individuals: If a representative makes application on behalf of an institutionalized individual, the representative is relied upon for information. The ISD worker sends all notices to the applicant/recipient in care of the representative. If the individual who makes an application is an employee of the institution, the ISD worker contacts the applicant's family or other involved individuals. The ISD worker focuses on the applicant/recipient's current circumstances and on past circumstances which may provide clues to existing or potential resources.
[8.281.600.10 NMAC - Rp, 8.281.600.10 NMAC, 1/1/2019]

8.281.600.11 INITIAL BENEFITS:

A. For an applicant/recipient who loses supplemental security income (SSI) eligibility after entering an institution, the institutional care medicaid application date is the first day of the month of SSI termination, or the month the application is received by the ISD worker, whichever is earlier.

B. Notice of determination: Applicants eligible for institutional care medicaid are notified of the

approval and advised of the amount, if any, of the medical care credit. Applicants who are ineligible are notified of the denial and provided with an explanation of appeal rights.
[8.281.600.11 NMAC - Rp, 8.281.600.11 NMAC, 1/1/2019]

8.281.600.12 ONGOING BENEFITS: A complete redetermination of eligibility must be performed by the ISD worker for each open case at least annually.

A. Regular reviews: For each regular yearly review, the ISD worker must determine:

(1) whether medical care credit payments are up to date; an overdue balance may indicate a change in circumstances that is unreported, particularly where rental property is involved; and

(2) whether the deposit to the recipient's personal fund is consistently no more than the applicable personal needs allowance amount per month; a larger deposit may indicate an increase in income that is unreported or a previously unidentified source of income.

B. Level of care reviews are required to be completed at least annually. Level of care determinations are made by the utilization review contractor or a member's selected or assigned managed care organization.
[8.281.600.12 NMAC - Rp, 8.281.600.12 NMAC, 1/1/2019]

8.281.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three months of retroactive medicaid coverage can be furnished to applicants who have received medicaid-covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three months prior to the month of application. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.281.600.13 NMAC - Rp, 8.281.600.13 NMAC, 1/1/2019]

8.281.600.14 CHANGES IN ELIGIBILITY:

A. The following procedures apply when an institutional care medicaid recipient leaves an institution:

(1) the recipient is notified in writing that their eligibility for institutional care medicaid has terminated;

(2) the institutional care medicaid case is closed;

(3) the recipient is screened for other medicaid program eligibility; or

(4) the recipient is referred to the social security administration for determination of eligibility for SSI benefits if appropriate; if a recipient dies in an institution, the case is closed the following month.

B. Discharge status: Discharge status continues after the utilization review (UR) contractor determines that there is no medical necessity for a high nursing facility (NF) or low NF placement. Discharge status does not apply to an acute care placement. After placement in discharge status, the recipient continues to be eligible for institutional care medicaid since they still require institutional care.

(1) Abstract submission: Discharge status requires a new abstract be submitted at regular intervals. The institution must attach verification to the abstract that adequate placement has been and is being sought.

(2) Case closure: The ISD worker takes no action to close a case until the recipient is actually discharged from the institution. If the recipient is transferred from high NF to low NF, medicaid coverage is not interrupted, unless the recipient is ineligible for other reasons.
[8.281.600.14 NMAC - Rp, 8.281.600.14 NMAC, 1/1/2019]

HISTORY OF 8.281.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 12/29/1983.
ISD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 8/11/1987.
MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 2/5/1988.
MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 2/25/1988.
MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 6/1/1988.
MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 1/31/1989.
MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 6/21/1989.
MAD Rule 880.0000, Medical Assistance for Persons Requiring Institutional Care, filed 3/21/1990.
MAD Rule 880, Medical Assistance for Persons Requiring Institutional Care, filed 5/3/1991.
MAD Rule 880, Medical Assistance for Persons Requiring Institutional Care, filed 6/12/1992.
MAD Rule 880, Medical Assistance for Persons Requiring Institutional Care, filed 11/16/1994.
MAD Rule 882, Resources - Medical Assistance for Persons Requiring Institutional Care, filed 3/9/1993.

MAD Rule 882, Resources - Medical Assistance for Persons Requiring Institutional Care, filed 11/16/1994.
MAD Rule 882, Resources, filed 12/29/1994.
MAD Rule 883, Income - Medical Assistance for Persons Requiring Institutional Care, filed 3/18/1993.
MAD Rule 883, Income - Medical Assistance for Persons Requiring Institutional Care, filed 11/16/1994.
MAD Rule 883, Income, filed 12/29/1994.
MAD Rule 885, Medical Care Credit, filed 11/16/1994.
MAD Rule 888, Medicare Catastrophic Coverage Act of 1988 Regarding Transfers of Assets, filed 3/10/1994.
MAD Rule 888, Transfers of Assets, filed 12/27/1994.
MAD Rule 889, Spousal Impoverishment, filed 8/17/1992.
MAD Rule 889, Spousal Impoverishment, filed 2/17/1994.

History of Repealed Material:
MAD Rule 880, Medical Assistance for Persons Requiring Institutional Care, filed 11/16/1994 - Repealed effective 2/1/1995.
MAD Rule 882, Resources, filed 12/29/1994 - Repealed effective 2/1/1995.
MAD Rule 883, Income, filed 12/29/1994 - Repealed effective 2/1/1995.
MAD Rule 885, Medical Care Credit, filed 11/16/1994 - Repealed effective 2/1/1995.
MAD Rule 888, Transfers of Assets, filed 12/27/1994 - Repealed effective 2/1/1995.
MAD Rule 889, Spousal Impoverishment, filed 2/17/1994 - Repealed effective 2/1/1995.
8 NMAC 4.ICM.600, Benefit Description, filed 12/30/1994 - Repealed effective 4/1/2009.
8.281.600 NMAC – Benefit Description, filed 3/13/2009 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 285 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY – EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS
PART 400 RECIPIENT REQUIREMENTS

8.285.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.285.400.1 NMAC - Rp, 8.285.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.285.400.2 SCOPE: The rule applies to the general public.
[8.285.400.2 NMAC - Rp, 8.285.400.2 NMAC, 1/1/2014]

8.285.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.285.400.3 NMAC - Rp, 8.285.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.285.400.4 DURATION: Permanent.
[8.285.400.4 NMAC - Rp, 8.285.400.4 NMAC, 1/1/2014]

8.285.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.285.400.5 NMAC - Rp, 8.285.400.5 NMAC, 1/1/2014]

8.285.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs.
[8.285.400.6 NMAC - Rp, 8.285.400.6 NMAC, 1/1/2014]

8.285.400.7 DEFINITIONS: [**RESERVED**]

8.285.400.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.285.400.8 NMAC - N, 1/1/2014; A, 5/1/2020]

8.285.400.9 EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS - CATEGORY 085: Certain non-citizens who are undocumented or who do not meet the qualifying immigration criteria specified in 8.200.410 NMAC, but who meet all eligibility criteria for the following medical assistance categories of eligibility (COEs): other adults (COE 100), parent/caretaker (COE 200), pregnant women (COE 300), pregnancy-related services (COE 301), children under age 19 (COEs 400, 401, 402, 403, 420, and 421) or supplemental security income (COEs 001, 003, and 004) can receive coverage for emergency services. See 42 CFR Section 440.225.
[8.285.400.9 NMAC - Rp, 8.285.400.9 NMAC, 1/1/2014; A, 5/1/2020; A, 1/1/2022]

8.285.400.10 BASIS FOR DEFINING THE GROUP: The definition of an emergency medical condition is found at 8.325.10.13 NMAC.
[8.285.400.10 NMAC - Rp, 8.285.400.10 NMAC, 1/1/2014; A, 5/1/2020]

8.285.400.11 [**RESERVED**]

8.285.400.12 ENUMERATION: A non-citizen applicant is exempt from the requirement to provide a social security number (SSN). If the applicant is found eligible for coverage of emergency services, the claims are paid using an eligibility system generated identification number.
[8.285.400.12 NMAC - Rp, 8.285.400.12 NMAC, 1/1/2014; A, 5/1/2020]

8.285.400.13 CITIZENSHIP: An applicant must be a non-citizen who is undocumented or who does not meet the qualifying immigration criteria specified in 8.200.410 NMAC. Per 42 CFR 440.255(c), effective January 1, 1987, non-citizens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined at 8.325.10.13 NMAC.
[8.285.400.13 NMAC - Rp, 8.285.400.13 NMAC, 1/1/2014; A, 5/1/2020]

8.285.400.14 RESIDENCE: An applicant must be a resident of the state of New Mexico in accordance with 8.200.410.14 and 8.291.410.15 NMAC.
[8.285.400.14 NMAC - Rp, 8.285.400.14 NMAC, 1/1/2014; A, 5/1/2020]

8.285.400.15 EMPLOYMENT, TRAINING, AND WORK REGISTRATION: Registration for employment or training is not a factor of eligibility.
[8.285.400.15 NMAC - Rp, 8.285.400.15 NMAC, 1/1/2014]

8.285.400.16 [**RESERVED**]

8.285.400.17 SSI STATUS: Applicants who apply under supplemental security income (SSI) coverage must meet the income and resource limits. Eligibility is determined using the SSI methodology contained in 8.215 NMAC. Disability is determined by disability determination services.
[8.285.400.17 NMAC - Rp, 8.285.400.17 NMAC, 1/1/2014]

8.285.400.18 RECIPIENT RIGHTS AND RESPONSIBILITIES: It is the responsibility of the applicant to provide the required information, documents or undertake the actions necessary for HCA to establish eligibility. The applicant must grant HCA permission to contact other persons, agencies or sources of information which are necessary in the establishment of eligibility. Failure of the applicant to provide or take action will result in a HCA action to deny eligibility.
[8.285.400.18 NMAC - Rp, 8.285.400.18 NMAC, 1/1/2014]

8.285.400.19 ASSIGNMENT OF SUPPORT: See 8.200.430 NMAC.
[8.285.400.19 NMAC - Rp, 8.285.400.19 NMAC, 1/1/2014]

HISTORY OF 8.285.400 NMAC:

History of Repealed Material:
8.285.400 NMAC, Recipient Policies, filed 11-17-08 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 290 MEDICAID ELIGIBILITY - HOME AND COMMUNITY-BASED SERVICES WAIVER (CATEGORIES 090, 091, 092, 093, 094, 095 AND 096)
PART 400 RECIPIENT POLICIES

8.290.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.290.400.1 NMAC - Rp, 8.290.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.290.400.2 SCOPE: The rule applies to the general public.
[8.290.400.2 NMAC - Rp, 8.290.400.2 NMAC, 1/1/2019]

8.290.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.290.400.3 NMAC - Rp, 8.290.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.290.400.4 DURATION: Permanent.
[8.290.400.4 NMAC - Rp, 8.290.400.4 NMAC, 1/1/2019]

8.290.400.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.290.400.5 NMAC - Rp, 8.290.400.5 NMAC, 1/1/2019]

8.290.400.6 OBJECTIVE: The objective of this rule is to provide eligibility criteria for the medicaid program.
[8.290.400.6 NMAC - Rp, 8.290.400.6 NMAC, 1/1/2019]

8.290.400.7 DEFINITIONS:

A. Adaptive behavior: The effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for their age and cultural group.

B. Comprehensive care plan (CCP): The comprehensive care plan of services that meets the member's physical, behavioral and long-term care needs in managed care.

C. Developmental disability: For the purposes of the developmental disabilities (DD) waiver, a developmental disability is limited to an intellectual disability or a related condition as defined by the department of health/developmental disabilities supports division (DOH/DDSD) that is likely to continue indefinitely and results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency.

D. Developmental period: The time between birth and the 18th birthday.

E. Disability determination unit (DDU): The unit that determines disability as described in Section 8.200.420.11 NMAC.

F. General intellectual functioning: The results of one or more individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.

G. Individual service plan (ISP): A treatment plan for an eligible recipient that includes the eligible recipient's needs, functional level, intermediate and long range goals, statement for achieving the goals and specifies responsibilities for the care needs. The plan determines the services allocated to the eligible recipient within program allowances.

H. Intermediate care facility for individuals with intellectual disabilities (ICF/IID): This term replaces all references to intermediate care facility for mental retardation (ICF/MR).

I. Intellectual disability (ID): Refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Intellectual disability replaces all references to mental retardation.

J. **Letter of allocation:** Written notice to the applicant that they may proceed with the home and community-based services (HCBS) waiver application process.

K. **Level of care:** The level of institutional care needed by the eligible recipient.

L. **Medically Fragile:** For the purposes of the medically fragile waiver (MFW), medically fragile is a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary.

M. **Primary Freedom of Choice (PFOC):** The form included in the allocation packet that allows a registrant to confirm their interest in pursuing the opportunity to apply for community benefits.

N. **Prospective:** A period of time starting with the date of application going forward.

O. **Restricted coverage:** Medicaid eligibility without long term care services coverage.

P. **Significantly subaverage intellectual functioning:** IQ of 70 or below.

Q. **Unduplicated recipient positions (UDR):** Space available in a particular HCBS waiver program.

R. **Waiver:** Permission from the centers for medicare and medicaid services (CMS) to waive certain medicaid requirements in order for a state to furnish an array of home and community-based services to state-specified target group(s) of medicaid recipients who need a level of institutional care.

[8.290.400.7 NMAC - Rp, 8.290.400.7 NMAC, 1/1/2019; A, 5/1/2021]

8.290.400.8 **MISSION STATEMENT:** To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.290.400.8 NMAC - A/E, 12/15/2020; A, 5/1/2021]

8.290.400.9 **HOME AND COMMUNITY-BASED SERVICES WAIVER - Category 091, 093, 094, 095, 096:** The health care authority (HCA) is the single state agency designated to administer the medicaid program in New Mexico. HCA is charged with developing and implementing the community benefit to elderly, blind, and disabled individuals who meet both financial and medical criteria for nursing facility (NF) level of care (categories 091, 093, and 094). The department of health (DOH) and the HCA are charged with developing and implementing HCBS waivers to medicaid applicants/recipients who meet both financial and medical criteria for intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care, for medically fragile (category 095) and developmentally disabled (category 096) individuals. Provision of these services under a waiver allows applicants/recipients to receive the care required at home at less cost than in an institution. The services to be furnished under the waiver must be cost-effective. This means the aggregate cost of care must be an amount less than the cost of maintaining individuals in institutions at the appropriate level of care. The types of services for which recipients are eligible vary based on the individual waiver.

[8.290.400.9 NMAC - Rp, 8.290.400.9 NMAC, 1/1/2019]

8.290.400.10 **BASIS FOR DEFINING THE GROUP:** Eligibility for applicants/recipients who apply for waiver services is determined as if they were actually institutionalized, although this requirement has been waived. Entry into some of the waiver programs may be based upon the number of UDRs (i.e., slots) available. The individual waiver program manager notifies the income support division (ISD) when a UDR is available.

A. Elderly, blind, and disabled individuals (categories 091, 093, and 094): For applicants/recipients who are under age 65 to qualify as disabled or blind, disability or blindness must have been determined to exist by the social security administration or the DDU. To qualify as an elderly person, the applicant/recipient must be 65 years of age or older. Applicants/recipients must also meet both the financial and non-financial eligibility requirements and meet the medical level of care for nursing facility services.

B. Developmental disabilities (DD) waiver: The DD waiver identified as category 096 was approved effective July 1984, subject to renewal. DD waiver services are intended for eligible recipients who have developmental disabilities limited to intellectual disability (IID) or a related condition as determined by the DOH/DDSD. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated. The eligible recipient must also require the level of care provided in an intermediate care facility for individuals with developmental disabilities (ICF/IID), in accordance with Section 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements.

(1) Intellectual disability: An individual is considered to have an intellectual disability if they have significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(a) General intellectual functioning is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.

(b) Significantly sub-average is defined as an intelligence quotient (IQ) of 70 or below.

(c) Adaptive behavior is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group.

(d) The developmental period is defined as the period of time between birth and the 18th birthday.

(2) Related condition: An individual is considered to have a related condition if they have a severe chronic disability, other than mental illness, that meets all of the following:

(a) is attributable to a condition, other than mental illness, found to be closely related to ID because this condition results in limitations in general intellectual functioning or adaptive behavior similar to that of persons with ID and requires similar treatment or services;

(b) is manifested before the person reaches age 22 years, is likely to continue indefinitely; and

(c) results in substantial functional limitations (adaptive behavior scores equal to or less than 70) in three or more of the following areas:

(i) self-care;
(ii) receptive and expressive language;
(iii) learning;
(iv) mobility;
(v) self-direction;
(vi) capacity for independent living; and
(v) economic self-sufficiency.

C. Medically fragile (MF) waiver: The medically fragile (MF) waiver identified as category 095 was established effective August, 1984, subject to renewal. Medically fragile is characterized by one or more of the following: a life threatening condition characterized by reasonable frequent periods of acute exacerbation which require frequent medical supervision, or physician consultation and which in the absence of such supervision or consultation would require hospitalization; a condition requiring frequent, time consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include but are not limited to ventilators, dialysis machines, enteral or parenteral nutrition support and supplemental oxygen. The eligible recipient must require the level of care provided in an ICF/IID, in accordance with 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements and must have:

(1) a developmental disability, developmental delay, or be at risk for developmental delay as determined by the DDU, and

(2) a diagnosed medically fragile condition prior to the age of 22, defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary, and which is characterized by one or more of the following:

(a) a life threatening condition characterized by reasonably frequent periods of acute exacerbation, which require frequent medical supervision or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(b) frequent, time-consuming administration of specialized treatments, which are medically necessary;

(c) dependency on medical technology such that without the technology a reasonable level of health could not be maintained; examples include, but are not limited to, ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen; and

(d) periods of acute exacerbation of a life-threatening condition, the need for extraordinary supervision or observation, frequent or time-consuming administration of specialized treatments, dependency on mechanical (life) support devices, and developmental delay or disability.

D. Acquired immunodeficiency syndrome (AIDS) and AIDS related condition (ARC) waiver: The acquired immunodeficiency syndrome (AIDS) and AIDS related condition waiver designated as category 090, was established effective July 1987, subject to renewal. The AIDS and AIDS related condition waiver stopped covering new individuals effective January 01, 2014, as the waiver was sunset and not renewed. Individuals already

on the AIDS and AIDS related condition waiver are grandfathered and remain eligible as long as eligibility requirements are met.

E. Brain injury (BI): The brain injury category 092 stopped covering new individuals effective January 01, 2014. Individuals already on the brain injury category are grandfathered and remain eligible as long as eligibility requirements are met.

[8.290.400.10 NMAC - Rp, 8.290.400.10 NMAC, 1/1/2019; A/E, 12/15/2020; A, 5/1/2021]

8.290.400.11 GENERAL RECIPIENT REQUIREMENTS: Eligibility for the waiver programs is always prospective per 8.290.600.11 NMAC. Applicants/recipients must meet, or expect to meet, all non-financial eligibility criteria in the month for which determination of eligibility is made including any mandatory income or resources deemed to a minor child per 8.290.500.17 and 8.290.500.21 NMAC.

A. Enumeration: An applicant/recipient must furnish their social security number in accordance with 8.200.410.10 NMAC.

B. Citizenship: Refer to 8.200.410.11 NMAC for citizenship requirements.

C. Residence: To be eligible for medicaid, an applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have declared an intent to remain in the state. If the applicant/recipient does not have the present mental capacity to declare intent, the applicant's/recipient's representative may assume responsibility for the declaration of intent. If the applicant/recipient does not have the mental capacity to declare intent and there is no representative to assume this responsibility, the state where the applicant/recipient is living will be recognized as the state of residence. If waiver services are suspended because the recipient is temporarily absent from the state but is expected to return within 90 consecutive days at which time waiver services will resume, the medicaid case remains open. If waiver services are suspended for any other reason for 90 consecutive days, the medicaid case is closed after appropriate notice is provided to the recipient.

D. Non-concurrent receipt of assistance: HCBS waiver services furnish medicaid benefits to an applicant/recipient who qualifies both financially and medically for institutional care but who, with provision of waiver services, can receive the care they need in the community at less cost to the medicaid program than the appropriate level of institutional care. Individuals receiving services under a HCBS waiver may not receive concurrent services under nursing facility (NF), ICF/IID, personal care or any other HCBS waiver.

(1) SSI recipients: Applicants receiving supplemental security income (SSI) benefits are categorically eligible for waiver services. No further verification of income, resources, citizenship, age, disability, or blindness is required. The applicant must, however, meet the level of care requirement. (An SSI recipient must meet the assignment of rights and TPL requirements and not be ineligible because of a trust).

(2) Married SSI couples: All married SSI couples where neither member is institutionalized in a medicaid-certified facility are treated as separate individuals for purposes of determining eligibility and benefit amounts beginning the month after the month they began living apart. See Section 8012 of the Omnibus Budget Reconciliation Act of 1989. In the case of an initial application, or reinstatement following a period of ineligibility, when members of a married couple are not living together on the date of application or date of request for reinstatement, each member of the couple is considered separately as of the date of application or request, regardless of how recently the separation occurred.

E. INTERVIEW REQUIREMENTS: An interview is not required in accordance with 8.281.400.11 NMAC.

[8.290.400.11 NMAC - Rp, 8.290.400.11 NMAC, 1/1/2019; A/E, 12/15/2020; A, 5/1/2021]

8.290.400.12 SPECIAL RECIPIENT REQUIREMENTS:

A. Age: To be considered elderly, an applicant/recipient must be 65 years of age or older. See Section 8.281.400.16 NMAC, AGE, for information on verification of age.

B. Blind: To be considered blind, an applicant/recipient must have central visual acuity of 20/200 or less with corrective lenses or must be considered blind for practical purposes. The ISD worker is responsible for submitting medical reports to the DDU, if necessary. See Section 8.281.400.17 NMAC, *Blind*, For Information on documentation and verification of blindness.

C. Disability: To be considered disabled, an applicant/recipient must be unable to engage in any substantial gainful activity because of any medical determinable physical, developmental, or mental impairment, which has lasted, or is expected to last, for a continuous period of at least 12 months. The ISD worker is responsible for submitting medical reports to the DDU, if necessary. See Section 8.281.400.18 NMAC, *Disability*, for information on documentation and verification of disability.

D. Requires institutional care: An institutional level of care must be recommended for the applicant/recipient by a physician, nurse practitioner or a doctor of osteopathy, licensed to practice in the state of New Mexico. Institutions are defined as acute care hospitals, nursing facilities (either high NF or low NF as defined by medicaid regulations) and ICF/IID. Level of care reviews are completed by the medical assistance division (MAD) utilization review contractor or a member's selected or assigned managed care organization (MCO), as applicable to the applicant's HCBS program.
[8.290.400.12 NMAC - Rp, 8.290.400.12 NMAC, 1/1/2019]

8.290.400.13 RECIPIENT RIGHTS AND RESPONSIBILITIES: An applicant/recipient is responsible for establishing their eligibility for medicaid. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant/recipient must also grant the HCA permission to contact other persons, agencies or sources of information, which are necessary to establish eligibility. See 8.200.430 NMAC, *Recipient Rights And Responsibilities* for specific information.
[8.290.400.13 NMAC - Rp, 8.290.400.13 NMAC, 1/1/2019]

8.290.400.14 REPORTING REQUIREMENTS: A medicaid applicant/recipient, case manager, direct service provider or any other responsible party must report any changes in circumstances which may affect the applicant's/recipient's eligibility within 10 days of the date of the change to the county income support division (ISD) office. These changes include but are not limited to: changes in income, resources, living arrangements, or marital status. The ISD worker must evaluate the effect of the change and take any required action as soon as possible; however, the action must take effect no later than the end of the month following the month in which the change took place.
[8.290.400.14 NMAC - Rp, 8.290.400.14 NMAC, 1/1/2019]

HISTORY OF 8.290.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records-State Records Center and Archives:
MAD Rule 898, Transfers Of Assets, 12/29/1994.

History of Repealed Material:
8.290.400 NMAC - Recipient Policies, filed 4/16/2002 Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 290 MEDICAID ELIGIBILITY - HOME AND COMMUNITY-BASED SERVICES WAIVER (CATEGORIES 090, 091, 092, 093, 094, 095 AND 096)
PART 600 BENEFIT DESCRIPTION

8.290.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.290.600.1 NMAC - Rp, 8.290.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.290.600.2 SCOPE: The rule applies to the general public.
[8.290.600.2 NMAC - Rp, 8.290.600.2 NMAC, 1/1/2019]

8.290.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority (HCA) pursuant to state statute. See Section 27-2-12 *et seq.*, NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.290.600.3 NMAC - Rp, 8.290.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.290.600.4 DURATION: Permanent.
[8.290.600.4 NMAC - Rp, 8.290.600.4 NMAC, 1/1/2019]

8.290.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.290.600.5 NMAC - Rp, 8.290.600.5 NMAC, 1/1/2019]

8.290.600.6 OBJECTIVE: The objective of this rule is to provide eligibility criteria for the medical assistance division (MAD) programs.
[8.290.600.6 NMAC - Rp, 8.290.600.6 NMAC, 1/1/2019]

8.290.600.7 DEFINITIONS: See Section 8.290.400.7 NMAC.
[8.290.600.7 NMAC - Rp, 8.290.600.7 NMAC, 1/1/2019]

8.290.600.8 [**RESERVED**]

8.290.600.9 BENEFIT DESCRIPTION: Eligible recipients are eligible for specified services available under the particular waiver and ancillary services available under the general medicaid program. See specific program policy sections for covered services.
[8.290.600.9 NMAC - Rp, 8.290.600.9 NMAC, 1/1/2019]

8.290.600.10 BENEFIT DETERMINATION: Application for the waiver programs is made using the HCA 100 application. Upon notification by the appropriate program manager that an unduplicated recipient (UDR) is available for waiver services, applicants are registered on the income support division (ISD) eligibility system. Applications must be acted upon and notice of approval, denial, or delay sent out within 45 calendar days from the date of application, or within 90 calendar days if a disability determination is required from the disability determination unit (DDU). The eligible recipients must assist in completing the application, may complete the form themselves, or may receive help from a relative, friend, guardian, or other designated representative.

A. Representatives applying on behalf of individuals: If a representative makes application on behalf of the eligible recipient, that representative will continue to be relied upon for information regarding the eligible recipient's circumstances. The ISD caseworker will send all notices to the eligible recipient in care of the representative.

B. Additional forms: The following forms are also required as part of the application process:

(1) the eligible recipient or representative must complete and sign the primary freedom of choice (PFOC) form at the time of allocation; and

(2) the eligible recipient or representative must sign the applicant's statement of understanding at the time waiver services are declined or terminated.

C. Additional information furnished during application: The ISD caseworker provides an explanation of the waiver programs, including, but not limited to, income and resource limits and possible alternatives, such as institutionalization. The ISD caseworker refers potentially eligible recipients to the social security administration to apply for supplemental security income (SSI) benefits. If a disability decision by the DDU is required, but has not been made, the ISD caseworker must follow established procedures to refer the case for evaluation.
[8.290.600.10 NMAC - Rp, 8.290.600.10 NMAC, 1/1/2019]

8.290.600.11 INITIAL BENEFITS:

A. The application process begins once the letter of allocation and the medicaid application for assistance are received by ISD. Once ISD has confirmed the applicant/recipient meets all eligibility criteria, the application can be approved effective the first month for which an approved level of care has been established. Medicaid eligibility covers acute and ancillary medicaid services that are effective immediately on the first day of the first month of medicaid eligibility. Home and community-based waiver services are prospective and are only available once the individual services plan (ISP) or comprehensive care plan (CCP) is approved and implemented. Following initial approval, waiver services must be provided when appropriate to eligible waiver recipients within 90 calendar days of approval. Medicaid eligibility under the waiver program is contingent on the receipt of waiver services. If an applicant/recipient is transitioning from one home and community-based services (HCBS) waiver program to another, ISD must be contacted to coordinate the start date based on the month the ISP or CCP is established for the new program. This is to ensure there is no interruption in services for the recipient.

B. Notice of determination: Applicants determined to be ineligible for waiver services are notified of the reason for the denial and provided with an explanation of appeal rights.

C. Applicants determined to be eligible for waiver services are notified of the approval.
[8.290.600.11 NMAC - Rp, 8.290.600.11 NMAC, 1/1/2019]

8.290.600.12 ONGOING BENEFITS:

A. A complete redetermination of eligibility must be performed annually by the ISD caseworker for each open case.

B. Level of care determinations are made by the utilization review contractor or a member's selected or assigned managed care organization, as applicable to the centennial care, community benefit program. Level of care reviews are required to be completed at least annually except for certain community benefit members whose chronic condition is not expected to improve. These individuals may be eligible for an ongoing nursing facility (NF) level of care (LOC). To qualify for ongoing NF LOC, the community benefit member must have met a NF LOC for the previous three years. The ongoing NF LOC status must be reviewed and approved annually by the managed care organization's medical director and must be supported in documentation by the member's physician. The complete criteria for an ongoing NF LOC can be found in the New Mexico medicaid nursing facility level of care criteria and instructions document.

C. 90 day reconsideration period: HCA will reconsider in a timely manner the waiver eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination without requiring a new application per 42 CFR 435.916(C)(iii).
[8.290.600.12 NMAC - Rp, 8.290.600.12 NMAC, 1/1/2019]

8.290.600.13 RETROACTIVE BENEFITS: Eligibility for these categories is prospective so retroactive coverage is not available in accordance with 8.200.400.14 NMAC.
[8.290.600.13 NMAC - Rp, 8.290.600.13 NMAC, 1/1/2019]

8.290.600.14 CHANGES IN ELIGIBILITY: If the eligible recipient ceases to meet any of the eligibility criteria, the case is closed following provision of advance notice as appropriate. See Section 8.200.430.9 NMAC and following subsections for information about notices and hearing rights.

A. Non-provision of waiver services: To continue to be eligible for waiver services, an eligible recipient must be receiving waiver services, early and periodic screening, diagnostic and treatment (EPSDT) benefits or managed care services, other than case management, (42 CFR Section 435.217). If at any time waiver services are no longer being provided (e.g., a suspension) and are not expected to be provided for 90 consecutive days, the recipient is **ineligible** for the waiver category and the case must be closed after appropriate notice is provided by the ISD caseworker.

B. Admission to a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF-IID): If an eligible waiver recipient enters an acute care hospital, a nursing facility, or an ICF-IID and remains for more than 90 consecutive days, the waiver case must be closed and an application for institutional care medicaid (ICM) must be processed. The eligible recipient is not required to complete a new application if the periodic review on the waiver case is not due in either the month of entry into the institution or the following month. If the waiver recipient is institutionalized within less than 90 consecutive days and still receives waiver services within that time frame, the waiver case is not closed and an application for ICM need not be processed.

C. Reporting changes in circumstances: The primary responsibility for reporting changes in the eligible recipient's circumstances rests with the eligible recipient or their representative. At the initial eligibility determination and all on-going eligibility redeterminations, the ISD caseworker must explain the reporting responsibilities requirement to the eligible recipient or their representative and document that such explanation was given. In the event that waiver services cease to be provided, the case manager or the waiver program manager (or designee) must immediately notify the income support division office of that fact by telephone. The telephone call is to be followed by a written notice to the ISD caseworker.

[8.290.600.14 NMAC - Rp, 8.290.600.14 NMAC, 1/1/2019]

HISTORY OF 8.290.600 NMAC:

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

MAD Rule 898, Transfers Of Assets, 12/29/1994.

History of Repealed Material:

8.290.600 NMAC - Benefit Description, filed 4/12/2002 Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 291 MEDICAID ELIGIBILITY - AFFORDABLE CARE
PART 400 ELIGIBILITY REQUIREMENTS

8.291.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.291.400.1 NMAC - Rp, 8.291.400.1 NMAC, 10/1/2017; A, 7/1/2024]

8.291.400.2 SCOPE: The rule applies to the general public.
[8.291.400.2 NMAC - Rp, 8.291.400.2 NMAC, 10/1/2017]

8.291.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.291.400.3 NMAC - Rp, 8.291.400.3 NMAC, 10/1/2017; A, 7/1/2024]

8.291.400.4 DURATION: Permanent.
[8.291.400.4 NMAC - Rp, 8.291.400.4 NMAC, 10/1/2017]

8.291.400.5 EFFECTIVE DATE: October 1, 2017, unless a later date is cited at the end of a section.
[8.291.400.5 NMAC - Rp, 8.291.400.5 NMAC, 10/1/2017]

8.291.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.291.400.6 NMAC - Rp, 8.291.400.6 NMAC, 10/1/2017]

8.291.400.7 DEFINITIONS:

A. Action: an approval, termination, suspension, or reduction of medicaid eligibility or a reduction in the level of benefits and services, including a determination of income for the purposes of imposing any premiums, enrollment fees, or cost-sharing. It also means determinations made by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determination made by a state with regard to the preadmission screening and resident review requirements.

B. Advance payments of the premium tax credit (APTC): payment of the tax credits specified in Section 36B of the Internal Revenue Code which are provided on an advance basis to an eligible individual enrolled in a qualified health plan through an exchange.

C. Affordable Care Act (ACA): the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and the Three Percent Withholding Repeal and Job Creation Act (Public Law 112-56).

D. Affordable insurance exchanges (exchanges): a governmental agency or non-profit entity that meets the applicable requirements and makes qualified health plans available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to state exchanges, regional exchanges, subsidiary exchanges, and a federally-facilitated exchange.

E. Agency: the single state agency designated or established by a state to administer or supervise the administration of the medicaid state plan. This designation includes a certification by the state attorney general, citing the legal authority for the single state agency to make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

F. Appeal record: the appeal decision, all papers and requests filed in the proceeding, and if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing, and any exhibits introduced at the hearing.

G. Appeal request: a clear expression, either verbally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have any eligibility determination or redetermination contained in a notice issued reviewed by an appeals entity.

H. Appeals entity: a body designated to hear appeals of eligibility determinations or

redeterminations contained in notices, or notices issued in accordance with future guidance on exemptions.

I. Appeals decision: a decision made by a hearing officer adjudicating a fair hearing, including by a hearing officer employed by an exchange appeals entity to which the agency has delegated authority to conduct such hearings.

J. Applicable modified adjusted gross income (MAGI) standard: the income standard for each category of ACA eligibility.

K. Application: the single streamlined application required by ACA and other medicaid applications used by the agency.

L. Authorized representative: the agency must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency.

(1) Such a designation must be in writing including the applicant's signature, and must be permitted at the time of application and at other times. Legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the applicant or beneficiary.

(2) Representatives may be authorized to:

(a) sign an application on the applicant's behalf;

(b) complete and submit a renewal form;

(c) receive copies of the applicant or beneficiary's notices and other communications from the agency; and

(d) act on behalf of the applicant or beneficiary in all other matters with the agency.

(3) The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on their behalf, or the authorized representative informs the agency that they are no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and should include the applicant or authorized representative's signature as appropriate.

(4) The authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual they represent, and must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

(5) As a condition of serving as an authorized representative, a provider, staff member or volunteer of an organization must sign an agreement that they will adhere to the regulations relating to confidentiality (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

M. Beneficiary: an individual who has been determined eligible and is currently receiving medicaid.

N. Citizenship: a national of the United States means a citizen of the United States or a person who, though not a citizen of the United States, owes permanent allegiance to the United States.

O. Code: the internal revenue code.

P. Coordinated content: information included in an eligibility notice regarding the transfer of the individual's or households electronic account to another insurance affordability program for a determination of eligibility.

Q. Current beneficiaries: individuals who have been determined financially eligible for medicaid using MAGI-based methods.

R. Dependent child: an un-emancipated child who is under the age of 19.

S. Documentary evidence: a photocopy facsimile, scanned or other copy of a document must be accepted to the same extent as an original document.

T. Electronic account: an electronic file that includes all information collected and generated by the state regarding each individual's medicaid eligibility and enrollment, including all documentation required to support the agency's decision on the case.

U. Expedited appeals: the agency must establish and maintain an expedited review process for hearings when an individual requests or a provider requests, or supports the individual's request, that the time otherwise permitted for a hearing could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function. If the agency denies a request for an expedited appeal, it must use the standard appeal timeframe.

V. Family size: the number of persons counted as members of an individual's household. In the

case of determining the family size of a pregnant individual, the pregnant individual is counted as themselves plus the number of children they are expected to deliver. In the case of determining the family size of other individuals who have a pregnant individual in their household, the pregnant individual is counted as themselves plus the number of children they are expected to deliver.

W. **Insurance affordability program:** a state medicaid program under Title XIX of the act, state children's health insurance program (CHIP) under Title XXI of the act, a state basic health program established under ACA and coverage in a qualified health plan through the exchange with cost-sharing reductions established under Section 1402 of ACA.

X. **MAGI-based income:** For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine a modified adjusted gross income as defined in Section 36B(d)(2) (B) of the Internal Revenue Code, with the certain exceptions.

Y. **Managed care organization (MCO):** an organization licensed or authorized through an agreement among state entities to manage, coordinate and receive payment for the delivery of specified services to medicaid eligible members.

Z. **Modified adjusted gross income (MAGI):** has the meaning of 26 CFR 1.36B-1 Section (2).

AA. **Non-applicant:** an individual who is not seeking an eligibility determination for themselves and is included in an applicant's or beneficiary's household to determine eligibility for such applicant or beneficiary.

BB. **Non-citizen:** an individual who is not a citizen or national of the United States (8 USC 1101(a)(22).

CC. **Parent caretaker:** a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes) and who is one of the following:

(1) the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;

(2) the spouse of such parent or relative, even after the marriage is terminated by death or divorce; or

(3) other relatives within the fifth degree of relationship (42 CFR 435.4).

DD. **Patient Protection and Affordable Care Act (PPACA):** also known as the Affordable Care Act (ACA) and is the health reform legislation passed by the 111th congress and signed into law in March of 2010.

EE. **Tax dependent:** has the same meaning as the term "dependent" under Section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under Section 151 of the Internal Revenue Code for a taxable year.

[8.291.400.7 NMAC - Rp, 8.291.400.7 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.8 **MISSION:** To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.291.400.8 NMAC - Rp, 8.291.400.8 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.9 **LEGAL BASIS:** HCA is the single state agency designated to administer the New Mexico Title XIX medicaid program in accordance with 42 CFR 431.10, single state agency. State authority is provided by Section 27-2-12 NMSA 1978 (Repl. 1984). Title XIX of the Social Security Act and United States department of health and human services rules establish the requirements for state plans for medical assistance.

[8.291.400.9 NMAC - Rp, 8.291.400.9 NMAC, 10/1/2017]

8.291.400.10 **BASIS FOR DEFINING GROUP:** Medicaid is a federally matched program that makes certain essential health care services available to eligible New Mexico residents who otherwise would not have the financial resources to obtain them. With certain exceptions, medicaid benefits are provided through the HCA's medicaid managed care program.

A. Requirements outlined in 8.291.400 through 8.298.600 NMAC provides eligibility requirements for the ACA related categories listed below.

B. ACA related categories include the following:

(1) other adult;

(2) parent caretaker;

(3) pregnant women;

(4) pregnancy-related services;

(5) children under 19 years of age;

(6) adult caretaker recipients who are in transition to self-support due to the amount of spousal support; and

(7) adult caretaker recipients who are in transition to self-support due to the amount of earned income.

[8.291.400.10 NMAC - Rp, 8.291.400.10 NMAC, 10/1/2017]

8.291.400.11 CONTINUOUS ELIGIBILITY FOR CHILDREN (42 CFR 435.926):

A. HCA provides continuous eligibility for the period specified in Subsection B of 8.291.400.11 NMAC for an individual who is:

(1) under age 19; and

(2) eligible and enrolled for mandatory or optional coverage under the state plan.

B. The continuous eligibility period is 12 months. The continuous eligibility period begins on the effective date of the individual's eligibility or most recent redetermination or renewal of eligibility.

C. A child's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) the child attains the maximum age of 19;

(2) the child or child's representative requests a voluntary termination of eligibility;

(3) the child ceases to be a resident of New Mexico;

(4) the agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or

(5) The child dies.

[8.291.400.11 NMAC - Rp, 8.291.400.11 NMAC, 10/1/2017]

8.291.400.12 REPORTING REQUIREMENTS: A medicaid eligible recipient is required to report certain changes which might affect their eligibility to ISD within 10 calendar days from the date the change occurred. A timely change that is reported within 10 calendar days that may result in a more beneficial medicaid eligibility category shall be evaluated in the month the change occurred. An untimely change that is reported after 10 calendar days that may result in a more beneficial medicaid eligibility category shall be evaluated in the month the change was reported. A reported change that does not result in the same or a more beneficial medicaid category is considered an adverse action and is applied prospectively in accordance with 8.100.180.10 NMAC. See 8.100.110.9 NMAC for the various ways applicants and recipients can submit changes to the HCA. The following changes must be reported to ISD:

A. living arrangements or change of address: any change in where an individual lives or receives mail must be reported;

B. household size: any change in the household size must be reported, this includes the death of an individual included in the assistance unit or budget group;

C. enumeration: any new social security number must be reported; or

D. income: any increase or decrease in the amount of income or change in the source of income must be reported.

[8.291.400.12 NMAC - Rp, 8.291.400.12 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.13 PRESUMPTIVE ELIGIBILITY: Presumptive eligibility (PE) provides medicaid benefits under one of the eligible groups outlined in Subsection B of 8.291.400.10 NMAC, starting with the date of the PE determination and ending with the last day of the following month or, if an ongoing application is submitted at the time the PE is granted or at any time during the approved PE period, the PE will remain open until the ongoing application is approved or denied.

A. Only one PE approval is allowed per pregnancy or per 12-month period for other ACA related categories.

B. Determinations can only be made by individuals employed by eligible entities and certified as presumptive eligibility determiners (PEDs) by the medical assistance division (MAD).

(1) Processing PE information: PEDs must notify MAD within 24 hours of the determination of presumptive eligibility.

(2) PE: The PED must process the presumptive eligibility and encourage clients to submit an ongoing application for medicaid eligibility. If the client elects to do so, the PED must assist the client with the

submission of an application for medical assistance.

(3) Provider eligibility: Entities who may participate in the PE program must be:

(a) a qualified hospital that participates as a provider under the medicaid state plan or a medicaid 1115 demonstration who notifies the medicaid agency of its election to make presumptive eligibility determinations and agrees to make PE determinations consistent with state policies and procedures; or

(b) an entity or provider that has not been disqualified by the medicaid agency for failure to make PE determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the medicaid agency; or

(c) a federally qualified health center (FQHC), an Indian health service (IHS) facility, a state of New Mexico agency, a school, or a head start agency or a primary care provider who is contracted with at least one HCA contracted MCO; or

(d) other entities HCA has determined as an eligible presumptive participant.

C. PE approval limitations:

(1) all MAD authorized PE determiners can approve PE for children and pregnant women ACA categories;

(2) hospitals opting to participate in the PE program and correctional facilities (state prisons and county jails), health facilities operated by the Indian health service, a tribe, or tribal organization or an urban Indian organization can approve PE for all ACA related categories.

D. If, at the time of a PE approval, the client agrees to submit an application for ongoing coverage, the PED must submit the application within ten days of the PE approval.

E. A pregnant individual who has been approved for PE can receive ambulatory prenatal care during the PE approval period as defined in 8.291.400.13 NMAC.

(1) For PE, an approved PED must accept self-attestation of pregnancy.

(2) The needs and income of the unborn child(ren) are considered when determining the woman's countable family size.

[8.291.400.13 NMAC - Rp, 8.291.400.13 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.14 PREGNANT INDIVIDUALS ELIGIBLE FOR EXTENDED OR CONTINUOUS ELIGIBILITY (42 CFR 435.170):

A. Extended eligibility for pregnant individuals: For a pregnant individual who was eligible and enrolled for mandatory or optional coverage under the state plan on the date their pregnancy ends (regardless of the reason the pregnancy ends), HCA provides full medicaid coverage through the last day of the month in which the 12-month postpartum period ends.

B. Continuous eligibility for pregnant individuals: For a pregnant individual who was eligible and enrolled for mandatory or optional coverage under the state plan and who, because of a change in circumstance (e.g., income, household, composition, aging out etc.), will not otherwise remain eligible, HCA provides full medicaid coverage through the last day of the month in which the 12-month postpartum period ends.

(1) The following populations are provided continuous eligibility effective April 1, 2022:

(a) Current medicaid recipients who are pregnant as of April 1, 2022, or who enroll based on pregnancy or become pregnant after April 1, 2022.

(b) Current medicaid recipients who are receiving medicaid while pregnant and who are no longer pregnant as of April 1, 2022, but who are still within a 12-month postpartum period; and

(c) Individuals who apply for medicaid after their pregnancy ends, who received medicaid-covered services while pregnant on or after April 1, 2022, if such services were received during an approved period of retroactive eligibility.

(2) The following applies to certain categories or individuals:

(a) An individual approved on the other adult category who becomes pregnant may remain on the adult category and receive services under the alternative benefit plan (ABP). The ABP is considered full benefits for the purpose of the 12-month extended postpartum period. An individual on the other adult category who becomes pregnant may also transition to another full coverage medicaid category such as pregnant women or parent/caretaker and will remain eligible until their 12-month postpartum period expires.

(b) Children turning age 19 aging out of a children's medicaid category will remain on a children's medicaid category until their 12-month postpartum period expires.

(c) An individual covered on the parent/caretaker category during a 12-month postpartum period and who has increased earnings or spousal support above the parent/caretaker category limit will remain on the parent/caretaker category until their 12-month postpartum period expires and then can transition to a

four or 12-month transitional medical assistance period.

(d) An individual who becomes pregnant during the 12-month postpartum period is entitled to 12-months continuous coverage through the end of the second pregnancy and the 12-month postpartum period following.

(e) The extended 12-month postpartum period applies to individuals receiving medicaid who are lawfully residing children under age 21 and pregnant individuals referred to as "CHIPRA 214".

C. Renewals: Medicaid renewals are conducted at the end of the individual's 12-month postpartum period. Individuals remain enrolled in the eligibility group in which the individual was enrolled during pregnancy through the end of the 12-month postpartum period as described in Subsection B of 8.291.400.14 NMAC.

D. There is not extended or continuous medicaid eligibility for a pregnant individual covered during a presumptive eligibility period under section 1920 of the ACT.

E. An individual's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) the individual or their representative requests a voluntary termination of eligibility;

(2) the individual ceases to be a resident of New Mexico;

(3) eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of HCA error or fraud, abuse, or perjury attributed to the individual; or

(4) the individual dies.

[8.291.400.14 NMAC - N, 4/5/2022]

HISTORY OF 8.291.400 NMAC:

History of Repealed Material:
8.291.400 NMAC, Eligibility Requirements, filed 9/17/2013 - Duration expired 12/31/2013.
8.291.400 NMAC, Eligibility Requirements, filed 12/2/2013 - Repealed effective 10/1/2017.

NMAC History:
8.291.400 NMAC, Eligibility Requirements, filed 9/17/2013 was replaced by 8.291.400 NMAC, Eligibility Requirements effective 10/1/2017.

TITLE 8 SOCIAL SERVICES
CHAPTER 291 MEDICAID ELIGIBILITY - AFFORDABLE CARE
PART 410 GENERAL RECIPIENT REQUIREMENTS

8.291.410.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.291.410.1 NMAC - Rp, 8.291.410.1 NMAC, 10/1/2017; A, 7/1/2024]

8.291.410.2 SCOPE: The rule applies to the general public.
[8.291.410.2 NMAC - Rp, 8.291.410.2 NMAC, 10/1/2017]

8.291.410.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.291.410.3 NMAC - Rp, 8.291.410.3 NMAC, 10/1/2017; A, 7/1/2024]

8.291.410.4 DURATION: Permanent.
[8.291.410.4 NMAC - Rp, 8.291.410.4 NMAC, 10/1/2017]

8.291.410.5 EFFECTIVE DATE: October 1, 2017, unless a later date is cited at the end of a section.
[8.291.410.5 NMAC - Rp, 8.291.410.5 NMAC, 10/1/2017]

8.291.410.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medical assistance programs (MAP) and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.291.410.6 NMAC - Rp, 8.291.410.6 NMAC, 10/1/2017]

8.291.410.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.291.410.7 NMAC - Rp, 8.291.410.7 NMAC, 10/1/2017]

8.291.410.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.291.410.8 NMAC - Rp, 8.291.410.8 NMAC, 10/1/2017; A, 1/1/2022]

8.291.410.9 GENERAL RECIPIENT REQUIREMENTS: To be eligible for MAP, applicants or recipients must meet specific requirements as outlined in this part.
[8.291.410.9 NMAC - Rp, 8.291.410.9 NMAC, 10/1/2017]

8.291.410.10 USE OF SOCIAL SECURITY NUMBER: Refer to 8.200.410.10 NMAC.
[8.291.410.10 NMAC - Rp, 8.291.410.10 NMAC, 10/1/2017]

8.291.410.11 AGE: The age of the applicant recipient is verified to determine if they are under or over the specified age limit.

A. Age of child: Verification of age, including self-attestation of an applicant or recipient under 21 years of age is mandatory for MAP enrollment.

B. Age of adults: Age of an applicant or recipient 21 years of age or older is verified if questionable.

C. Documents that can be used to verify age can be found in 8.100.130 NMAC.

[8.291.410.11 NMAC - Rp, 8.291.410.11 NMAC, 10/1/2017]

8.291.410.12 RELATIONSHIP: Verification of relationship is mandatory, see 8.291.410.20 NMAC

A. Documents that can be used to verify relationship can be found at 8.100.130 NMAC.

B. The documentary evidence must contain the names of related individuals in question.

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

(2) In situations in which both parents are living in the home and the father's paternity has not been established by operation of law or determined through court order, it will be necessary to establish the relationship of the applicant or recipient under 21 years of age to the father by completion of the HCA child support services division (CSSD) acknowledgment of paternity packet.

(3) If the child is living with a relative, it will be necessary to establish the relationship of the absent parents. A CSSD acknowledgement of paternity will be an acceptable means of establishing relationship.

C. The following relatives are within the fifth degree of relationship:

(1) father (biological or adoptive);

(2) mother (biological or adoptive);

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

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

(5) spouse of child's parent (stepparent);

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

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

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

(9) uncle of the whole or half blood, uncle-in-law, great uncle, great great uncle;

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

(11) first cousin and spouse of first cousin;

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

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

(14) nephew or niece and spouses.

D. Effect of divorce or death on relationship: A relationship based upon marriage, such as the "in-law" or "step" relationships, continues to exist following the dissolution of the marriage by divorce or death.
[8.291.410.12 NMAC - Rp, 8.291.410.12 NMAC, 10/1/2017]

8.291.410.13 IDENTITY: Refer to 8.200.410.12 NMAC.
[8.291.410.13 NMAC - Rp, 8.291.410.13 NMAC, 10/1/2017]

8.291.410.14 CITIZENSHIP/NON-CITIZEN STATUS: Refer to 8.200.410.12 NMAC.
[8.291.410.14 NMAC - Rp, 8.291.410.14 NMAC, 10/1/2017; A, 1/1/2022]

8.291.410.15 RESIDENCE: To meet MAP requirements for eligibility, applicants or recipients must be living in New Mexico on the date of application or final determination of eligibility and have demonstrated an intention to remain in the state.

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

B. Recipients receiving benefits out-of-state: Applicants or recipients who receive financial or medical assistance in another state which makes residence in that state a condition of eligibility are considered residents of that state until the ISD office receives verification from the other state agency indicating that it has been notified by an applicant or recipient of the abandonment of residence in that state.

C. Applicants or recipients court ordered into full or partial responsibility of the state children youth and families department (CYFD): When CYFD places an applicant or recipient in a new state of residence, the new state of residence is responsible for the provision of medicaid; however, New Mexico must provide limited coverage for services that are part of the New Mexico MAD benefit package and not available in the new state of residence.

D. Abandonment: Residence is not abandoned by temporary absences. Temporary absences occur when applicants or recipients leave New Mexico for specific purposes with time-limited goals. An applicant or recipient may be temporarily absent from the state is the person intends to return when the purpose of the absence has been accomplished, unless another state has determined they are a resident there for the purposes of MAP enrollment. Residence is considered abandoned when the applicant or recipient leaves New Mexico for any of the following reasons:

(1) intends to establish residence in another state;

(2) for no specific purpose with no clear intention of returning;

(3) applies for financial, food or medical assistance in another state which makes residence in that state a condition of eligibility; or

(4) for more than 30 calendar days, without notifying HCA of their departure or intention of returning.

E. Dispute in residency: If there is a dispute in state residency, the applicant or recipient may be considered a resident in the state in which they are physically located.

F. Evidence of immigration status may not be used to determine that an individual is not a state resident per 42 CFR. 435.956 (c)(2).

[8.291.410.15 NMAC - Rp, 8.291.410.15 NMAC, 10/1/2017]

8.291.410.16 NON-CONCURRENT RECEIPT OF ASSISTANCE: A MAP applicant or recipient receiving medicaid in another state is not eligible for MAP enrollment in accordance with 8.200.410 NMAC.

[8.291.410.16 NMAC - Rp, 8.291.410.16 NMAC, 10/1/2017]

8.291.410.17 APPLICATIONS FOR OTHER BENEFITS: As a condition of eligibility, a MAP applicant or recipient must take all necessary steps to obtain any benefits they are entitled to in accordance with 8.200.410 NMAC.

[8.291.410.17 NMAC - Rp, 8.291.410.17 NMAC, 10/1/2017]

8.291.410.18 APPLICATIONS (42 CFR 435.907):

A. Basis and implementation. In accordance with section 1413(b)(1)(A) of the Affordable Care Act, HCA will accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603, or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility:

(1) Via the internet web site;

(2) By telephone;

(3) Via mail;

(4) In person; and

(5) Through other commonly available electronic means.

B. The application must be:

(1) The single, streamlined application for all insurance affordability programs or

(2) An alternative single, streamlined application for all insurance affordability programs, which may be no more burdensome on the applicant than the application described in Paragraph (1) of Subsection B of 8.291.410.18 NMAC. HCA uses the HCA 100 and MAD 100 application forms, and Your Eligibility System NM (Yes NM).

C. For individuals applying, or who may be eligible, for assistance on a basis other than the applicable modified adjusted gross income (MAGI) standard in accordance with 42 CFR435.911 HCA will use an application described in Subsection B of 8.291.410.18 NMAC and supplemental forms to collect additional information needed to determine eligibility on such other basis.

D. HCA may not require an in-person interview as part of the application process for a determination of eligibility using MAGI-based income.

E. Limits on information: HCA will only require an applicant to provide the information necessary to make an eligibility determination or for a purpose directly connected to the administration of the state plan.

F. HCA accepts on applications electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission.

[8.291.410.18 NMAC - Rp, 8.291.410.18 NMAC, 10/1/2017]

8.291.410.19 Periodic renewal of medicaid eligibility (42 CFR 435.916):

A. Renewal of individuals whose medicaid eligibility is based on MAGI.

(1) Except as provided in Subsection D of 8.291.410.19 NMAC, the eligibility of medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months.

(2) Renewal on basis of information available to HCA. HCA will make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to HCA, including but not limited to

information accessed through any data bases accessed by HCA under 42 CFR 435.948, 435.949 and 435.956. If the HCA is able to renew eligibility based on such information, HCA will notify the individual:

(a) Of the eligibility determination, and basis; and

(b) That the individual must inform the HCA, through any of the modes permitted for submission of applications under 42 CFR 435.907(a) and Subsection A of 8.291.410.18 NMAC, if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

(3) Use of a pre-populated renewal form. If HCA cannot renew eligibility in accordance with Paragraph (2) of Subsection A of 8.291.410.19 NMAC, HCA will:

(a) Provide the individual with:

(i) A renewal form containing information available to HCA that is needed to renew eligibility.

(ii) At least 30 days from the date of the renewal form to respond and provide any necessary information through any of the modes of submission specified in 42 CFR 435.907(a) and 8.291.410.18(A) NMAC and to sign the renewal form in a manner consistent with 42 CFR 435.907(f) and Subsection F of 8.291.410.18 NMAC.

(iii) Notice of the HCA decision concerning the renewal of eligibility.

(b) Verify any information provided by the beneficiary in accordance with 42 CFR 435.945 through 435.956.

(c) Reconsider in a timely manner the eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination without requiring a new application;

(d) Not require an individual to complete an in-person interview as part of the renewal process.

B. Redetermination of individuals whose medicaid eligibility is determined on a basis other than modified adjusted gross income: HCA will redetermine the eligibility of medicaid beneficiaries excepted from modified adjusted gross income per 42 CFR 435.603, for circumstances that may change, at least every 12 months. HCA will make a redetermination of eligibility in accordance with the provisions of Paragraph (2) of Subsection A of 8.291.410.19 NMAC, if sufficient information is available to do so. HCA adopts the procedures described at 42 CFR 435.916(a)(3) for individuals whose eligibility cannot be renewed in accordance with Paragraph (3) of Subsection A of 8.291.410.19 NMAC.

(1) HCA will consider blindness as continuing until the reviewing physician under 42 CFR 435.531 determines that a beneficiary's vision has improved beyond the definition of blindness contained in the plan; and

(2) HCA will consider disability as continuing until the review team, under 42 CFR 435.541, determines that a beneficiary's disability no longer meets the definition of disability contained in the plan.

C. Procedures for reporting changes: HCA has procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility and that such changes may be reported through any of the modes for submission of applications described in 43 CFR 435.907(a) and Subsection A of 8.291.410.18 NMAC.

D. HCA action on information about changes: Consistent with the requirements of 42 CFR 435.952, HCA will promptly redetermine eligibility between regular renewals of eligibility described in Subsections B and C of 8.291.410.19 NMAC whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility. Auto renewal is only applicable to the following medicaid categories: working disabled individuals, qualified medicare beneficiaries, specified low income medicare beneficiary, qualified individuals, parent caretaker, pregnant women, children's medicaid, children's health insurance program (CHIP), pregnancy related services, other adult and family planning.

(1) For renewals of medicaid beneficiaries whose financial eligibility is determined using MAGI-based income, the agency must limit any requests for additional information from the individual to information relating to such change in circumstance.

(2) If HCA has enough information available to it to renew eligibility with respect to all eligibility criteria, the HCA will begin a new 12-month renewal period.

(3) If HCA has information about anticipated changes in a beneficiary's circumstances that may affect their eligibility, HCA will redetermine eligibility at the appropriate time based on such changes.

E. HCA will request from beneficiaries only the information needed to renew eligibility. Requests for non-applicant information must be conducted in accordance with 42 CFR 435.907.

F. Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for medicaid.

(1) Prior to making a determination of ineligibility, HCA will consider all bases of eligibility, consistent with 42 CFR 435.911.

(2) For individuals determined ineligible for medicaid, the agency must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200.

G. Any renewal form or notice will be accessible to persons who are limited english proficient and persons with disabilities, consistent with 42 CFR 435.905.

[8.291.410.19 NMAC - N, 10/1/2017]

8.291.410.20 VERIFICATION METHODS: Verification will be obtained through various methods. Not all methods will necessarily be used in each case. This section details the specific types of methods to be used in establishing the applicant or recipient's eligibility.

A. Prior case data not subject to change: Verification of an eligibility factor not subject to change, which previously has been verified and accepted, will not be subject to re-verification. The caseworker shall not ask an applicant or recipient for verification of any eligibility factors which have previously been established through documents in HCA's possession and are not subject to change. Such factors include U.S. citizenship, birth date, relationship and enumeration.

B. Electronic data: Every applicant or recipient shall be informed that the information provided is subject to verification through state, federal and contracted data systems. The caseworker shall not require further verification of such information unless it is disputed by the applicant or recipient, or the information is otherwise questionable as defined in 8.100.130 NMAC.

C. Self-attestation is the information that an applicant or recipient reports on an application and is certifying as true and correct to the best of their knowledge.

D. Documentary evidence is the primary source of verification for information not established in prior case information or electronic source data. Obtaining necessary verification through documentary evidence readily available to the applicant or recipient shall always be explored before collateral contacts or sworn statements are used. Documentary evidence consists of a written confirmation of a household's circumstances. Acceptable verification is not limited to any single type of document. The types of documents which may be accepted as verification are specified under the sections pertaining to verification methods later in this chapter. The caseworker shall provide applicants or recipients with receipts for verification documents provided subsequent to the interview.

E. Collateral contact is defined at 8.100.130 NMAC.

F. Sworn statement is defined at 8.100.130 NMAC.

[8.291.410.20 - Rp, 8.291.410.19, 10/1/2017]

8.291.410.21 VERIFICATION STANDARDS: Below is a list of standards HCA will utilize to determine eligibility for MAP categories defined at 8.291.400.10 NMAC. If verification cannot be confirmed utilizing the various methods described in each section of this rule, HCA may request additional information. If information is provided and becomes questionable as defined at 8.100.130 NMAC, then additional documentation must be provided as described by 8.100.130 NMAC.

A. Income: Verification of income is mandatory for ACA related MAP and HCA will utilize electronic sources and documents provided by the applicant or recipient to verify their income. Examples of acceptable documentation can be found at 8.100.130 NMAC.

B. Residency: Self attestation is an acceptable form of verification of residency.

C. Age: Self attestation is an acceptable form of verification of age.

D. Enumeration: HCA will utilize electronic sources to verify an applicant or recipient's enumeration.

E. Citizenship: HCA will utilize electronic sources to verify an applicant or recipient's citizenship.

F. Immigration status: HCA will utilize electronic sources to verify an applicant or recipient's immigration status.

G. Relationship: Self attestation is an acceptable form of verification of relationship.

H. Receipt of other benefits: HCA will utilize electronic sources to verify an applicant or recipient's receipt of other benefits.

[8.291.410.21 - Rp, 8.291.410.20, 10/1/2017]

8.291.410.22 VERIFYING FINANCIAL INFORMATION (42 CFR 435.948):

A. HCA will request the following information relating to financial eligibility from other agencies in the state and other states and federal programs to the extent HCA determines such information is useful to verifying the financial eligibility of an individual.

(1) Information related to wages, net earnings from self-employment, unearned income and resources from the state wage information collection agency (SWICA), the internal revenue service (IRS), the social security administration (SSA), the agencies administering the state unemployment compensation laws, the state-administered supplementary payment programs under section 1616(a) of the Act, and any state program administered under a plan approved under Titles I, X, XIV, or XVI of the Act; and

(2) Information related to eligibility or enrollment from the supplemental nutrition assistance program (SNAP), the state program funded under Part A of Title IV of the Act, and other insurance affordability programs.

B. To the extent that the information identified in Subsection A of 8.291.410.22 NMAC is available through the electronic service established in accordance with 8.291.410.23 NMAC HCA will obtain the information through such service.

C. HCA will request the information by SSN, or if an SSN is not available, using other personally identifying information in the individual's account, if possible.

[8.291.410.22 NMAC - N, 10/1/2017]

8.291.410.23 VERIFICATION OF INFORMATION THROUGH AN ELECTRONIC SERVICE (42 CFR 435.949(a) and (b)): The federal government will establish an electronic service through which HCA may verify certain information with, or obtain such information from, federal agencies and other data sources, including SSA, the department of treasury, and the department of homeland security. To the extent that information related to eligibility for medicaid is available through the electronic service, HCA must obtain the information through such service.

[8.291.410.23 NMAC - N, 10/1/2017]

8.291.410.24 USE OF INFORMATION AND REQUESTS OF ADDITIONAL INFORMATION FROM INDIVIDUALS (42 CFR 435.952):

A. HCA will promptly evaluate information received or obtained by it in accordance with regulations per 42 CFR 435.940 through 435.960 to determine whether such information may affect the eligibility of an individual or the benefits to which they are entitled.

B. If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by HCA in accordance with 42. CFR 435.948, 435.949 or 435.956 HCA will determine or renew eligibility based on such information.

C. An individual must not be required to provide additional information or documentation unless information needed by the agency HCA in accordance with 42 CFR 435.948, 435.949 or 435.956 cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as provided in the verification plan described in 8.291.410.24 NMAC with information provided by or on behalf of the individual.

(1) Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold.

(2) If information provided by or on behalf of an individual is not reasonably compatible with information obtained through an electronic data match, HCA must seek additional information from the individual including:

(a) A statement which reasonably explains the discrepancy; or

(b) Other information (which may include documentation), provided that documentation from the individual is permitted only to the extent electronic data are not available and establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage.

(c) HCA must provide the individual a reasonable period, defined as 10 calendar days, to furnish any additional information required under Subsection C of 8.291.410.24 NMAC.

(3) Exception for special circumstances. HCA must establish an exception to permit, on a case-by-case basis, self-attestation of individuals for all eligibility criteria when documentation does not exist at the time of application or renewal, or is not reasonably available, such as in the case of individuals who are homeless or

have experienced domestic violence or a natural disaster. This exception does not apply if documentation is specifically required under title XI or XIX, such as requirements for verifying citizenship and immigration status.

D. HCA may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received in accordance with regulations under 42 CFR 435.940 through 435.960 of this subpart unless HCA has sought additional information from the individual in accordance with Subsection C of 8.291.410.24 NMAC and provided proper notice and hearing rights to the individual.

[8.291.410.24 NMAC - N, 10/1/2017]

8.291.410.25 VERIFICATION PLAN: HCA has a verification plan describing the verification policies and procedures to implement the provisions set forth in 42 CFR 435.940 through 435.956 and 8.100.130 and 8.291.410 NMAC. The state verification plan is posted on the HCA website.

[8.291.410.25 NMAC - N, 10/1/2017]

8.291.410.26 TIMEFRAME FOR DISPOSITION: An applicant or recipient is given a timeframe to provide necessary verification in order for ISD to process an application within the timeframe set forth in this section. This requirement pertains to requests for verification for initial applications as well as for verification for ongoing eligibility. ISD shall make an eligibility decision within three working days of the receipt of all necessary verification.

A. The application disposition deadline for MAP is 45 days from the date of application.

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

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

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

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

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

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

(5) After day 45:

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

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

B. Tracking the application processing time limit: The application processing time limit begins on the day the signed application is received in the ISD county office.

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

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

E. Lack of verification: If verification needed to determine eligibility is not provided and no extension of time is requested, the application will be denied on the 45th day after the application date or by the next work day if 45th day falls on weekend or holiday.

F. Per 42 CFR 435.912(c)(3) the determination of eligibility for any medicaid applicant may not exceed:

(1) ninety days for applicants who apply for medicaid on the basis of disability; and

(2) forty-five days for all other medicaid applicants.

G. Per 42 CFR 435.912(g) HCA may not use the time standards cited at Subsection F of 8.291.410.26 NMAC:

(1) as a waiting period before determining eligibility; or

(2) as a reason for denying eligibility (because it has not determined eligibility within the time standards.

H. Case documentation (42 CFR 435.914).

(1) HCA includes in each applicant's case record facts to support the agency's decision on the application.

(2) HCA disposes of each application by a finding of eligibility or ineligibility, unless:

(a) there is an entry in the case record that the applicant voluntarily withdrew the application, and that HCA sent a notice confirming the decision;

(b) there is a supporting entry in the case record that the applicant has died; or

(c) there is a supporting entry in the case record that the applicant cannot be located.

[8.291.410.26 - Rp 8.291.410.21, 10/1/2017]

HISTORY OF 8.291.410 NMAC:

History of Repealed Material:
8.291.410 NMAC, General Recipient Requirements, filed 9/17/2013 - Duration expired 12/31/2013.
8.291.410 NMAC, General Recipient Requirements, filed 12/17/2013 – Repealed effective 10/1/2017.

NMAC History:
8.291.410 NMAC, General Recipient Requirements, filed 12/17/2013 was replaced by 8.291.410 NMAC, General Recipient Requirements effective 10/1/2017.

TITLE 8 SOCIAL SERVICES
CHAPTER 291 MEDICAID ELIGIBILITY - AFFORDABLE CARE
PART 420 RECIPIENT RIGHTS AND RESPONSIBILITIES

8.291.420.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.291.420.1 NMAC - Rp, 8.291.420.1 NMAC, 1/1/2014; A, 7/1/2024]

8.291.420.2 SCOPE: The rule applies to the general public.
[8.291.420.2 NMAC - Rp, 8.291.420.2 NMAC, 1/1/2014]

8.291.420.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.291.420.3 NMAC - Rp, 8.291.420.3 NMAC, 1/1/2014; A, 7/1/2024]

8.291.420.4 DURATION: Permanent.
[8.291.420.4 NMAC - Rp, 8.291.420.4 NMAC, 1/1/2014]

8.291.420.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.291.420.5 NMAC - Rp, 8.291.420.5 NMAC, 1/1/2014]

8.291.420.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.291.420.6 NMAC - Rp, 8.291.420.6 NMAC, 1/1/2014]

8.291.420.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.291.420.7 NMAC - Rp, 8.291.420.7 NMAC, 1/1/2014]

8.291.420.8 RIGHT TO APPLY:

A. An individual has the right to apply for medicaid and other health care programs MAD administers regardless of whether it appears they may be eligible.

(1) The income support division (ISD) determines eligibility for medicaid, unless otherwise determined by another entity as stated in another NMAC rule. A decision shall be made promptly on applications in accordance with the timeliness standards set forth in 8.291.410 NMAC.

(2) Individuals who might be eligible for supplemental security income (SSI) are referred to the social security administration (SSA) office to apply.

B. Application: A signed electronic or paper application, as defined in 8.291.410 NMAC, is required from the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant may complete a joint application for all benefits that HCA administers. A recipient will not be required to submit an application if there is a need to switch from one medicaid benefit to another unless a redetermination is due in that month or the following month. Additional information may be requested if the new benefit requires additional information and verification of eligibility.
[8.291.420.8 NMAC - Rp, 8.291.420.8 NMAC, 1/1/2014]

8.291.420.9 FREEDOM OF CHOICE OF PROVIDER: Refer to 8.200.430.10 NMAC.
[8.291.420.9 NMAC - Rp, 8.291.420.9 NMAC, 1/1/2014]

8.291.420.10 RELEASE OF INFORMATION/CONFIDENTIALITY: Refer to 8.200.430.11 NMAC.
[8.291.420.10 NMAC - Rp, 8.291.420.10 NMAC, 1/1/2014]

8.291.420.11 RIGHT TO ADEQUATE NOTICE AND ADMINISTRATIVE HEARING: Refer to 8.200.430.12 NMAC.

[8.291.420.11 NMAC - Rp, 8.291.420.11 NMAC, 1/1/2014]

8.291.420.12 ASSIGNMENT OF MEDICAL SUPPORT RIGHTS: Refer to 8.200.430.13 NMAC.
[8.291.420.12 NMAC - Rp, 8.291.420.12 NMAC, 1/1/2014]

8.291.420.13 ELIGIBLE RECIPIENT RESPONSIBILITY TO COOPERATE WITH ASSIGNMENT OF SUPPORT RIGHTS: Refer to 8.200.430.14 NMAC.
[8.291.420.13 NMAC - Rp, 8.291.420.13 NMAC, 1/1/2014]

8.291.420.14 ELIGIBLE RECIPIENT RESPONSIBILITY TO GIVE PROVIDER PROPER IDENTIFICATION AND NOTICE OF ELIGIBILITY CHANGES: Refer to 8.200.430.15 NMAC.
[8.291.420.14 NMAC - Rp, 8.291.420.14 NMAC, 1/1/2014]

8.291.420.15 ELIGIBLE RECIPIENT FINANCIAL RESPONSIBILITIES: Refer to 8.200.430.16 NMAC.
[8.291.420.15 NMAC - Rp, 8.291.420.15 NMAC, 1/1/2014]

8.291.420.16 RESTITUTION: Refer to 8.200.430.17 NMAC.
[8.291.420.16 NMAC - Rp, 8.291.420.16 NMAC, 1/1/2014]

8.291.420.17 THIRD PARTY LIABILITY: Refer to 8.200.420.12 NMAC.
[8.291.420.17 NMAC - Rp, 8.291.420.17 NMAC, 1/1/2014]

8.291.420.18 MAD ESTATE RECOVERY: Refer to 8.200.420.13 NMAC.
[8.291.420.18 NMAC - Rp, 8.291.420.18 NMAC, 1/1/2014]

HISTORY OF 8.291.420 NMAC:

History of Repealed Material:
8.291.420 NMAC, Recipient Rights and Responsibilities, filed 9/17/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 292 MEDICAID ELIGIBILITY - PARENT CARETAKER
PART 400 RECIPIENT REQUIREMENTS

8.292.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.292.400.1 NMAC - Rp, 8.292.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.292.400.2 SCOPE: The rule applies to the general public.
[8.292.400.2 NMAC - Rp, 8.292.400.2 NMAC, 1/1/2014]

8.292.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.292.400.3 NMAC - Rp, 8.292.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.292.400.4 DURATION: Permanent.
[8.292.400.4 NMAC - Rp, 8.292.400.4 NMAC, 1/1/2014]

8.292.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.292.400.5 NMAC - Rp, 8.292.400.5 NMAC, 1/1/2014]

8.292.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.292.400.6 NMAC - Rp, 8.292.400.6 NMAC, 1/1/2014]

8.292.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.292.400.7 NMAC - Rp, 8.292.400.7 NMAC, 1/1/2014]

8.292.400.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.292.400.8 NMAC - Rp, 8.292.400.8 NMAC, 1/1/2014; A, 7/1/2021]

8.292.400.9 WHO CAN BE A RECIPIENT: To be eligible, an individual must meet specific eligibility requirements:

A. In accordance with 42 Code of Federal Regulations (CFR) 435.4 an individual must be a parent or caretaker relative defined as a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes), and who is within the fifth degree of relationship per Subsection C of 8.291.410.12 NMAC.

B. In accordance with 42 CFR 435.4 a dependent child is defined as one who meets both of the following criteria:

(1) is under the age of 18, or;

(2) is age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training.

C. An individual who meets the eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC.

D. Prior to the parent caretaker individual becoming an eligible recipient, all children listed on an application must meet the following:

(1) be evaluated for eligibility for a medicaid program if not already eligible; or

(2) if not medicaid eligible, have current health insurance coverage that meets criteria as a qualified health plan.
[8.292.400.9 NMAC - Rp, 8.292.400.9 NMAC, 1/1/2014; A, 7/1/2021]

8.292.400.10 PARENT CARETAKER ASSISTANCE UNIT AND BUDGET GROUP: To be considered in a parent caretaker assistance unit, an individual must apply and be determined eligible. Individuals living with the parent caretaker who meet criteria in 8.291.430 NMAC are included in the budget group.
[8.292.400.10 NMAC - Rp, 8.292.400.10 NMAC, 1/1/2014]

HISTORY OF 8.292.400 NMAC:

History of Repealed Material:
8.292.400 NMAC, Recipient Requirements, filed 9/17/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 292 MEDICAID ELIGIBILITY - PARENT CARETAKER
PART 500 INCOME AND RESOURCE STANDARDS

8.292.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.292.500.1 NMAC - Rp, 8.292.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.292.500.2 SCOPE: The rule applies to the general public.
[8.292.500.2 NMAC - Rp, 8.292.500.2 NMAC, 1/1/2014]

8.292.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.292.500.3 NMAC - Rp, 8.292.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.292.500.4 DURATION: Permanent.
[8.292.500.4 NMAC - Rp, 8.292.500.4 NMAC, 1/1/2014]

8.292.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.292.500.5 NMAC - Rp, 8.292.500.5 NMAC, 1/1/2014]

8.292.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.292.500.6 NMAC - Rp, 8.292.500.6 NMAC, 1/1/2014]

8.292.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.292.500.7 NMAC - Rp, 8.292.500.7 NMAC, 1/1/2014]

8.292.500.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.292.500.8 NMAC - Rp, 8.292.500.8 NMAC, 1/1/2014; A, 1/1/2022]

8.292.500.9 RESOURCE STANDARDS: There are no resource standards for this category of eligibility.
[8.292.500.9 NMAC - Rp, 8.292.500.9 NMAC, 1/1/2014]

8.292.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430.11 NMAC.

B. Income test: In order to become eligible for parent caretaker medicaid, the total countable income of the budget group must be less than the income standard for parent caretaker eligibility at 8.291.430 NMAC.
[8.292.500.10 NMAC - Rp, 8.292.500.10 NMAC, 1/1/2014]

8.292.500.11 AVAILABLE INCOME: Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined pursuant to 8.291.430 NMAC.
[8.292.500.11 NMAC - Rp, 8.292.500.11 NMAC, 1/1/2014]

8.292.500.12 INCOME ELIGIBILITY: Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2), the HCA bases financial eligibility on current monthly household income and family size. Current monthly household

income is defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.
[8.292.500.12 NMAC - Rp, 8.292.500.12 NMAC, 1/1/2014; A, 1/1/2022]

8.292.500.13 DISREGARDS: Once a MAGI is calculated, no disregard will be given unless the individual is in receipt of medicare or has reached the age of 65, in which case the household will receive an income disregard in accordance with 8.291.430 NMAC.
[8.292.500.13 NMAC - Rp, 8.292.500.13 NMAC, 1/1/2014]

HISTORY OF 8.292.500 NMAC:

History of Repealed Material:
8.292.500 NMAC, Income and Resource Standards, filed 9/17/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 292 MEDICAID ELIGIBILITY - PARENT CARETAKER
PART 600 BENEFIT DESCRIPTION

8.292.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.292.600.1 NMAC - Rp, 8.292.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.292.600.2 SCOPE: The rule applies to the general public.
[8.292.600.2 NMAC - Rp, 8.292.600.2 NMAC, 1/1/2019]

8.292.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.292.600.3 NMAC - Rp, 8.292.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.292.600.4 DURATION: Permanent.
[8.292.600.4 NMAC - Rp, 8.292.600.4 NMAC, 1/1/2019]

8.292.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.292.600.5 NMAC - Rp, 8.292.600.5 NMAC, 1/1/2019]

8.292.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.292.600.6 NMAC - Rp, 8.292.600.6 NMAC, 1/1/2019]

8.292.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.292.600.7 NMAC - Rp, 8.292.600.7 NMAC, 1/1/2019]

8.292.600.8 [**RESERVED**]
[8.292.600.8 NMAC - Rp, 8.292.600.8 NMAC, 1/1/2019]

8.292.600.9 BENEFIT DESCRIPTION: This medicaid category provides the full range of medicaid-covered services for individuals considered a parent caretaker.
[8.292.600.9 NMAC - Rp, 8.292.600.9 NMAC, 1/1/2019]

8.292.600.10 BENEFIT DETERMINATION: The HCA income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.292.600.10 NMAC - Rp, 8.292.600.10 NMAC, 1/1/2019]

8.292.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A redetermination of eligibility is conducted in accordance with 8.291.410 NMAC.

B. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.

[8.292.600.11 NMAC - Rp, 8.292.600.11 NMAC, 1/1/2019]

HISTORY OF 8.292.600 NMAC:

History of Repealed Material:
8.292.600 NMAC, Benefit Description, filed 9/17/2013 - Duration expired 12/31/2013.

8.292.600 NMAC, Benefit Description, filed 12/17/2013 – Repeal effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 293 MEDICAID ELIGIBILITY - PREGNANT WOMEN
PART 400 RECIPIENT REQUIREMENTS

8.293.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.293.400.1 NMAC - Rp, 8.293.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.293.400.2 SCOPE: The rule applies to the general public.
[8.293.400.2 NMAC - Rp, 8.293.400.2 NMAC, 1/1/2014]

8.293.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.293.400.3 NMAC - Rp, 8.293.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.293.400.4 DURATION: Permanent.
[8.293.400.4 NMAC - Rp, 8.293.400.4 NMAC, 1/1/2014]

8.293.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.293.400.5 NMAC - Rp, 8.293.400.5 NMAC, 1/1/2014]

8.293.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.293.400.6 NMAC - Rp, 8.293.400.6 NMAC, 1/1/2014]

8.293.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.293.400.7 NMAC - Rp, 8.293.400.7 NMAC, 1/1/2014]

8.293.400.8 [RESERVED]
[8.293.400.8 NMAC - Rp, 8.293.400.8 NMAC, 1/1/2014; A, 10/1/2017]

8.293.400.9 WHO CAN BE A RECIPIENT: To be eligible, a woman must meet the following eligibility requirements:

A. Per 42 CFR 435.956(e), HCA accepts self-attestation of pregnancy unless HCA has reason to believe the information is questionable as defined in 8.100.130.12 NMAC.

B. a woman who meets all ACA eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC; and

C. the existence of creditable health insurance is not a disqualifying factor.

[8.293.400.9 NMAC - Rp, 8.293.400.9 NMAC, 1/1/2014; A, 10/1/2017]

8.293.400.10 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP: At the time of application, an applicant or recipient and the department shall identify everyone who is to be considered for inclusion in the assistance unit and budget group as defined in 8.291.430 NMAC. Each member of the assistance unit and budget group, including any unborn child(ren), is counted as one in the household size.
[8.293.400.10 NMAC - Rp, 8.293.400.10 NMAC, 1/1/2014]

8.293.400.11 PREGNANCY ASSISTANCE UNIT: The assistance unit is the pregnant woman who applies for medicaid and for whom an eligibility determination is made.
[8.293.400.11 NMAC - Rp, 8.293.400.11 NMAC, 1/1/2014]

8.293.400.12 BUDGET GROUP: The budget group is established in accordance with 8.291.430 NMAC.
[8.293.400.12 NMAC - Rp, 8.293.400.12 NMAC, 1/1/2014]

HISTORY OF 8.293.400 NMAC:

History of Repealed Material:
8.293.400 NMAC, Recipient Requirements, filed 9/17/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 293 MEDICAID ELIGIBILITY - PREGNANT WOMEN
PART 500 INCOME AND RESOURCE STANDARDS

8.293.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.293.500.1 NMAC - Rp, 8.293.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.293.500.2 SCOPE: The rule applies to the general public.
[8.293.500.2 NMAC - Rp, 8.293.500.2 NMAC, 1/1/2014]

8.293.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.293.500.3 NMAC - Rp, 8.293.500.3 NMAC, 1/1/2014 ; A, 7/1/2024]

8.293.500.4 DURATION: Permanent.
[8.293.500.4 NMAC - Rp, 8.293.500.4 NMAC, 1/1/2014]

8.293.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.293.500.5 NMAC - Rp, 8.293.500.5 NMAC, 1/1/2014]

8.293.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.293.500.6 NMAC - Rp, 8.293.500.6 NMAC, 1/1/2014]

8.293.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.293.500.7 NMAC - Rp, 8.293.500.7 NMAC, 1/1/2014]

8.293.500.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.293.500.8 NMAC - Rp, 8.293.500.8 NMAC, 1/1/2014; A, 1/1/2022]

8.293.500.9 RESOURCE STANDARDS: Resources are not an eligibility factor for this category of eligibility.
[8.293.500.9 NMAC - Rp, 8.293.500.9 NMAC, 1/1/2014]

8.293.500.10 INCOME STANDARD:
A. Financial eligibility: An applicant's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.
B. Income test: In order to become eligible for pregnant women medicaid, the total countable income of the budget group must be less than the income standard for pregnant woman eligibility found in 8.291.430 NMAC.
[8.293.500.10 NMAC - Rp, 8.293.500.10 NMAC, 1/1/2014; A, 7/1/2014; A, 5/1/2015]

8.293.500.11 AVAILABLE INCOME: Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined pursuant to 8.291.430 NMAC.
[8.293.500.11 NMAC - Rp, 8.293.500.11 NMAC, 1/1/2014]

8.293.500.12 INCOME ELIGIBILITY: Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2), HCA bases

financial eligibility on current monthly household income and family size. Current monthly household income is defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.
[8.293.500.12 NMAC - Rp, 8.293.500.12 NMAC, 1/1/2014; A, 1/1/2022]

8.293.500.13 DISREGARDS: An income disregard according to 8.291.430 NMAC will be given only to an applicant whose countable modified adjusted gross income (MAGI) income is at or above the income standard for a pregnant for the size of the budget group.
[8.293.500.13 NMAC - Rp, 8.293.500.13 NMAC, 1/1/2014; A, 7/1/2014; A, 5/1/2015]

HISTORY OF 8.293.500 NMAC:

History of Repealed Material:
8.293.500 NMAC, Income and Resource Standards, filed 9/7/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 293 MEDICAID ELIGIBILITY - PREGNANT WOMEN
PART 600 BENEFIT DESCRIPTION

8.293.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.293.600.1 NMAC - Rp, 8.293.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.293.600.2 SCOPE: The rule applies to the general public.
[8.293.600.2 NMAC - Rp, 8.293.600.2 NMAC, 1/1/2019]

8.293.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 *et seq*., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.293.600.3 NMAC - Rp, 8.293.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.293.600.4 DURATION: Permanent.
[8.293.600.4 NMAC - Rp, 8.293.600.4 NMAC, 1/1/2019]

8.293.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.293.600.5 NMAC - Rp, 8.293.600.5 NMAC, 1/1/2019]

8.293.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.293.600.6 NMAC - Rp, 8.293.600.6 NMAC, 1/1/2019]

8.293.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.293.600.7 NMAC - Rp, 8.293.600.7 NMAC, 1/1/2019]

8.293.600.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.293.600.8 NMAC - Rp, 8.293.600.8 NMAC, 1/1/2019; A, 4/5/2022]

8.293.600.9 BENEFIT DESCRIPTION: This category provides the full range of medicaid coverage for the duration of the pregnancy and for the 12-month postpartum period.
[8.293.600.9 NMAC - Rp, 8.293.600.9 NMAC, 1/1/2019; A, 4/5/2022]

8.293.600.10 BENEFIT DETERMINATION: The HCA income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. An individual eligible for pregnant women medicaid remains eligible throughout the pregnancy and for a 12-month postpartum period in accordance with 8.291.400.14 NMAC. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.293.600.10 NMAC - Rp, 8.293.600.10 NMAC, 1/1/2019; A, 4/5/2022]

8.293.600.11 REPORTING REQUIREMENTS: All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.
[8.293.600.11 NMAC - Rp, 8.293.600.11 NMAC, 1/1/2019]

HISTORY OF 8.293.600 NMAC:

History of Repealed Material:

8.293.600 NMAC, Benefit Description, filed 9/17/2013 - Duration expired 12/31/2013.
8.293.600 NMAC, Benefit Description, filed 12/17/2013 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 294 MEDICAID ELIGIBILITY - PREGNANCY-RELATED SERVICES
PART 400 RECIPIENT REQUIREMENTS

8.294.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.294.400.1 NMAC - Rp, 8.294.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.294.400.2 SCOPE: The rule applies to the general public.
[8.294.400.2 NMAC - Rp, 8.294.400.2 NMAC, 1/1/2014]

8.294.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See, Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.294.400.3 NMAC - Rp, 8.294.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.294.400.4 DURATION: Permanent.
[8.294.400.4 NMAC - Rp, 8.294.400.4 NMAC, 1/1/2014]

8.294.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.294.400.5 NMAC - Rp, 8.294.400.5 NMAC, 1/1/2014]

8.294.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.294.400.6 NMAC - Rp, 8.294.400.6 NMAC, 1/1/2014]

8.294.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.294.400.7 NMAC - Rp, 8.294.400.7 NMAC, 1/1/2014]

8.294.400.8 [RESERVED]
[8.294.400.8 NMAC - Rp, 8.294.400.8 NMAC, 1/1/2014; A, 10/1/2017]

8.294.400.9 WHO CAN BE A RECIPIENT: To be eligible, a woman must meet the following eligibility requirements:

A. Per 42 CFR 435.956(e), HCA accepts self-attestation of pregnancy unless HCA has reason to believe the information is questionable as defined in 8.100.130.12 NMAC.

B. a woman who meets all affordable care act (ACA) eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC; and

C. the existence of creditable health insurance is not a disqualifying factor.

[8.294.400.9 NMAC - Rp, 8.294.400.9 NMAC, 1/1/2014; A, 10/1/2017]

8.294.400.10 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP: At time of application, an applicant or recipient and the department shall identify everyone who is to be considered for inclusion in the assistance unit and budget group as defined in 8.291.430 NMAC. Each member of the assistance unit and budget group, including any unborn child(ren), is counted as one in the household size.
[8.294.400.10 NMAC - Rp, 8.294.400.10 NMAC, 1/1/2014]

8.294.400.11 PREGNANCY ASSISTANCE UNIT: The assistance unit is the pregnant woman who applies for medicaid and for whom an eligibility determination is made.
[8.294.400.11 NMAC - Rp, 8.294.400.11 NMAC, 1/1/2014]

8.294.400.12 BUDGET GROUP: The budget group is established in accordance with 8.291.430 NMAC.
[8.294.400.12 NMAC - Rp, 8.294.400.12 NMAC, 1/1/2014]

HISTORY OF 8.294.400 NMAC:

History of Repealed Material:
8.294.400 NMAC, Recipient Requirements, filed 9/17/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 294 MEDICAID ELIGIBILITY - PREGNANCY-RELATED SERVICES
PART 500 INCOME AND RESOURCE STANDARDS

8.294.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.294.500.1 NMAC - Rp, 8.294.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.294.500.2 SCOPE: The rule applies to the general public.
[8.294.500.2 NMAC - Rp, 8.294.500.2 NMAC, 1/1/2014]

8.294.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.294.500.3 NMAC - Rp, 8.294.500.3 NMAC, 1/1/2014 ; A, 7/1/2024]

8.294.500.4 DURATION: Permanent.
[8.294.500.4 NMAC - Rp, 8.294.500.4 NMAC, 1/1/2014]

8.294.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.294.500.5 NMAC - Rp, 8.294.500.5 NMAC, 1/1/2014]

8.294.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.294.500.6 NMAC - Rp, 8.294.500.6 NMAC, 1/1/2014]

8.294.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.294.500.7 NMAC - Rp, 8.294.500.7 NMAC, 1/1/2014]

8.294.500.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.294.500.8 NMAC - Rp, 8.294.500.8 NMAC, 1/1/2014; A, 1/1/2022]

8.294.500.9 RESOURCE STANDARDS: Resources are not an eligibility factor for this category of eligibility.
[8.294.500.9 NMAC - Rp, 8.294.500.9 NMAC, 1/1/2014]

8.294.500.10 INCOME STANDARD:
A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.
B. Income test: In order to become eligible for pregnancy medicaid, the total countable income of the budget group must be less than two hundred and fifty percent of the federal poverty guidelines found at 8.291.430 NMAC.
[8.294.500.10 NMAC - Rp, 8.294.500.10 NMAC, 1/1/2014; A, 1/1/2022]

8.294.500.11 AVAILABLE INCOME: Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined pursuant to 8.291.430 NMAC.
[8.294.500.11 NMAC - Rp, 8.294.500.11 NMAC, 1/1/2014]

8.294.500.12 INCOME ELIGIBILITY: Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2) HSD bases

financial eligibility on current monthly household income and family size. Current monthly household income is defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.
[8.294.500.12 NMAC - Rp, 8.294.500.12 NMAC, 1/1/2014; A, 1/1/2022]

8.294.500.13 DISREGARDS: An income disregard according to 8.291.430 NMAC will be given only to individuals whose countable MAGI income is at or above two hundred and fifty percent of the federal poverty level for the size of the budget group.
[8.294.500.13 NMAC - Rp, 8.294.500.13 NMAC, 1/1/2014; A, 1/1/2022]

HISTORY OF 8.294.500 NMAC:

History of Repealed Material:
8.294.500 NMAC, Income and Resource Standards, filed 9/17/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 294 MEDICAID ELIGIBILITY - PREGNANCY-RELATED SERVICES
PART 600 BENEFIT DESCRIPTION

8.294.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.294.600.1 NMAC - Rp, 8.294.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.294.600.2 SCOPE: The rule applies to the general public.
[8.294.600.2 NMAC - Rp, 8.294.600.2 NMAC, 1/1/2019]

8.294.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.294.600.3 NMAC - Rp, 8.294.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.294.600.4 DURATION: Permanent.
[8.294.600.4 NMAC - Rp, 8.294.600.4 NMAC, 1/1/2019]

8.294.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.294.600.5 NMAC - Rp, 8.294.600.5 NMAC, 1/1/2019]

8.294.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.294.600.6 NMAC - Rp, 8.294.600.6 NMAC, 1/1/2019]

8.294.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.294.600.7 NMAC - Rp, 8.294.600.7 NMAC, 1/1/2019]

8.294.600.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.294.600.8 NMAC - Rp, 8.294.600.8 NMAC, 1/1/2019; A, 4/5/2022]

8.294.600.9 BENEFIT DESCRIPTION: This category provides the full range of Medicaid coverage for the duration of the pregnancy and for the 12-month postpartum period.
[8.294.600.9 NMAC - Rp, 8.294.600.9 NMAC, 1/1/2019; A, 4/5/2022]

8.294.600.10 BENEFIT DETERMINATION: The HCA income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. An individual eligible for pregnancy-related services medicaid remains eligible throughout the pregnancy and for a 12-month postpartum period in accordance with 8.291.400.14 NMAC. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.294.600.10 NMAC - Rp, 8.294.600.10 NMAC, 1/1/2019; A, 4/5/2022]

8.294.600.11 REPORTING REQUIREMENTS: All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.
[8.292.600.11 NMAC - Rp, 8.294.600.11 NMAC, 1/1/2019]

HISTORY OF 8.294.600 NMAC:

History of Repealed Material:
8.294.600 NMAC, Benefit Description, filed 9/17/2013 - Duration expired 12/31/2013.
8.294.600 NMAC, Benefit Description, filed 12/17/2013 – Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 295 MEDICAID ELIGIBILITY - CHILDREN UNDER 19
PART 400 RECIPIENT REQUIREMENTS

8.295.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.295.400.1 NMAC - Rp, 8.295.400.1 NMAC, 1/1/2014; A, 7/1/2024]

8.295.400.2 SCOPE: The rule applies to the general public.
[8.295.400.2 NMAC - Rp, 8.295.400.2 NMAC, 1/1/2014]

8.295.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX and XXI of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.295.400.3 NMAC - Rp, 8.295.400.3 NMAC, 1/1/2014; A, 7/1/2024]

8.295.400.4 DURATION: Permanent.
[8.295.400.4 NMAC - Rp, 8.295.400.4 NMAC, 1/1/2014]

8.295.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.295.400.5 NMAC - Rp, 8.295.400.5 NMAC, 1/1/2014]

8.295.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.295.400.6 NMAC - Rp, 8.295.400.6 NMAC, 1/1/2014]

8.295.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.295.400.7 NMAC - Rp, 8.295.400.7 NMAC, 1/1/2014]

8.295.400.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.295.400.8 NMAC - Rp, 8.295.400.8 NMAC, 1/1/2014]

8.295.400.9 WHO CAN BE A RECIPIENT: To be eligible, an applicant must meet specific medical assistance programs (MAP) requirements:

A. an individual under 19 years of age; and

B. an individual who meets Affordable Care Act (ACA) eligibility requirements pursuant to 8.291.400 through 2.291.430 NMAC.

[8.295.400.9 NMAC - Rp, 8.295.400.9 NMAC, 1/1/2014; A, 5/1/2015]

8.295.400.10 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP: To be considered in a child assistance unit, an individual must apply and be determined eligible. Individuals living with the applicant who meet criteria in 8.291.430 NMAC are included in the budget group.
[8.295.400.10 NMAC - Rp, 8.295.400.10 NMAC, 1/1/2014; A, 5/1/2015]

8.295.400.11 CHILDRENS HEALTH INSURANCE PROGRAM (CHIP):

A. A budget group that includes the applicant and has countable income between the following federal income poverty limits (FPL) is considered to be eligible for the CHIP:

(1) if the applicant in the assistance unit is under the age of six and the assistance unit and budget group's countable income is between two hundred-forty and three hundred percent of FPL for the countable household size; or

(2) if the assistance unit consists of the applicant age six or over and the assistance unit's and budget group's countable income is between one hundred-ninety and two hundred-forty percent of FPL for the

countable household size.

B. In order to be eligible for CHIP, the applicant in the assistance unit cannot have other qualified health plan (QHP) coverage. Individuals who have voluntarily dropped a QHP will be eligible for inclusion in the assistance unit in the month the individual no longer has a QHP.

[8.295.400.11 NMAC - Rp, 8.295.400.11 NMAC, 1/1/2014; A, 5/1/2015]

HISTORY OF 8.295.400 NMAC:

History of Repealed Material:
8.295.400 NMAC, Recipient Requirements, filed 9/17/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 295 MEDICAID ELIGIBILITY - CHILDREN UNDER 19
PART 500 INCOME AND RESOURCE STANDARDS

8.295.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.295.600.1 NMAC - Rp, 8.295.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.295.500.2 SCOPE: The rule applies to the general public.
[8.295.500.2 NMAC - Rp, 8.295.500.2 NMAC, 1/1/2014]

8.295.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX and XXI of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.295.600.3 NMAC - Rp, 8.295.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.295.500.4 DURATION: Permanent.
[8.295.500.4 NMAC - Rp, 8.295.500.4 NMAC, 1/1/2014]

8.295.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.295.500.5 NMAC - Rp, 8.295.500.5 NMAC, 1/1/2014]

8.295.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.295.500.6 NMAC - Rp, 8.295.500.6 NMAC, 1/1/2014]

8.295.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.295.500.7 NMAC - Rp, 8.295.500.7 NMAC, 1/1/2014]

8.295.500.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.295.500.8 NMAC - Rp, 8.295.500.8 NMAC, 1/1/2014; A, 1/1/2022]

8.295.500.9 RESOURCE STANDARDS: Resources are not an eligibility factor for this category of eligibility.
[8.295.500.9 NMAC - Rp, 8.295.500.9 NMAC, 1/1/2014]

8.295.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.

B. Income test: In order to become eligible for children's medicaid, the total countable income of the budget group must be less than the income standard for eligibility found at 8.291.430 NMAC.

(1) If the assistance unit consists of a child under the age of six, the assistance unit and budget group's countable income must be less than three hundred percent of FPL for the countable household size.

(2) If the assistance unit consists of a child age six to age 19, the assistance unit and budget group's countable income must be less than two hundred and forty percent of FPL for the countable household size.
[8.295.500.10 NMAC - Rp, 8.295.500.10 NMAC, 1/1/2014; A, 1/1/2022]

8.295.500.11 INCOME ELIGIBILITY: Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2), HCA bases financial eligibility on current monthly household income and family size. Current monthly household income is

defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.
[8.295.500.11 NMAC - Rp, 8.295.500.11 NMAC, 1/1/2014; A, 1/1/2022]

8.295.500.12 DISREGARDS: An income disregard according to 8.291.430 NMAC, will be given only to the following:

A. individuals whose budget group's countable MAGI income is at or above one hundred and ninety percent of the FPL if the assistance unit consists of a child age six to age 19, or two hundred and forty percent of the FPL if the assistance unit consists of a child under the age of six; when a child has a QHP, an income disregard will be given when the existence of the QHP makes the individual ineligible due to CHIP requirements found at 8.295.400 NMAC; or

B. individuals whose budget group's countable MAGI income is at or above two hundred and forty percent of the FPL if the assistance unit consists of a child age six to age 19, or three hundred percent of the FPL if the assistance unit consists of a child under the age of six.
[8.295.500.12 NMAC - Rp, 8.295.500.12 NMAC, 1/1/2014; A, 1/1/2022]

HISTORY OF 8.295.500 NMAC:

History of Repealed Material:
8.295.500 NMAC, Income and Resource Standards, filed 9/17/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 295 MEDICAID ELIGIBILITY - CHILDREN UNDER 19
PART 600 BENEFIT DESCRIPTION

8.295.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.295.600.1 NMAC - Rp, 8.295.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.295.600.2 SCOPE: The rule applies to the general public.
[8.295.600.2 NMAC - Rp, 8.295.600.2 NMAC, 1/1/2019]

8.295.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX and XXI of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.295.600.3 NMAC - Rp, 8.295.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.295.600.4 DURATION: Permanent.
[8.295.600.4 NMAC - Rp, 8.295.600.4 NMAC, 1/1/2019

8.295.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.295.600.5 NMAC - Rp, 8.295.600.5 NMAC, 1/1/2019]

8.295.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.295.600.6 NMAC - Rp, 8.295.600.6 NMAC, 1/1/2019]

8.295.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.295.600.7 NMAC - Rp, 8.295.600.7 NMAC, 1/1/2019]

8.295.600.8 [RESERVED]
[8.295.600.8 NMAC - Rp, 8.295.600.8 NMAC, 1/1/2019]

8.295.600.9 BENEFIT DESCRIPTION: This category provides full range of medicaid-covered services for eligible children.

A. An eligible child age five and under, whose budget group's countable income is less than two hundred forty percent of the federal poverty level (FPL) guidelines, receives the full range of medicaid services.

B. An eligible child age six through 18, whose budget group's countable income is less than one hundred ninety percent of the FPL guidelines, receives the full range of medicaid services.

C. An eligible child age five and under, whose budget group's countable income is greater than two hundred forty percent but less than three hundred percent of the FPL guidelines receives the full range of medicaid services.

D. An eligible recipient child age six through 18, whose budget group's countable income is greater than one hundred ninety percent but less than two hundred forty percent of the FPL guidelines, receives the full range of medicaid services.

[8.295.600.9 NMAC - Rp, 8.295.600.9 NMAC, 1/1/2019]

8.295.600.10 BENEFIT DETERMINATION: The HCA income support division determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.295.600.10 NMAC - Rp, 8.295.600.10 NMAC, 1/1/2019]

8.295.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A redetermination of eligibility is made in accordance with 8.291.410 NMAC.

B. Continuous eligibility is applicable for medicaid eligible children. Refer to 8.291.400 NMAC.

C. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.

[8.295.600.11 NMAC - Rp, 8.295.600.11 NMAC, 1/1/2019]

HISTORY OF 8.295.600 NMAC:

History of Repealed Material:

8.295.600 NMAC, Benefit Description, filed 9/17/2013 - Duration expired 12/31/2013.

8.295.600 NMAC, Benefit Description, filed 12/17/2013 – Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 296 MEDICAID ELIGIBILITY - OTHER ADULTS
PART 400 RECIPIENT REQUIREMENTS

8.296.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.296.400.1 NMAC - Rp, 8.296.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.296.400.2 SCOPE: The rule applies to the general public.
[8.296.400.2 NMAC - Rp, 8.296.400.2 NMAC, 1/1/2019]

8.296.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.296.400.3 NMAC - Rp, 8.296.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.296.400.4 DURATION: Permanent.
[8.296.400.4 NMAC - Rp, 8.296.400.4 NMAC, 1/1/2019]

8.296.400.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.296.400.5 NMAC - Rp, 8.296.400.5 NMAC, 1/1/2019]

8.296.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.296.400.6 NMAC - Rp, 8.296.400.6 NMAC, 1/1/2019]

8.296.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.296.400.7 NMAC - Rp, 8.296.400.7 NMAC, 1/1/2019]

8.296.400.8 [RESERVED]
[8.296.400.8 NMAC - Rp, 8.296.400.8 NMAC, 1/1/2019]

8.296.400.9 WHO CAN BE A RECIPIENT: To be eligible, an individual must meet specific eligibility requirements:

A. is age 19 or older and under age 65;
B. is not pregnant;
C. are not entitled to or enrolled in part A or B medicare benefits;
D. meets ACA eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC; and
E. has household income that is at or below one hundred thirty-three percent of the federal poverty level (FPL) for the applicable family size.

[8.296.400.9 NMAC - Rp, 8.296.400.9 NMAC, 1/1/2019; A, 2/1/2020]

8.296.400.10 OTHER ADULT ASSISTANCE UNIT AND BUDGET GROUP: To be considered in the other adult assistance unit, an individual must apply and be determined eligible. Individuals living with the other adult who meet criteria in 8.291.430 NMAC are included in the budget group.
[8.296.400.10 NMAC - Rp, 8.296.400.10 NMAC, 1/1/2019]

HISTORY OF 8.296.400 NMAC:

History of Repealed Material:
8.296.400 NMAC, Recipient Requirements, filed 9/17/2013 - Duration expired 12/31/2013.
8.296.400 NMAC, Recipient Requirements, filed 12/17/2013 - Repealed 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 296 MEDICAID ELIGIBILITY - OTHER ADULTS
PART 500 INCOME AND RESOURCE STANDARDS

8.296.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.296.500.1 NMAC - Rp, 8.296.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.296.500.2 SCOPE: The rule applies to the general public.
[8.296.500.2 NMAC - Rp, 8.296.500.2 NMAC, 1/1/2014]

8.296.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.296.500.3 NMAC - Rp, 8.296.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.296.500.4 DURATION: Permanent.
[8.296.500.4 NMAC - Rp, 8.296.500.4 NMAC, 1/1/2014]

8.296.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.296.500.5 NMAC - Rp, 8.296.500.5 NMAC, 1/1/2014]

8.296.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.296.500.6 NMAC - Rp, 8.296.500.6 NMAC, 1/1/2014]

8.296.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.296.500.7 NMAC - Rp, 8.296.500.7 NMAC, 1/1/2014]

8.296.500.8 MISSION: To transform lives. Working with our partners we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.296.500.8 NMAC - Rp, 8.296.500.8 NMAC, 1/1/2014; A, 1/1/2022]

8.296.500.9 RESOURCE STANDARDS: There are no resource standards for this category of eligibility.
[8.296.500.9 NMAC - Rp, 8.296.500.9 NMAC, 1/1/2014]

8.296.500.10 INCOME STANDARD:

A. Financial eligibility: An individual's financial eligibility is based on the rules in this chapter and 8.291.430 NMAC.

B. Income test: In order to become eligible for other adult medicaid, the total countable income of the budget group must be less than one hundred and thirty-three percent of the federal poverty guidelines found at 8.291.430 NMAC.

[8.296.500.10 NMAC - Rp, 8.296.500.10 NMAC, 1/1/2014; A, 1/1/2022]

8.296.500.11 INCOME ELIGIBILITY: Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2), HCA bases financial eligibility on current monthly household income and family size. Current monthly household income is defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.
[8.296.500.11 NMAC - Rp, 8.296.500.11 NMAC, 1/1/2014; A, 1/1/2022]

8.296.500.12 DISREGARD: An income disregard according to 8.291.430 NMAC will be given only to individuals whose countable MAGI income is at or above one hundred and thirty-three percent of federal poverty level for the size of the budget group.
[8.296.500.12 NMAC - Rp, 8.296.500.12 NMAC, 1/1/2014; A, 1/1/2022]

HISTORY OF 8.296.500 NMAC:

History of Repealed Material:
8.296.500 NMAC, Income and Resource Standards, filed 9/17/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 296 MEDICAID ELIGIBILITY - OTHER ADULTS
PART 600 BENEFIT DESCRIPTION

8.296.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.296.600.1 NMAC - Rp, 8.296.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.296.600.2 SCOPE: The rule applies to the general public.
[8.296.600.2 NMAC - Rp, 8.296.600.2 NMAC, 1/1/2019]

8.296.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.296.600.3 NMAC - Rp, 8.296.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.296.600.4 DURATION: Permanent.
[8.296.600.4 NMAC - Rp, 8.296.600.4 NMAC, 1/1/2019]

8.296.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.296.600.5 NMAC - Rp, 8.296.600.5 NMAC, 1/1/2019]

8.296.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.296.600.6 NMAC - Rp, 8.296.600.6 NMAC, 1/1/2019]

8.296.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.296.600.7 NMAC - Rp, 8.296.600.7 NMAC, 1/1/2019]

8.296.600.8 [RESERVED]
[8.296.600.8 NMAC - Rp, 8.296.600.8 NMAC, 1/1/2019]

8.296.600.9 BENEFIT DESCRIPTION: This medicaid category provides alternative benefit plan services for individuals who meet other adult eligibility requirements. Refer to 8.309 NMAC.
[8.296.600.9 NMAC - Rp, 8.296.600.9 NMAC, 1/1/2019]

8.296.600.10 BENEFIT DETERMINATION: The HCA income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.296.600.10 NMAC - Rp, 8.296.600.10 NMAC, 1/1/2019]

8.296.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A redetermination of eligibility is conducted in accordance with 8.291.410 NMAC.

B. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.

[8.292.600.11 NMAC - Rp, 8.296.600.11 NMAC, 1/1/2019]

HISTORY OF 8.296.600 NMAC:

History of Repealed Material:
8.296.600 NMAC, Benefit Description, filed 9/17/2013 - Duration expired 12/31/2013.

8.296.600 NMAC, Benefit Description, filed 12/17/2013 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 297 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO SPOUSAL SUPPORT
PART 400 RECIPIENT REQUIREMENTS

8.297.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.297.400.1 NMAC - Rp, 8.297.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.297.400.2 SCOPE: The rule applies to the general public.
[8.297.400.2 NMAC - Rp, 8.297.400.2 NMAC, 1/1/2019]

8.297.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.297.400.3 NMAC - Rp, 8.297.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.297.400.4 DURATION: Permanent.
[8.297.400.4 NMAC - Rp, 8.297.400.4 NMAC, 1/1/2019]

8.297.400.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.297.400.5 NMAC - Rp, 8.297.400.5 NMAC, 1/1/2019]

8.297.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.297.400.6 NMAC - Rp, 8.297.400.6 NMAC, 1/1/2019]

8.297.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.297.400.7 NMAC - Rp, 8.297.400.7 NMAC, 1/1/2019]

8.297.400.8 [RESERVED]
[8.297.400.8 NMAC - Rp, 8.297.400.8 NMAC, 1/1/2019]

8.297.400.9 WHO CAN BE AN ELIGIBLE RECIPIENT: A four month transitional medical assistance (TMA) period is established following the loss of parent caretaker eligibility due to new or increased spousal support. TMA is the full medicaid coverage of last resort. A parent or caretaker is evaluated for other full medicaid coverage, including other adults, before being placed on the TMA category of eligibility. A parent or caretaker losing full medicaid coverage during any month(s) of their four month TMA period is automatically placed on the TMA category. Coverage under the TMA category ends after the four month TMA period expires. Only parent(s) and guardian(s) are placed on the TMA category. The medicaid eligibility of dependent children living in the home is extended to at least match the TMA period of parent(s) and guardian(s).

A. To be a medicaid eligible recipient, the assistance unit must have:

(1) received parent caretaker medicaid in at least one month of the six months prior to ineligibility for parent caretaker medicaid;

(2) lost parent caretaker medicaid wholly or in part due to new or increased spousal support;

(3) at least one medicaid eligible dependent child living in the home; and

(4) met the medicaid eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC.

B. An individual with a new TMA period beginning on or after July 1, 2019, is subject to a premium for eligibility months the individual is on TMA category 027. Native Americans are exempt from the premium requirement.

C. An applicant or an eligible recipient may have a qualified health plan.

[8.297.400.9 NMAC - Rp, 8.297.400.9 NMAC, 1/1/2019]

HISTORY OF 8.297.400 NMAC:

History of Repealed Material:
8.297.400 NMAC, Recipient Requirements, filed 9/17/2013 - Duration expired 12/31/2013.
8.297.400 NMAC, Recipient Requirements, filed 12/17/2013 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 297 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO SPOUSAL SUPPORT
PART 500 INCOME AND RESOURCE STANDARDS

8.297.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.297.500.1 NMAC - Rp, 8.297.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.297.500.2 SCOPE: The rule applies to the general public.
[8.297.500.2 NMAC - Rp, 8.297.500.2 NMAC, 1/1/2014]

8.297.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.297.500.3 NMAC - Rp, 8.297.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.297.500.4 DURATION: Permanent.
[8.297.500.4 NMAC - Rp, 8.297.500.4 NMAC, 1/1/2014]

8.297.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.297.500.5 NMAC - Rp, 8.297.500.5 NMAC, 1/1/2014]

8.297.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.297.500.6 NMAC - Rp, 8.297.500.6 NMAC, 1/1/2014]

8.297.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.297.500.7 NMAC - Rp, 8.297.500.7 NMAC, 1/1/2014]

8.297.500.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.297.500.8 NMAC - Rp, 8.297.500.8 NMAC, 1/1/2014]

8.297.500.9 RESOURCE STANDARDS: There are no resource standards for this category of eligibility.
[8.297.500.9 NMAC - Rp, 8.297.500.9 NMAC, 1/1/2014]

8.297.500.10 INCOME STANDARDS: There are no income standards for this category of eligibility.
[8.297.500.10 NMAC - Rp, 8.297.500.10 NMAC, 1/1/2014]

HISTORY OF 8.297.500 NMAC:

History of Repealed Material:
8.297.500 NMAC, Income and Resource Standards, filed 9/17/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 297 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO SPOUSAL SUPPORT
PART 600 BENEFIT DESCRIPTION

8.297.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.297.600.1 NMAC - Rp, 8.297.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.297.600.2 SCOPE: The rule applies to the general public.
[8.297.600.2 NMAC - Rp, 8.297.600.2 NMAC, 1/1/2019]

8.297.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.297.600.3 NMAC - Rp, 8.297.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.297.600.4 DURATION: Permanent.
[8.297.600.4 NMAC - Rp, 8.297.600.4 NMAC, 1/1/2019]

8.297.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.297.600.5 NMAC - Rp, 8.297.600.5 NMAC, 1/1/2019]

8.297.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.297.600.6 NMAC - Rp, 8.297.600.6 NMAC, 1/1/2019]

8.297.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.297.600.7 NMAC - Rp, 8.297.600.7 NMAC, 1/1/2019]

8.297.600.8 [RESERVED]
[8.297.600.8 NMAC - Rp, 8.297.600.8 NMAC, 1/1/2019]

8.297.600.9 BENEFIT DESCRIPTION: A medicaid eligible recipient under this category is eligible to receive the full range of medicaid covered services.
[8.297.600.9 NMAC - Rp, 8.297.600.9 NMAC, 1/1/2019]

8.297.600.10 BENEFIT DETERMINATION: The HCA income support division (ISD) determines initial and ongoing eligibility.
[8.297.600.10 NMAC - Rp, 8.297.600.10 NMAC, 1/1/2019]

8.297.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A four month period of eligibility following parent caretaker medicaid is established without a new application. At the end of the four month period of eligibility a beneficiary is evaluated for other medicaid coverage in accordance with 8.291.410.19 NMAC. Retroactive medicaid coverage is not provided in accordance with 8.200.400.14 NMAC.

B. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.

[8.297.600.11 NMAC - Rp, 8.297.600.11 NMAC, 1/1/2019]

HISTORY OF 8.297.600 NMAC:

History of Repealed Material:
8.297.600 NMAC, Benefit Description, filed 9/17/2013 - Duration expired 12/31/2013.
8.297.600 NMAC, Benefit Description, filed 12/17/2013 - Repealed effective 12/17/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 298 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO EARNINGS FROM EMPLOYMENT
PART 400 RECIPIENT REQUIREMENTS

8.298.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.298.400.1 NMAC - Rp, 8.298.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.298.400.2 SCOPE: The rule applies to the general public.
[8.298.400.2 NMAC - Rp, 8.298.400.2 NMAC, 1/1/2019]

8.298.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.298.400.3 NMAC - Rp, 8.298.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.298.400.4 DURATION: Permanent.
[8.298.400.4 NMAC - Rp, 8.298.400.4 NMAC, 1/1/2019]

8.298.400.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.298.400.5 NMAC - Rp, 8.298.400.5 NMAC, 1/1/2019]

8.298.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.298.400.6 NMAC - Rp, 8.298.400.6 NMAC, 1/1/2019]

8.298.400.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.298.400.7 NMAC - Rp, 8.298.400.7 NMAC, 1/1/2019]

8.298.400.8 [RESERVED]
[8.298.400.8 NMAC - Rp, 8.298.400.8 NMAC, 1/1/2019]

8.298.400.9 WHO CAN BE AN ELIGIBLE RECIPIENT: A 12 month transitional medical assistance (TMA) period is established following the loss of parent caretaker eligibility due to new or increased earnings. TMA is the full medicaid coverage of last resort. A parent or caretaker is evaluated for other full medicaid coverage, including other adults, before being placed on the TMA category of eligibility. A parent or caretaker losing full medicaid coverage during any month(s) of their 12 month TMA period is automatically placed on the TMA category. Coverage under the TMA category ends after the 12 month TMA period expires. Only parent(s) and guardian(s) are placed on the TMA category. The medicaid eligibility of dependent children living in the home is extended to at least match the TMA period of parent(s) and guardian(s).

A. To be a medicaid eligible recipient, the assistance unit must have:

(1) received parent caretaker medicaid in at least one month of the six months prior to ineligibility for parent caretaker medicaid;

(2) lost parent caretaker medicaid wholly or in part due to new or increased earnings;

(3) at least one medicaid eligible dependent child living in the home; and

(4) met the medicaid eligibility requirements pursuant to 8.291.400 through 8.291.430 NMAC.

B. An individual with a new TMA period beginning on or after July 1, 2019, is subject to a premium for eligibility months the individual is on TMA category 028. Native Americans are exempt from the premium requirement.

C. An applicant or an eligible recipient may have a qualified health plan.

[8.298.400.9 NMAC - Rp, 8.298.400.9 NMAC, 1/1/2019]

HISTORY OF 8.298.400 NMAC:

History of Repealed Material:
8.298.400 NMAC, Recipient Requirements, filed 9/17/2013 - Duration expired 12/31/2013.
8.298.400 NMAC, Recipient Requirements, filed 12/17/2013 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 298 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO EARNINGS FROM EMPLOYMENT
PART 500 INCOME AND RESOURCE STANDARDS

8.298.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.298.500.1 NMAC - Rp, 8.298.500.1 NMAC, 1/1/2014; A, 7/1/2024]

8.298.500.2 SCOPE: The rule applies to the general public.
[8.298.500.2 NMAC - Rp, 8.298.500.2 NMAC, 1/1/2014]

8.298.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.298.500.3 NMAC - Rp, 8.298.500.3 NMAC, 1/1/2014; A, 7/1/2024]

8.298.500.4 DURATION: Permanent.
[8.298.500.4 NMAC - Rp, 8.298.500.4 NMAC, 1/1/2014]

8.298.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.298.500.5 NMAC - Rp, 8.298.500.5 NMAC, 1/1/2014]

8.298.500.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.298.500.6 NMAC - Rp, 8.298.500.6 NMAC, 1/1/2014]

8.298.500.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.298.500.7 NMAC - Rp, 8.298.500.7 NMAC, 1/1/2014]

8.298.500.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.298.500.8 NMAC - Rp, 8.298.500.8 NMAC, 1/1/2014]

8.298.500.9 RESOURCE STANDARDS: There are no resource standards for this category of eligibility.
[8.298.500.9 NMAC - Rp, 8.298.500.9 NMAC, 1/1/2014]

8.298.500.10 INCOME STANDARDS: There are no income standards for this category of eligibility.
[8.298.500.10 NMAC - Rp, 8.298.500.10 NMAC, 1/1/2014]

HISTORY OF 8.298.500 NMAC:

History of Repealed Material:
8.298.500 NMAC, Income and Resource Standards, filed 9/17/2013 - Duration expired 12/31/2013.

TITLE 8 SOCIAL SERVICES
CHAPTER 298 MEDICAID ELIGIBILITY - LOSS OF PARENT CARETAKER MEDICAID DUE TO EARNINGS FROM EMPLOYMENT
PART 600 BENEFIT DESCRIPTION

8.298.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.298.600.1 NMAC - Rp, 8.298.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.298.600.2 SCOPE: The rule applies to the general public.
[8.298.600.2 NMAC - Rp, 8.298.600.2 NMAC, 1/1/2019]

8.298.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.298.600.3 NMAC - Rp, 8.298.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.298.600.4 DURATION: Permanent.
[8.298.600.4 NMAC - Rp, 8.298.600.4 NMAC, 1/1/2019]

8.298.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.298.600.5 NMAC - Rp, 8.298.600.5 NMAC, 1/1/2019]

8.298.600.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.298.600.6 NMAC - Rp, 8.298.600.6 NMAC, 1/1/2019]

8.298.600.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.298.600.7 NMAC - Rp, 8.298.600.7 NMAC, 1/1/2019]

8.298.600.8 [RESERVED]
[8.298.600.8 NMAC - Rp, 8.298.600.8 NMAC, 1/1/2019]

8.298.600.9 BENEFIT DESCRIPTION: A medicaid eligible recipient under this category is eligible to receive the full range of medicaid covered services.
[8.298.600.9 NMAC - Rp, 8.298.600.9 NMAC, 1/1/2019]

8.298.600.10 BENEFIT DETERMINATION: The HCA income support division (ISD) determines initial and ongoing eligibility.
[8.298.600.10 NMAC - Rp, 8.298.600.10 NMAC, 1/1/2019]

8.298.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A 12 month period of eligibility following parent caretaker medicaid is established without a new application. At the end of the 12 month period of eligibility a beneficiary is evaluated for other medicaid coverage in accordance with 8.291.410.19 NMAC. Retroactive medicaid coverage is not provided in accordance with 8.200.400.14 NMAC.

B. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change as detailed in 8.291.400 NMAC.

[8.298.600.11 NMAC - Rp, 8.298.600.11 NMAC, 1/1/2019]

HISTORY OF 8.298.600 NMAC:

History of Repealed Material:
8.298.600 NMAC, Benefit Description, filed 9/17/2013 - Duration expired 12/31/2013.
8.298.600 NMAC, Benefit Description, filed 12/17/2013 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 299 MEDICAID ELIGIBILITY - FAMILY PLANNING SERVICES
PART 400 RECIPIENT REQUIREMENTS

8.299.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.299.400.1 NMAC - Rp, 8.299.400.1 NMAC, 1/1/2019; A, 7/1/2024]

8.299.400.2 SCOPE: The rule applies to the general public.
[8.299.400.2 NMAC - Rp, 8.299.400.2 NMAC, 1/1/2019]

8.299.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.299.400.3 NMAC - Rp, 8.299.400.3 NMAC, 1/1/2019; A, 7/1/2024]

8.299.400.4 DURATION: Permanent.
[8.299.400.4 NMAC - Rp, 8.299.400.4 NMAC, 1/1/2019]

8.299.400.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.299.400.5 NMAC - Rp, 8.299.400.5 NMAC, 1/1/2019]

8.299.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.299.400.6 NMAC - Rp, 8.299.400.6 NMAC, 1/1/2019]

8.299.400.7 DEFINITIONS: [RESERVED]

8.299.400.8 [RESERVED]
[8.299.400.7 NMAC - Rp, 8.299.400.8 NMAC, 1/1/2019]

8.299.400.9 WHO CAN BE A RECIPIENT (42 CFR 435.214): HCA provides medicaid limited to family planning and family planning related services to individuals (of any gender) who:

A. are under the age of 51 and do not have other health insurance; or
B. who are under the age of 65 who have only medicare coverage and no other health insurance; and
C. who are not pregnant; and
D. meet the general recipient requirements found at 8.291.410 NMAC; and
E. meet the income eligibility requirements found at Subsection B of 8.299.500.10 NMAC.

[8.299.400.9 NMAC - Rp, 8.299.400.9 NMAC, 1/1/2019]

8.299.400.10 BASIS FOR DEFINING THE GROUP: At time of application, an applicant or recipient and the HCA shall identify everyone who is to be considered for inclusion in the assistance unit and budget group as defined in 8.291.430 NMAC.
[8.299.400.10 NMAC - Rp, 8.299.400.10 NMAC, 1/1/2019]

HISTORY OF 8.299.400 NMAC: [RESERVED]

History of Repealed Material:
8.299.400 NMAC - Recipient Requirements, filed 9/14/2017 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 299 MEDICAID ELIGIBILITY - FAMILY PLANNING SERVICES
PART 500 INCOME AND RESOURCE STANDARDS

8.299.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.299.500.1 NMAC - N, 10/1/2017; A, 7/1/2024]

8.299.500.2 SCOPE: The rule applies to the general public.
[8.299.500.2 NMAC - N, 10/1/2017]

8.299.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq, NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.299.500.3 NMAC - N, 10/1/2017; A, 7/1/2024]

8.299.500.4 DURATION: Permanent.
[8.299.500.4 NMAC - N, 10/1/2017]

8.299.500.5 EFFECTIVE DATE: October 1, 2017, unless a later date is cited at the end of a section.
[8.299.500.5 NMAC - N, 10/1/2017]

8.299.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.299.500.6 NMAC - N, 10/1/2017]

8.299.500.7 DEFINITIONS: [RESERVED]

8.299.500.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.299.500.8 NMAC - N, 10/1/2017; A, 1/1/2022]

8.299.500.9 RESOURCE STANDARDS: Resources are not an eligibility factor for this category of eligibility.
[8.299.500.9 NMAC - N, 10/1/2017]

8.299.500.10 INCOME STANDARD: In order to become eligible for family planning medicaid, the total countable income of the budget group must be less than two hundred fifty percent of the federal poverty guidelines found at 8.291.430 NMAC.
[8.299.500.10 NMAC - N, 10/1/2017]

8.299.500.11 INCOME ELIGIBILITY: Income methodology is based on modified adjusted gross income (MAGI) in accordance with 42 Code of Federal Regulations (CFR) 435.603. Per 42 CFR 435.603(h)(2) HSD bases financial eligibility on current monthly household income and family size. Current monthly household income is defined as a 30-day period. If an amount of income is received less frequently than monthly, that amount is converted by dividing the total income by the number of months the income is intended to cover.
[8.299.500.10 NMAC - N, 10/1/2017; A, 1/1/2022]

8.299.500.12 DISREGARD: An income disregard according to 8.291.430 NMAC will be given only to individuals whose countable modified adjusted gross income (MAGI) is at or above two hundred fifty percent of the federal poverty level for the size of the budget group.
[8.299.500.10 NMAC - N, 10/1/2017]

HISTORY OF 8.299.500 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 299 MEDICAID ELIGIBILITY - FAMILY PLANNING SERVICES
PART 600 BENEFIT DESCRIPTION

8.299.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.299.600.1 NMAC – Rp, 8.299.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.299.600.2 SCOPE: The rule applies to the general public.
[8.299.600.2 NMAC - Rp, 8.299.600.2 NMAC, 1/1/2019]

8.299.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.299.600.3 NMAC - Rp, 8.299.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.299.600.4 DURATION: Permanent.
[8.299.600.4 NMAC - Rp, 8.299.600.4 NMAC, 1/1/2019]

8.299.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.299.600.5 NMAC - Rp, 8.299.600.5 NMAC, 1/1/2019]

8.299.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.299.600.6 NMAC - Rp, 8.299.600.6 NMAC, 1/1/2019]

8.299.600.7 DEFINITIONS: [RESERVED]

8.299.600.8 [RESERVED]

8.299.600.9 BENEFIT DESCRIPTION: This category provides a limited range of medicaid-covered services for family planning and family planning-related services for both men and women.
[8.299.600.9 NMAC - Rp, 8.299.600.9 NMAC, 1/1/2019]

8.299.600.10 BENEFIT DETERMINATION: The HCA income support division (ISD) determines initial and ongoing eligibility. Refer to affordable care general provision chapters located at 8.291.400 through 8.291.430 NMAC for eligibility requirements. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.
[8.299.600.10 NMAC - Rp, 8.299.600.10 NMAC, 1/1/2019]

8.299.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:
A. A redetermination of eligibility is conducted in accordance with 8.291.410 NMAC.
B. All changes that may affect eligibility must be reported within 10 calendar days of the date of the change as detailed in 8.291.400 NMAC.
[8.299.600.11 NMAC - Rp, 8.299.600.11 NMAC, 1/1/2019]

HISTORY OF 8.299.600 NMAC: [RESERVED]

History of Repealed Material:
8.299.600 NMAC - Benefit Description, filed 9/14/2017 - Repealed effective 1/1/2019.

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 22 ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM

8.300.22.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.300.22.1 NMAC - N, 8/1/2011; A, 7/1/2024]

8.300.22.2 SCOPE: The rule applies to the general public.
[8.300.22.2 NMAC - N, 8/1/2011]

8.300.22.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.22.3 NMAC - N, 8/1/2011; A, 7/1/2024]

8.300.22.4 DURATION: Permanent
[8.300.22.4 NMAC - N, 8/1/2011]

8.300.22.5 EFFECTIVE DATE: August 1, 2011, unless a later date is cited at the end of a section.
[8.300.22.5 NMAC - N, 8/1/2011]

8.300.22.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.300.22.6 NMAC - N, 8/1/2011]

8.300.22.7 DEFINITIONS: [**RESERVED**]

8.300.22.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.300.22.8 NMAC - N, 8/1/2011; A,]

8.300.22.9 ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM: The New Mexico medical assistance division (MAD) administers the medicaid electronic health records incentive program (medicaid EHR incentive program) as authorized by the federal American Recovery and Reinvestment Act of 2009. Under this program, New Mexico MAD providers may qualify for incentive payments if they meet the eligibility guidelines in this section and demonstrate they are engaged in efforts to adopt, implement, upgrade (AIU), or meaningfully use certified electronic health records (EHR) technology. The medicaid EHR incentive program is governed by the rule in this section, the electronic health records program final rule issued by centers for medicare and medicaid (CMS) in CMS-0033-F and 45 CFR 170, and the conditions of approval of the MAD plan approved by CMS. New Mexico MAD providers must also follow MAD instructions for enrolling in the medicaid EHR incentive program and provide documentation as required. Payments are made with federal funds and are contingent on the availability of those funds and federal requirements for reimbursement. Should the federal government discontinue funding, the incentive payments, inclusive, then incentive payments from the HCA will terminate.
[8.300.22.9 NMAC - N, 8/1/2011]

8.300.22.10 ELIGIBLE PROVIDERS:

A. Health care to New Mexico MAD eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement or a MAD EHR incentive payment agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care

programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When approved, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement or a MAD EHR incentive payment agreement, and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

B. To qualify for incentive payments, a provider must be an eligible professional or an eligible hospital. A provider who receives incentive payments must have an existing fee-for-service (FFS) MAD provider participation agreement or a MAD EHR incentive payment agreement, and at least one of their facilities must be located within the state of New Mexico.

(1) An eligible professional provider may not be hospital-based, unless they practice predominantly at a federally qualified health center (FQHC) or a rural health center (RHC) as defined by the CMS final rule. A professional provider is considered "hospital-based" if they furnish ninety percent or more of their medicaid professional services during the relevant EHR reporting period in a hospital inpatient or emergency room, using the facilities and equipment of the hospital. An eligible professional provider may not participate in both the medicaid EHR incentive payment program and medicare EHR incentive payment program during the same payment year. Eligible professional providers include:

(a) a physician;
(b) a physician assistant practicing in a FQHC or RHC led by a physician assistant;
(c) a board certified pediatrician;
(d) a nurse practitioner;
(e) a certified nurse midwife;
(f) a dentist; or
(g) other type of provider when specifically allowed by CMS.

(2) Eligible hospitals are children's hospitals or acute care hospitals, including critical access hospitals and cancer hospitals. A hospital must meet either of the following definitions to be eligible for incentive payments:

(a) an acute care hospital is defined as a health care facility where the average length of patient stay is 25 days or fewer and that has a CMS certification number that has the last four digits in the series 0001-0879 and 1300-1399; or

(b) a children's hospital is defined as a separately certified children's hospital, either freestanding or hospital-within-hospital, that predominantly treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

[8.300.22.10 NMAC - N, 8/1/2011]

8.300.22.11 ELIGIBLE RECIPIENT VOLUME: An eligible professional provider and an eligible hospital must meet eligible recipient volume criteria to qualify for incentive payments. Eligible recipient volume criteria compliance will be verified by MAD through claims and encounter data and audits. Eligible recipient volume requirements represent Title XIX (medicaid) eligible recipients as a percent of total eligible recipients, except for an eligible professional provider practicing predominately in a FQHC or RHC, who may use "needy individuals" as defined below in calculating eligible recipient volume.

A. The CMS final rule provides two options for determining patient volume percentages. New Mexico MAD will allow both options, as described below:

(1) eligible recipient encounter method: medicaid eligible recipient encounters in any 90-day reporting period in the preceding calendar year divided by total eligible recipient encounters in same 90-day period; or

(2) unduplicated eligible recipient method: see formula below.

(total medicaid eligible recipients assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the year preceding the start of the 90-day period) + (unduplicated medicaid encounters in that same 90-day period) *100 divided by (total eligible recipients assigned to the provider in the same 90 days with at least one encounter in the year preceding the start of the 90-day period) + (all unduplicated encounters in that same 90-day period).

B. Eligible recipient volume thresholds vary by type of provider and practice location.

(1) An eligible professional provider must meet a thirty percent medicaid eligible recipient volume threshold over a continuous 90-day period in the preceding calendar year. The only exception is for pediatricians, as discussed in 8.300.22.16 NMAC, below.

(2) With the exception of a children's hospital, which have no eligible recipient volume requirement, an eligible hospital must meet a ten percent medicaid eligible recipient volume threshold over a continuous 90-day period in the preceding calendar year.

(3) An eligible professional provider practicing predominantly in an FQHC or RHC must meet thirty percent "needy individual" eligible recipient volume. To qualify as a "needy individual," patients must meet one of the following criteria:

(a) receives medicaid under an appropriate category of eligibility; or

(b) were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay, or were furnished uncompensated care by the provider.

(4) A clinic or group practice may calculate eligible recipient volume using the clinic's or group's entire eligible recipient volume under the following conditions:

(a) the clinic or group practice's eligible recipient volume is appropriate as an eligible recipient volume methodology calculation for the eligible professional provider; and

(b) there is an auditable data source to support the eligible recipient volume determination; and

(c) all eligible professional providers in the clinic or group practice use the same methodology for the payment year; and

(d) the clinic or group practice does not limit eligible recipient volume in any way; and

(e) if an eligible professional provider works inside and outside of the clinic or practice, the eligible recipient volume calculation includes only those encounters associated with the clinic or group practice, and not the eligible professional provider's outside encounters.

(5) A pediatrician may qualify for a two-thirds incentive payment if their medicaid eligible recipient volume is twenty to twenty-nine percent. To qualify as a pediatrician for the purpose of receiving a two-thirds payment under the medicaid EHR incentive program, the pediatrician must be enrolled as a pediatrician provider with MAD.

[8.300.22.11 NMAC - N, 8/1/2011; A, 7/1/2012]

8.300.22.12 NATIONAL REGISTRATION AND ATTESTATION SYSTEM: An eligible professional provider or eligible hospital choosing to participate in the medicaid EHR incentive program must register with the CMS national level registry (NLR) and provide demographic information as well as participation choices. The NLR registration process is described in the medicaid EHR incentive program participation instructions.

[8.300.22.12 NMAC - N, 8/1/2011]

8.300.22.13 ATTESTATION REQUIREMENTS: An eligible professional provider or eligible hospital must attest to meeting the medicaid EHR incentive program participation requirements as a prerequisite to receiving payment. Attestation is accomplished through on-line access to the state level registry (SLR) and completion of an agreement. The agreement must be signed by the eligible professional provider or the eligible hospital and when accepted by MAD becomes part of the MAD provider participation agreement or a MAD EHR incentive payment agreement. The medicaid EHR incentive program attestation includes several elements, described in subsequent sections.

A. An eligible professional provider or eligible hospital in their first participation year under the medicaid EHR incentive program may choose to attest to adopting, implementing, or upgrading certified electronic health record (EHR) technology. Proof of A/I/U must be submitted to MAD as part of the attestation.

B. An eligible professional provider in their second through sixth participation year and an eligible hospital in their second through third, or fourth participation year must attest to meaningful use of certified EHR technology. An eligible hospital must attest to meaningful use if they are participating in both the medicare and MAD medicaid EHR incentive programs in their first participation year. The definition of "meaningful EHR user" and "meaningful use" is found in 42 CFR 495.4 and 42 CFR 495.6, respectively.

[8.300.22.13 NMAC - N, 8/1/2011]

8.300.22.14 PAYMENT REQUIREMENTS: An eligible professional provider and eligible hospital may receive yearly payments under the medicaid EHR incentive program. All medicaid EHR incentive program payments are subject to certain conditions.

A. Attestations must be accepted by MAD and the attested items verified pursuant to MAD guidelines.

B. An eligible professional provider or eligible hospital must identify a taxpayer identification number (TIN) to assign payment. Valid entities may be the individual eligible professional provider, a group with which the eligible professional provider s associated or an organization recognized by MAD as a qualified organization promoting the use of EHR technology. The "qualified organization" may not retain more than five percent of the annual medicaid EHR incentive program for those costs unrelated to the certified EHR, which will include salaries and benefits, rent, maintenance, utilities, insurance and travel.

C. The eligible professional or eligible hospital must have a current MAD provider participation agreement or a MAD EHR incentive payment agreement by MAD or its designee.

D. The eligible professional provider or eligible hospital is responsible for repayment of any identified overpayment of the medicaid EHR incentive program funds. MAD will recoup the overpaid funds by reducing any future payments, or through other arrangements as it determines.

[8.300.22.14 NMAC - N, 8/1/2011]

8.300.22.15 PAYMENT CALCULATION: MAD will calculate yearly payment amounts and the total payment amounts based on the guidelines described below.

A. An eligible professional provider may receive a maximum of $63,750 in the incentive payments over six years, unless otherwise reduced or increased by CMS.

(1) An eligible professional provider must initiate registration to receive payment in 2016 in order to participate in the program.

(2) An eligible professional provider may receive payment on an annual or non-consecutive basis for up to six years between 2011 through 2021.

(3) Payment will be made one time per year per eligible professional provider.

(4) To receive an incentive payment in the second, third, fourth, fifth and sixth payment year, the eligible professional provider must demonstrate that it is a meaningful user of EHR technology, as described in 42 CFR 495.4.

	PY 2011	**PY 2012**	**PY 2013**	**PY 2014**	**PY 2015**	**PY 2016**
CY 2011	**$21,250**					
CY 2012	**$8,500**	**$21,250**				
CY 2013	**$8,500**	**$8,500**	**$21,250**			
CY 2014	**$8,500**	**$8,500**	**$8,500**	**$21,250**		
CY 2015	**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$21,250**	
CY 2016	**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$21,250**
CY 2017		**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$8,500**
CY 2018			**$8,500**	**$8,500**	**$8,500**	**$8,500**
CY 2019				**$8,500**	**$8,500**	**$8,500**
CY 2020					**$8,500**	**$8,500**
CY 2021						**$8,500**
Potential:	***$63,750***	***$63,750***	***$63,750***	***$63,750***	***$63,750***	***$63,750***

B. An eligible hospital aggregated incentive amount calculation will be a one-time, up front calculation for each hospital, based on the methodology described in Paragraph (2) of Subsection B below.

(1) An eligible hospital has a base amount of $2,000,000 for each of four years, plus a discharge-related amount, times the MAD share of the total. The detailed formula is below.

{Sum over four years of [(base amount + discharge related amount applicable for each year) * transition factor applicable for each year]} * [(MAD inpatient-bed-days + MAD managed care inpatient-bed-days) / {(total inpatient-bed-days) * (estimated total charges – charity care charges) / (estimated total charges)}].

(2) MAD will make payment to a hospital as follows:

(a) A hospital will be eligible for funding over three years with payments distributed at fifty percent of the total payment in the first participation year of program enrollment, forty percent of the total payment in the second participation year of program enrollment, and ten percent in the third participation year of program enrollment.

(b) MAD will accept the most recent submitted cost reports as the basis for calculation of EHR incentive program payments.

(c) MAD will use the MAD management information system (MMIS) data as the basis for validating hospital MAD eligible recipient volume.

(d) MAD will use the federal fiscal year as the basis for calculation of all measures related to a hospital.

(e) MAD will use the hospital audit agent to support the MAD calculation of each eligible hospital incentive payment and reach agreement with the eligible hospital and their representative, the New Mexico hospital association on the accuracy of each eligible hospital calculation before submitting the results for payment.

(f) A hospital may not request a re-calculation of the medicaid EHR incentive program payment once the parties have agreed to the base year for the medicare cost report.

[8.300.22.15 NMAC - N, 8/1/2011]

8.300.22.16 AUDIT AND RECORD RETETION: Medicaid EHR incentive program participation and payments are subject to audit and recoupment if determined to be paid improperly. MAD will provide both prepayment verification and post payment audit of the payments made through the medicaid EHR incentive program.

A. MAD expects to verify most aspects of medicaid EHR incentive program eligibility as part of its pre-payment screening, including:

(1) active MAD provider participation agreement for an eligible professional provider and an eligible hospital or a MAD EHR incentive payment agreement;

(2) MAD eligible recipient volume for an eligible professional provider in an independent practice (broken out by FFS and for each contracted MCO);

(3) participation in the group practice identified by the eligible professional provider as meeting the threshold for MAD eligible recipient volume;

(4) total MAD eligible recipient for group practice;

(5) all members of a group use the same methodology for assigning eligible recipients to participating eligible professional providers;

(6) A/I/U certified EHR software for eligible professionals;

(7) not a hospital based provider for eligible professional providers;

(8) hospital eligible recipient volume from audit reports; and

(9) hospital incentive payment calculation (one-time process).

B. MAD may conduct post payment audits of any medicaid EHR incentive program participant. Post payment audits may include any aspect of medicaid EHR incentive program eligibility. An eligible professional provider, group or eligible hospital must maintain and make available documentation to support their participation in the medicaid EHR incentive program. Post payment audits will focus on verification of eligibility components not readily available to MAD as part of normal MAD program administration, including:

(1) validation of total eligible recipient volume, including “needy individuals” for all eligible professional providers;

(2) out-of-state medicaid eligible recipients;

(3) practices predominantly in a FQHC or RHC for eligible professional providers claiming that status; and

(4) meaningful use through meeting objectives for collecting and submitting clinical quality measures.

C. MAD eligible professional providers and eligible hospitals participating in the medicaid EHR incentive program must maintain all documentation supporting their participation in the program for six years from the date of receipt of any payment.

[8.300.22.16 NMAC - N, 8/1/2011]

HISTORY OF 8.300.22 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 2 BILLING FOR MEDICAID SERVICES

8.302.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.302.2.1 NMAC - Rp, 8.302.2.1 NMAC, 10/1/2017; A, 7/1/2024]

8.302.2.2 SCOPE: The rule applies to the general public.
[8.302.2.2 NMAC - Rp, 8.302.2.2 NMAC, 10/1/2017]

8.302.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services (HHS) under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.302.2.3 NMAC - Rp, 8.302.2.3 NMAC, 10/1/2017; A, 7/1/2024]

8.302.2.4 DURATION: Permanent.
[8.302.2.4 NMAC - Rp, 8.302.2.4 NMAC, 10/1/2017]

8.302.2.5 EFFECTIVE DATE: October 1, 2017, unless a later date is cited at the end of a section.
[8.302.2.5 NMAC - Rp, 8.302.2.5 NMAC, 10/1/2017]

8.302.2.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.302.2.6 NMAC - Rp, 8.302.2.6 NMAC, 10/1/2017]

8.302.2.7 DEFINITIONS:

A. "Authorized representative" means the individual designated to represent and act on behalf of the eligible recipient or member's behalf. The member or authorized representative must provide formal 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 eligible recipient or member.

B. "Eligible recipient" means an individual who has met a medical assistance program (MAP) category of eligibility and receives their medical assistance division (MAD) services through the fee-for-service (FFS) program.

C. "Member" means a MAP eligible recipient and who receives their MAD services through a HCA contracted managed care organization (MCO).

D. "Co-payment" means a fixed dollar amount that a medicaid recipient must pay directly to a provider for a service, visit or item. A co-payment is to be charged at the time of service or receipt of the item.
[8.302.2.7 NMAC – Rp, 8.302.7 NMAC, 10/1/2017; A, 1/1/2019]

8.302.2.8 [RESERVED]
[8.302.2.8 NMAC - Rp, 8.302.2.8 NMAC, 10/1/2017]

8.302.2.9 BILLING FOR MEDICAID SERVICES: Health care for New Mexico medical assistance program MAP eligible recipients and members is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (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 must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instruction, service standards, utilization review (UR) instructions, and other

pertinent material. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. MAD makes available on the HCA website, on other program specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, service standards, UR instructions, and other pertinent material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, rules, billing instructions, service standards, UR instructions, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. See 8.308.14 NMAC for additional MCO provider responsibilities.
[8.302.2.9 NMAC - Rp, 8.302.2.9 NMAC, 10/1/2017]

8.302.2.10 BILLING INFORMATION:

A. Billing for services: MAD only makes payment to a provider or to the following individuals or organizations for services:

(1) a government agency or third party with a court order, based on a valid provider payment assignment; see 42 CFR Section 447.10(d)(e); or

(2) a business agent, such as billing service or accounting firm that provides statements and receives payment in the name of the provider; the agent's compensation must be related to the cost of processing the claims and not based on a percentage of the amount that is billed or collected or dependent upon collection of the payment.

B. Billing for services from group practitioners or employers of practitioners: MAD may make payments to a group practice and to an employer of an individual practitioner if the practitioner is required to turn over their fees to the employer as a condition of employment. See 42 CFR 447.10(g) (2) (3). MAD may make payments to a facility where the services are furnished or to a foundation, plan, or similar organization operating as an organized health care delivery system if the facility, foundation, plan, or organization is required by contract to submit claims for an individual practitioner.

C. Billing for referral services: A referring provider must submit to the provider receiving the referral, specimen, image, or other record, all information necessary for the provider rendering the service to bill MAD within specified time limits. An eligible recipient or their authorized representative or MAD is not responsible for payment if the provider rendering the service fails to obtain this information from the referring provider. Ordering, referring, prescribing, rendering and attending providers must participate in a MCO or the MAD (FFS) program, or otherwise be identifiable as a participating, out-of-network, or in-network provider for services, as determined by MAD.

D. Hospital-based services: For services that are hospital based, the hospital must provide MAP recipient eligibility and billing information to providers of services within the hospital, including professional components, hospital emergency room (ER) physicians, hospital anesthesiologists, and other practitioners for whom the hospital performs admission, patient registration, or the patient intake process. An eligible recipient, member or their authorized representative, or MAD is not responsible for payment if the hospital-based provider does not obtain this information from the hospital as necessary to bill within the specified time limits.

E. Coordinated service contractors: Some MAD services are managed by a coordinated service contractor. Contracted services may include behavioral health services, dental services, physical health services, transportation, pharmacy or other benefits as designated by the MAD. The coordinated service contractor may be responsible for any or all aspects of program management, prior authorization, (UR), claims processing, and issuance of remittance advices and payments. A provider must submit claims to the appropriate coordinated service contractor as directed by MAD.

F. Reporting of service units: A provider must correctly report service units.

(1) For current procedural terminology (CPT) codes or healthcare common procedural coding system (HCPCS) codes that describe how units associated with time should be billed, providers are to follow those instructions.

(2) For CPT or HCPCS for services for which the provider is to bill one unit per 15 minute or per hour of service, the provider must follow the chart below when the time spent is not exactly 15 minutes or one hour.

time spent	**number of 15-minute units that may be billed**	**number of 1-hour units that may be billed**
Less than 8 minutes	0	0

	services that are in their entirety less than 8 minutes cannot be billed.	*services that are in their entirety less than 8 minutes cannot be billed*
8 minutes through 22 minutes	1	.25
23 minutes through 37 minutes	2	.5
38 minutes through 52 minutes	3	.75
53 minutes through 67 minutes	4	1
68 minutes through 82 minutes	5	1.25
83 minutes through 97 minutes	6	1.5

(3) Only time spent directly working with an eligible recipient or member to deliver treatment services is counted toward the time codes.

(4) Total time spent delivering each service using a timed code must be recorded in the medical record of each eligible recipient or member. If services provided are appropriately described by using more than one CPT or HCPCS code within a single calendar day, then the total number of units that can be billed is limited to the total treatment time. Providers must assign the most units to the treatment that took the most time.

(5) The units for codes do not take precedence over centers for medicare and medicaid services (CMS) national correct coding initiative (NCCI).

(6) Anesthesia units must be billed according to 8.310.3 NMAC.

(7) Units billed by a home and community-based services waiver provider, a behavioral health provider, an early intervention provider, and all rehabilitation services providers must also follow the requirements of this section unless exceptions are specifically stated in published MAD program rules or provider billing instructions.

G. MAD requires co-payments for specific services under the medicaid managed care program. The rules for medicaid managed care co-payments, including the co-payment amounts, co-payment exemptions, provider responsibilities, and member rights and responsibilities, are detailed at 8.308.14 NMAC.

H. **Billing state gross receipts tax:** For providers subject and registered to pay, gross receipts tax, the provider may include gross receipt tax in the billed amount when the tax applies to the item or service. The provider may only bill tax to the extent the tax is also charged to the general public. A provider may not include gross receipts tax in the billed amount when the provider is not obligated to pay gross receipts tax to the state.
[8.302.2.10 NMAC - Rp, 8.302.2.10 NMAC, 10/1/2017; A, 1/1/2019]

8.302.2.11 BILLING AND CLAIMS FILING LIMITATIONS:

A. Claims must be received within the MAD filing limits as determined by the date of receipt by MAD or its selected claims processing contractor.

(1) Claims for services must be received within 90 calendar days of the date of service unless an alternative filing limit is stated within this section.

(2) Inpatient hospital and other inpatient facility claims must be received within 90 calendar days of the date of the eligible recipient or member's discharge, transfer, or otherwise leaving the facility.

(3) When the provider can document that a claim was filed with another primary payer including medicare, a HCA contracted MCO, medicare replacement plans, or another insurer, the claim must be received within 90 calendar days of the date the other payer paid or denied the claim as reported on the explanation of benefits or remittance advice of the other payer, not to exceed 210 calendar days from the date of service. It is the provider's responsibility to submit the claim to another primary payer within a sufficient timeframe to reasonably allow the primary payer to complete the processing of the claim and also meet the MAD timely filing limit. Denials by the primary payer due to the provider not meeting administrative requirements in filing the claim must be appealed by the provider to the primary payer. MAD only considers payment for a claim denied by the other primary payer when under the primary payer's plan the eligible recipient or member is not eligible, the diagnosis, service or item is not within the scope of the benefits, benefits are exhausted, pre-existing conditions are not covered, or out-of-pocket expenses or the deductibles have not been met. MAD will evaluate a claim for further payment including payment toward a deductible, co-insurance, co-payment or other patient responsibility. Claims for payment towards a deductible, co-insurance, co-payment or other patient responsibility also must be received within 90 calendar days of the date of the other payer's payment, not to exceed 210 calendar days from the date of service.

(4) For an eligible recipient or member for whom MAD benefits were not established at the time of service but retroactive eligibility has subsequently been established, claims must be received within 90

calendar days of the date the eligibility was added to the eligibility record of MAD or its selected claims processing contractor.

(5) For a provider of services not enrolled as a MAD provider at the time the services were rendered, including a provider that is in the process of purchasing an enrolled MAD provider entity such as a practice or facility, claims must be received within 90 calendar days of the date the provider is notified of the MAD approval of the PPA, not to exceed 210 calendar days from the date of service. It is the provider's responsibility to submit a PPA within a sufficient timeframe to allow completion of the provider enrollment process and submission of the claim within the MAD timely filing limit.

(6) For claims that were originally paid by a HCA contracted MCO from which the capitation payment is recouped resulting in recoupment of a provider's claim by the MCO, the claim must be received within 90 calendar days of the recoupment from the provider.

(7) For claims that were originally paid by MAD or its selected claims processing contractor and subsequently recouped by MAD or its selected claims processing contractor due to certain claims conflicts such as overlapping duplicate claims, a corrected claim subsequently submitted by the provider must be received within 90 calendar days of the recoupment.

B. The provider is responsible for submitting the claim timely, for tracking the status of the claim and determining the need to resubmit the claim.

(1) Filing limits are not waived by MAD due to the providers inadequate understanding of the filing limit requirements or insufficient staff to file the claim timely or failure to track pending claims, returns, denials, and payments in order to resubmit the claim or request an adjustment within the specified timely filing limitation.

(2) A provider must follow up on claims that have been transmitted electronically or hard copy in sufficient time to resubmit a claim within the filing limit in the event that a claim is not received by MAD or its selected claims processing contractor. It is the provider's responsibility to re-file an apparently missing claim within the applicable filing limit.

(3) In the event the provider's claim or part of the claim is returned, denied, or paid at an incorrect amount, the provider must resubmit the claim or an adjustment request within 90 calendar days of the date of the return, denial or payment of an incorrect amount, that was submitted in the initial timely filing period. This additional 90 calendar day period is a one-time grace period following the return, denial or mis-payment for a claim that was filed in the initial timely filing period and is based on the remittance advice date or return notice. Additional 90 calendar day grace periods are not allowed. However, within the 90 calendar day grace period the provider may continue to resubmit the claim or adjustment requests until the 90 calendar day grace period has expired.

(4) Adjustments to claims for which the provider feels additional payment is due, or for which the provider desires to change information previously submitted on the claim, the claim or adjustment request with any necessary explanations must be received by MAD or its selected claims processing contractor with the provider using a MAD-approved adjustment format and supplying all necessary information to process the claim within the one-time 90 calendar day allowed grace period.

C. The eligible recipient, member or their authorized representative is responsible for notifying the provider of MAP eligibility or pending eligibility and when retroactive MAP eligibility is received. When any provider including an enrolled provider, a non-enrolled provider, a MCO provider, and an out-of-network provider is informed of a recipient's MAP eligibility, the circumstances under which an eligible recipient, member or their authorized representative can be billed by the provider are limited.

(1) When the provider is unwilling to accept the eligible recipient as a (FFS) eligible recipient or a MCO member, the provider must provide the eligible recipient, member or their authorized representative written notification that they have the right to seek treatment with another provider that does accept a FFS eligible recipient or a MCO member. It is the provider's responsibility to have the eligible recipient, member or their authorized representative receive and sign a statement that they are aware the proposed service may be covered by MAD if rendered by an approved MAD or MCO provider and that by authorizing a non-approved provider to render the service, they agree to be held financially responsible for any payment to that provider. A provider may only bill or accept payment for services from an eligible recipient, member or their authorized representative if all the following requirements are satisfied:

(a) The eligible recipient, member or their authorized representative is advised by the provider before services are furnished that they do not accept patients whose medical services are paid for by MAD.

(b) The eligible recipient, member or their authorized representative is advised by the provider regarding the necessity, options, and the estimated charges for the service, and of the option of going to a provider who accepts MAD payment.

(2) The eligible recipient or member is financially responsible for payment if a provider's claims are denied because of the eligible recipient, member or their authorized representative's failure to notify the provider of established eligibility or retroactive eligibility in a timely manner sufficient to allow the provider to meet the filing limit for the claim.

(3) When a provider is informed of MAP eligibility or pending eligibility prior to rendering a benefit, the provider cannot bill the eligible recipient, member or their authorized representative for the benefit even if the claim is denied by MAD or its selected claims processing contractor unless the denial is due to the recipient not being eligible for the MAP category of eligibility or the benefit, or item is not a MAD benefit. In order to bill the eligible recipient or member for an item or benefit that is not a MAD benefit, prior to rendering the benefit or providing the item the provider must inform the eligible recipient, member or their authorized representative the benefit is not covered by MAD and obtain a signed statement from the eligible recipient, member or their authorized representative acknowledging such notice. It is the provider's responsibility to understand or confirm the eligible recipient or member's MAD benefits and to inform the eligible recipient, member or their authorized representative when the benefit is not a MAD benefit and to inform the eligible recipient, member or their authorized representative.

(4) The provider must accept MAD payment as payment in full and cannot bill a remaining balance to the eligible recipient, member or their authorized representative other than a MAD allowed co-payment, coinsurance or deductible.

(5) If the provider claim is denied, the provider cannot use a statement signed by the eligible recipient, member or their authorized representative to accept responsibility for payment unless such billing is allowed by MAD rules. It is the responsibility of the provider to meet the MAD program requirements for timely filing and other administrative requirements, to provide information to MAD or its selected claims processing contractor regarding payment issues on a claim, and to accept the decision of MAD or its selected claims processing contractor for a claim. The eligible recipient, member or their authorized representative does not become financially responsible when the provider has failed to meet the timely filing and other administrative requirements in filing a claim. The eligible recipient, member or their authorized representative does not become financially responsible for payment for services or items solely because MAD or its selected claims processing contractor denies payment for a claim.

(6) When a provider has been informed of MAP eligibility or pending eligibility of a recipient, the provider cannot turn an account over to collections or to any other entity intending to collect from the eligible recipient, member or their authorized representative. If a provider has turned an account over for collection, it is the provider's responsibility to retrieve that account from the collection agency and to accept the decision on payment of the claim by MAD or its selected claims processing contractor and to notify the eligible recipient or member.

D. The filing limit does not apply to overpayments or money being returned to MAD or its selected claims processing contractor.

(1) If a provider receives payment from another source, such as any insurance plan, or other responsible third party, after receiving payment from MAD, an amount equal to the lower of either the insurance payment or the amount paid through MAD must be remitted to MAD or its selected claims processing contractor third party liability unit, properly identifying the claim to which the refund applies.

(2) For claims for which an over-payment was made to the provider, the provider must return the overpayment to MAD or its selected claims processing contractor. For more details see 8.351.2 NMAC. The timely filing provisions for payments and adjustments to claims do not apply when the provider is attempting to return an overpayment.

E. MAD or its selected claims processing contractor may waive the filing limit requirement in the following situations:

(1) An error or delay on the part of MAD or its selected claims processing contractor prevented the claim from being filed correctly within the filing limit period. In considering waiver of a filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to initially file the claim in a timely manner and the follow up efforts made to secure payment in a timely manner from the other payer.

(2) The claim was filed within the filing limit period but the claim is being reprocessed or adjusted for issues not related to the filing limit.

(3) The claim could not be filed timely by the provider because another payer or responsible party could not or did not process the claim timely or provide other information necessary to file the claim timely. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to initially file the claim and to follow up on the payment from another payer or responsible party in order to attempt to meet the MAD filing limit.

(4) An eligible recipient or member for whom MAP or medicare eligibility was established by hearing, appeal, or court order. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to file the claim timely after the hearing or court decision.

(5) The claim is being reprocessed by MAD or its selected claims processing contractor for issues not related to the provider's submission of the claim. These circumstances may include when MAD is implementing retroactive price changes, or reprocessing the claim for accounting purposes.

(6) The claim was originally paid but recouped by another primary payer. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to file the claim timely after the recoupment.

(7) The claim is from a federal IHS facility operating within HHS which is responsible for native American health care or is a PL 93-638 tribally operated hospital and clinic which must be finalized within two years of the date of service.

(8) The claim is from a MAD school-based service program when providing services to an a eligible recipient or member through an individualized education plan or an individualized family service plan to which an initial filing limit of 90 calendar days is applied.

F. MAD is jointly funded through state and federal sources. Claims will not be processed when the federal standards are not met, thereby precluding federal financial participation in payment of the claim.

G. A provider may not bill an eligible recipient, member or their authorized representative for a service or item when a claim is denied due to provider error in filing the claim or failing to meet the timely filing requirements. It is the provider's responsibility to understand or verify the specific MAP category of eligibility in which an eligible recipient or member is enrolled, the covered or non-covered status of a service or item, the need for prior authorization for a service or item, and to bill the claim correctly and supply required documentation. The eligible recipient, member or their authorized representative cannot be billed by the provider when a claim is denied because these administrative requirements have not been met.

(1) The provider cannot bill the eligible recipient, member or their authorized representative for a service or item in the event of a denial of the claim unless the denial is due to the recipient not being eligible for the MAD service; or if the service is not a MAD benefit, prior to rendering the service the provider informed the eligible recipient, member or their authorized representative that the specific service is not covered by MAD and obtained a signed statement from the eligible recipient, member or their authorized representative acknowledging such.

(2) The provider cannot bill the eligible recipient, member or their authorized representative for the service in the event that a payment is recouped by another primary payer and MAD or its selected claims processing contractor determines that the claim will not be reimbursed by MAD or its selected claims processing contractor.

(3) The provider cannot turn an account over to collections or to any other factor intending to collect from the eligible recipient, member or their authorized representative. If a provider has turned an account over to a collection agency, it is the provider's responsibility to retrieve that account back from the collection agency and to accept the decision on payment of the claim by MAD or its selected claims processing contractor.

(4) The provider cannot bill the eligible recipient, or member or their authorized representative for office tasks such as billing claims, checking eligibility, making referrals calls, in the form of either routine charges or as penalties including missed appointments, failure to cancel an appointment, failure to show eligibility card or similar charges unless specifically allowed by MAD rules.

H. When documentation is required to show the provider met applicable filing limits, the date a claim is received by MAD or its selected claims processing contractor will be documented by the date on the claim transaction control number (TCN) as assigned by MAD or its selected claims processing contractor. Documentation of timely filing when another third party payer, including medicare, is involved will be accepted as documented on explanation of benefits payment dates and reason codes from the third party. Documentation may be required to be submitted with the claim.

[8.302.2.11 NMAC - Rp, 8.302.2.11 NMAC, 10/1/2017]

8.302.2.12 BILLING FOR DUAL-ELIGIBLE MEDICAID RECIPIENTS: To receive payment for services furnished to an eligible recipient or member who is also entitled to medicare, a provider must first bill the appropriate medicare payer. The medicare payer pays the medicare covered portion of the bill. After medicare payment, MAD pays the amount the medicare payer determines is owed for co-payments, co-insurance and deductibles, subject to MAD reimbursement limitations. If a medically necessary service is excluded from medicare and it is a MAD covered benefit, MAD will pay for service. When the medicare payment amount exceeds the amount that MAD would have allowed for the service, no further payment is made for the coinsurance, deductible, or co-payment. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare coinsurance, deductible, or co-payment from the eligible recipient or their authorized representative. For behavioral health professional services for which medicare part B applies to a "psych reduction" to the provider payment and increases the eligible recipient or member coinsurance rate, medicare coinsurance and deductible amounts are paid at an amount that allows the provider to receive eighty percent of the medicare allowed amount even if such amount exceeds the MAD allowed amount for the service. A provider must accept assignment on medicare claims for MAD eligible recipients and members. A provider who chooses not to participate in medicare or accept assignment on a medicare claim must inform the MAD eligible recipient, member or their authorized representative that the provider is not a medicare provider or will not accept assignment; and because of those provider choices, MAD cannot pay for the service. Additionally, the provider must inform the eligible recipient, member or their authorized representative of the estimated amount for which the eligible recipient or member will be responsible, that service is available from other providers who will accept assignment on a medicare claim, and identify an alternative provider to whom the eligible recipient or member may seek services. The provider cannot bill a dually eligible MAP recipient or member for a service that medicare cannot pay because the provider chooses not to participate in medicare, or which MAD cannot pay because the provider chooses not to accept assignment on a claim, without the expressed consent of the eligible recipient, member or their authorized representative even when the medicare eligibility is established retro-actively and covers the date of service.

A. Claim crossover: If there is sufficient information for medicare to identify an individual as an eligible recipient or member, medicare may send payment information directly to the MAD claims processing contractor in a form known as a "cross-over claim". In all cases where claims fail to crossover automatically to MAD, a provider must bill the appropriate MAD claims processing contractor directly, supplying the medicare payment and medicare "explanation of benefits" (EOB) information and meet the MAD filing limit.

B. Medicare replacement plan or other health maintenance organization (HMO) plan: When an eligible recipient or member belongs to a medicare replacement plan or HMO, MAD pays the amount the payer determines is owed for co-payment, coinsurance or deductible, subject to MAD reimbursement limitations. When the payer payment amount exceeds the amount that MAD would have allowed for the service, no further payment is made for the co-payment, coinsurance or deductible. The claim is considered paid in full. The provider may not collect any remaining portion of the payer co-payment, coinsurance or deductible from the eligible recipient, member or their authorized representative. For behavioral health services for which medicare part B applies to a "psych reduction" to the provider payment and increases the eligible recipient or member coinsurance rate, medicare coinsurance and deductible amounts are paid at the amount that allows the provider to receive up to eighty percent of the payer amount allowed even if the amount exceeds the MAD allowed amount for the services.

C. All other HMO and medicare replacement plan requirements, including provider network restrictions must be met for MAD to make payment on a claim.

[8.302.2.12 NMAC - Rp, 8.302.2.12 NMAC, 10/1/2017]

8.302.2.13 BILLING FOR CONTRACTED SERVICES: MAD only makes payment to a provider who actually rendered the services. However, in the following instances a MAD provider can bill and be paid for covered contracted services.

A. A provider is reimbursed at encounter rates or other all-inclusive rates that may have some contracted services built into those rates. These providers include NF, ICF-IDD, residential treatment centers, a group home, a hospice agency, a federally qualified health center, a rural health clinic, and an IHS or tribal 638 facility.

B. A practitioner group, a clinic, an institutional professional component, and providers of professional services may bill for services furnished by practitioners under contract when the provider applications are approved by MAD, and the following apply:

(1) the MAD provider participation applications are completed by the billing entity and the practitioner rendering the service or in their employ; and

(2) the practitioner is listed as the rendering provider on the claim form.

C. Transportation providers may bill for contracted personnel, equipment or vehicles.

D. A provider may bill MAD directly for contracted services for the construction or assembly of equipment or prosthetic devices, construction of dental devices and prosthetics, hearing and vision prosthesis, orthotics, and repairs, when:

(1) the provider customarily uses the dental laboratory, optical supplier, hearing aid supplier, prosthetic or orthotic supplier equipment dealer, or manufacturer to do work; and

(2) the contractor doing the work does not qualify as an eligible provider in their own right.

E. For all other contracted services not specified above, written prior approval must be obtained from MAD or its designee before the provision of services.

F. **Billing rates for contracted services:** All services provided by a contractor and billed through a participating MAD provider must be billed at a rate based on direct and indirect costs, plus a reasonable administrative charge. The billing provider must ensure all MAD requirements are met by the contractor furnishing the service, including prior approval requirements, if applicable. Reimbursement for contracted services is included in the fee paid to the provider. For example, the amount paid to a dentist for a crown includes the dentist's work fitting the crown and the dental lab fees for making the crown.

G. **Recipient freedom of choice:** A provider cannot enter into contracts that are used to restrict an eligible recipient or member's freedom of choice. Some restrictions to this freedom of choice may apply to the purchases of medical devices and laboratory and radiology tests, and transportation 42 CFR Section 431.54(e), or for providers whose enrollment is under a moratorium as identified or approved by the secretary of the federal HHS or by CMS.

[8.302.2.13 NMAC - Rp, 8.302.2.13 NMAC, 10/1/2017]

8.302.2.14 BILLING AND PAYMENT LIMITATIONS:

A. **Payment not allowed:** MAD does not pay factors either directly or by power of attorney 42 CFR Section 447.10(h). A factor is an individual or an organization, such as a collection agency or service bureau.

B. **No reimbursement for the discharge day:** An institutional or other residential provider, such as a NF, a hospital, an ICF-IID, and a provider of treatment foster care services are reimbursed for services furnished to an eligible recipient or member on the day of admission but are not reimbursed for services furnished on day of discharge.

C. **No payment made for wrong services:** A provider shall not bill MAD for:

(1) services provided to the wrong patient;

(2) a service performed on the wrong body part of an eligible recipient or member; and

(3) an incorrect procedure performed on an eligible recipient or member.

D. **Payments for acquired conditions:** MAD may deny or limit payment on claims for services to treat an eligible recipient or member for a condition acquired during the course of a facility stay or in the rendering of other services.

[8.302.2.14 NMAC - Rp, 8.302.2.14 NMAC, 10/1/2017]

8.302.2.15 INTEREST RATES ON COST SETTLEMENTS: MAD charges interest on overpayments and pays interest on underpayments as a result of year-end cost settlements, unless waived.

A. **Interest periods:** Interest accrues from the date of the final determination of costs or from a date required by a subsequent administrative reversal. Interest is charged on the overpayment balance or paid on the underpayment balance for each 30 calendar day period that payment is delayed.

(1) For purposes of this provision, a final determination is considered to occur when:

(a) MAD, the MAD selected claims processing contractor, or the MAD audit contractor makes a written demand for payment or a written determination of underpayment; or

(b) a cost report which was filed in a timely manner indicates that an amount is due MAD and the amount due is not included with the report.

(2) The date of final determination for an additional overpayment or underpayment, as determined by the MAD audit contractor, is considered to occur if any of the previously mentioned events occur.

(3) The date of final determination for an unfiled cost report occurs the day after the date the cost report was due. A single extension of time not to exceed 30 calendar days is granted for good cause. A written request for the time extension must be received and approved by MAD before the cost report due date. When the cost report is filed, a second final determination date is calculated based on the occurrence of either of the aforementioned events.

B. Interest rates: The interest rate on overpayments and underpayments is based on the prevailing rate specified in bulletins issued under article 8020.20 of the treasury fiscal requirement manual. When a provider signs a repayment agreement with MAD for an overpayment, the following provisions apply:

(1) the rate of interest specified in the agreement is binding unless a default in the agreement occurs; or

(2) the rate of interest on the balance may change to the prevailing rate if the provider or supplier defaults on an installment and the prevailing rate in effect on the date the installment becomes overdue is higher than the rate specified in the agreement.

C. Accrual of interest: Even though a filed cost report does not show an overpayment, interest begins to accrue on the date of final determination, if MAD, the MAD audit contractor, or the MAD selected claims processing contractor determines that providers have been overpaid.

(1) Interest continues to accrue during administrative or judicial appeals and until final disposition of claims.

(2) If a cost report is filed which indicates that an amount is due MAD, interest on the amount due accrues from the date the cost report is filed unless:

(a) the full payment on the amount due accompanies the cost report; or

(b) the provider and the MAD audit contractor agree in advance to liquidate the overpayment through a reduction in interim payments over the next 30 calendar day period.

(3) If the MAD audit contractor determines that a further overpayment exists, interest accrues from the date of final determination.

(4) If the cost report is not filed, interest accrues from the day following the date the report was due, plus a single extension of time not to exceed 30 calendar days if granted for good cause, until the time the cost report is filed. Written requests for time extensions must be received for approval by MAD before cost reports due dates.

(5) Interest accrues on an underpayment owed by MAD to a provider beginning 30 calendar days from the date of MAD's notification of the underpayment by the MAD audit contractor.

D. Interest charge waivers: MAD may waive the interest charges when:

(1) the overpayment is liquidated within 30 calendar days from the date of the final determination; or

(2) MAD determines that the administrative cost of collection exceeds the interest charges; interest is not waived for the period of time during which cost reports are due but remain unfiled for more than 30 calendar days.

E. Interest charges with installment or partial payments: If an overpayment is repaid in installments or recouped by withholding from several payments due to a billing provider, the amounts are applied in the following manner:

(1) each payment or recoupment is applied first to accrued interest and then to the principle; and

(2) after each payment or recoupment, interest accrues on the remaining unpaid balance; if an overpayment or an underpayment determination is reversed following an administrative hearing, appropriate adjustments are made on the overpayment or underpayment and the amount of interest charged.

F. Allowable interest cost: Allowable interest cost is the necessary and proper interest on both current and capital indebtedness. An interest cost is not allowable if it is one of the following:

(1) an interest assessment on a determined overpayment; or

(2) interest on funds borrowed to repay an overpayment; following an administrative review and favorable provider decision, interest paid on funds borrowed to repay an overpayment or the interest assessed on an overpayment becomes an allowable cost.

[8.302.2.15 NMAC - Rp, 8.302.2.15 NMAC, 10/1/2017]

HISTORY OF 8.302.2 NMAC:

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

SP-004.1902, Methods and Standards of Establishing Payment Rates - Other Types of Care, filed 3/5/1981.

SP-004.2000, Section 4, General Program Administration Direct Payments to Certain Recipients for Physician's or Dentist's Services, filed 3/5/1981.

SP-004.2100, Section 4, General Program Administration Prohibition Against Reassignment of Provider Claims, filed 3/5/1981.

SP-006.0100, Section 6, Financial Administration Fiscal Policies and Accountability, filed 3/5/1981.
SP-006.0200, Section 6, Financial Administration Cost Allocation, filed 3/5/1981.
SP-006.0300, Section 6, Financial Administration State Financial Participation, filed 3/5/1981.
SP-004.1905, Definition of Timely Payment Requirement for the State of New Mexico, filed 6/10/1981.
ISD 304.1000, Provider Reimbursement Responsibility, filed 1/7/1980.
ISD 304.1000, Provider Reimbursement Responsibility, filed 9/9/1981.
ISD 304.2000, Recipient Reimbursement Responsibility, filed 1/9/1980.
ISD 304.3000, Reimbursement Limitations, filed 1/7/1980.
ISD 304.3000, Reimbursement Limitations, filed 9/9/1981.
ISD 304.3000, Reimbursement Limitations, filed 12/17/1985.
ISD 304.4000, Billing Limitations, filed 1/7/1980.
ISD 304.4000, Billing Limitations, filed 9/9/1981.
ISD 304.7000, Reimbursement To Out-of-State Providers, filed 1/7/1980.
ISD 304.7000, Reimbursement To Out-of-State Providers, filed 9/9/1981.
ISD 304.8000, Third Party Liability, filed 1/7/1980.
ISD 304.8000, Third Party Liability, filed 9/9/1981.
ISD 304.9000, Usual and Customary, filed 1/7/1980.
ISD 304.9000, Reasonable Charge Pricing, filed 9/9/1981.
ISD Rule 304.9000, Reasonable Charge Pricing, filed 2/17/1984.
ISD Rule 304.9000, Reasonable Charge Price, filed 3/30/1984.
MAD Rule 304.9, Reimbursement, filed 12/15/1987.
MAD Rule 304.9, Reimbursement, filed 8/11/1988.
MAD Rule 304, Billing and Reimbursement, filed 11/8/1989.
MAD Rule 304, Billing and Reimbursement, filed 4/21/1992.

History of Repealed Material:
MAD Rule 304, Billing And Reimbursement, filed 4/21/1992 - Repealed effective 2/1/1995.
8.302.2 NMAC, Billing for Medicaid Services, filed 4/16/2004 - Repealed effective 1/1/2014.
8.302.2 NMAC, Billing for Medicaid Services filed 12/17/2013 - Repealed effective 10/1/2017.

NMAC History: 8.302.2 NMAC, Billing for Medicaid Services filed 12/17/2013 was replaced by 8.302.2 NMAC, Billing for Medicaid Services effective 10/1/2017.

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 Health Care Authority.
[8.302.3.1 NMAC - Rp, 8.302.3.1 NMAC, 5/1/2018; A, 7/1/2024]

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. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.302.3.3 NMAC - Rp, 8.302.3.3 NMAC, 5/1/2018; A, 7/1/2024]

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, HCA 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 HCA. These provisions apply to the medical assistance program payments and to payments made on behalf of members by HCA 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, HCA 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 HCA 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 services division (CSSD) provides information to MAD or its contractors on cases identified by CSSD 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 CSSD.

(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 their policy has 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 HCA: 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 HCA for benefits paid on behalf of eligible recipients in the following situations:

(1) HCA has paid or is paying benefits;

(2) HCA 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 HCA. HCA 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 HCA.

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.

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

8.308.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.2.1 NMAC - Rp, 8.308.2.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.2.2 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. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.2.3 NMAC - Rp, 8.308.2.3 NMAC, 5/1/2018; A, 7/1/2024]

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 HCA 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 HCA'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 their location, licensure, certification, or status to the MAD provider web portal to update their 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 their 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 HCA, 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 HCA 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: HCA 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. HCA 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: HCA 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. HCA 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 their place of residence.

(2) Subsequent change in PCP initiated by a member: the MCO shall allow its member to change their 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 their 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 their 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 HCA 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 HCA.

(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 HCA 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 HCA 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 their 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 their 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 their 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 HCA 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 HCA. 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 they are 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 HCA 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 HCA 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 HCA, 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 HCA 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 HCA 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 HCA.

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 HCA 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 HCA'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.

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 6 MANAGED CARE ORGANIZATION (MCO) ENROLLMENT

8.308.6.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.6.1 NMAC - Rp, 8.308.6.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.6.2 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. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.6.3 NMAC - Rp, 8.308.6.3 NMAC, 5/1/2018; A, 7/1/2024]

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 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.308.6.8 NMAC - Rp, 8.308.6.8 NMAC, 5/1/2018; A, 8/10/2021]

8.308.6.9 MANAGED CARE ELIGIBILITY:

A. General requirements: HCA determines eligibility for medicaid. An eligible recipient is required to participate in a HCA 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 HCA, 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 (SLIMB) only;
(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;
(8) family planning-only eligible recipients and;
(9) residents in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

C. Native Americans may opt into managed care. If a Native American is dually eligible or in need of long-term care services, they are 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 HCA, HCA 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; A, 1/1/2019; A, 8/10/2021]

8.308.6.10 SPECIAL SITUATIONS:

A. HCA newborn enrollment 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. HCA shall ensure that upon receipt of the MAD form 313 and upon completion of the eligibility process, the newborn is enrolled into their mother's MCO. The newborn is eligible for a period of 13 months, starting with the month of their 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 HCA-contracted MCO, HCA will enroll the newborn into the mother's MCO as of the month of their 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 HCA-contracted MCO, HCA shall auto-assign and enroll the newborn in a medicaid MCO as of the month of their birth.

(4) The newborn member's parent or legal guardian will have three months from the first day of the month of birth to change the newborn's MCO assignment. After the three-month period, the newborn's MCO enrollment may only be changed for cause, as set forth in Paragraph (2) of Subsection H of 8.308.7.9 NMAC.

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 approach as outlined in 8.308.12 NMAC.

(2) Members who meet NFLOC and are eligible to receive community benefits must be enrolled in a centennial care MCO.

C. ICF/IID discharge: When an ICF/IID resident is discharged, enrollment into managed care will begin within two months following discharge.
[8.308.6.10 NMAC - Rp, 8.308.6.10 NMAC, 5/1/2018; A, 1/1/2019; A, 8/10/2021]

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.

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

8.308.7.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.7.1 NMAC - Rp, 8.308.7.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.7.2 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. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.7.3 NMAC - Rp, 8.308.7.3 NMAC, 5/1/2018; A, 7/1/2024]

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 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.308.7.8 NMAC - Rp, 8.308.7.8 NMAC, 5/1/2018; A, 8/10/2021]

8.308.7.9 MANAGED CARE ENROLLMENT:

A. General: A medical assistance division (MAD) eligible recipient is required to enroll in a HCA managed care organization (MCO) unless they are:

(1) a Native American who opts into managed care. If a Native American is dually eligible or in need of long-term care services, they are required to enroll in a MCO; 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 HCA. 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. HCA reserves the right to limit enrollment in a specific MCO.

B. Newly eligible recipients: An individual who applies for a MAP category of eligibility (COE) and has an approved COE effective date of January 1, 2019, or later, and who is required to enroll in a MCO, must select a MCO at the time of their application for a MAP COE. An eligible recipient who fails to select a MCO at such time will be auto assigned to a MCO. See Subsection C of this Section. Members may choose a different MCO one time during the first three months of their enrollment.

C. Auto assignment: HCA 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 their 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). HCA 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.

(1) The HCA auto-assignment process will consider the following:

(a) if the eligible recipient was previously enrolled with a MCO and lost their eligibility for a period of six months or less, they will be re-enrolled with that MCO, provided they are eligible for reenrollment in that MCO at the time of auto assignment;

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

(c) if the eligible recipient has family members who are enrolled with different MCOs, they will be enrolled with the MCO that the majority of other family members are enrolled with;

(d) if the eligible recipient is a newborn, they will be assigned to the mother's MCO for the month of birth, at a minimum; see Subsection A of 8.308.6.10 NMAC; or

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

E. Retroactive MCO enrollment is limited to up to six months prior to the current month for the following reasons:

(1) retroactive medicare enrollment; or

(2) retroactive changes in eligibility; or

(3) retroactive nursing facility coverage; or

(4) changes in race code from Native American to non-Native American.

F. 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 of their initial MCO enrollment, either by the member's choice or by auto-assignment, they 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 their first three months of enrollment, 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 HCA assigned MCO, and they choose a different MCO, they are 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 two months prior to the expiration date of the member's lock-in period, the deadline by when to choose a new MCO.

(4) If an inmate, as defined at 8.200.410.17 NMAC, becomes a newly eligible recipient during incarceration and remains eligible at the time of their release, they will be enrolled with the MCO of their choice or auto-assigned to a MCO, unless they are Native American. Their initial 12-month lock-in period will begin on the first of the month of their release from incarceration.

(5) If a member misses what would have been their annual switch enrollment period due to incarceration, hospitalization or incapacitation, the member will have two months to choose a new MCO.

G. Eligible recipient MCO open enrollment period: The open enrollment period is the last two months of an eligible recipient's 12-month lock-in period, and is the time period during which a member can change their MCO without having to provide a specific reason to HCA. The open enrollment period may be initiated at HCA's discretion in order to support program needs.

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

I. Change of enrollment initiated by a member during a MCO lock-in period:

(1) A member may select another MCO during their 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 may submit the request to HCA's consolidated customer service center or the medical assistance division. 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 their 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.

(d) continuity of care (for example, a member's physician or specialist is no longer in the MCO's provider network or a member lives in a rural area and the closest physician that accepts their current MCO is too far away);

(e) family continuity (for example, a switch that is requested so that all family members are enrolled with the same MCO);

(f) administrative error (for example, a member chooses an MCO at initial enrollment or requests to change MCOs during an allowable switch period but the request was not honored).

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

(4) Native American opt-in and opt-out:

(a) Native American members in fee-for-service (FFS) may opt-in to managed care at any time during the year. MCO enrollment begins on the first calendar day of the month following HCA's receipt of the member's MCO opt-in request.

(b) Native American members may opt-out of managed care at any time during the year. MCO enrollment ends on the last calendar day of the enrollment month in which HCA receives the opt-out request.

(c) Native Americans who opt-in to managed care are not retroactively enrolled into managed care for prior months.

(d) A Native American who is approved for a category of eligibility that is required to be enrolled with a MCO must follow Subsection E, F and H of 8.308.7.9 NMAC regarding MCO enrollment.

[8.308.7.9 NMAC - Rp, 8.308.7.9 NMAC, 5/1/2018; A, 1/1/2019; A, 8/10/2021]

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 their utilization of medical or behavioral health services, their diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs.

B. Other HCA member disenrollment: A member may be disenrolled from a MCO or may lose their MAD eligibility if:

(1) they move out of the state of New Mexico;

(2) they no longer qualify for a MAP category of eligibility or has a change to a MAP category of eligibility that is not eligible for managed care enrollment;

(3) they request 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 HCA;

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

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

C. Effective date of disenrollment: All HCA-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 HCA. In all instances, the effective date shall be indicated on the termination record sent by HCA to the MCO.

[8.308.7.10 NMAC - Rp, 8.308.7.10 NMAC, 5/1/2018; A, 1/1/2019]

8.308.7.11 MASS TRANSFER PROCESS: The mass transfer process is initiated when HCA 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 them 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 HCA'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 their 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: HCA 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 - Repealed, 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.

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

8.308.8.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.8.1 NMAC - Rp, 8.308.8.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.8.2 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. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.8.3 NMAC - Rp, 8.308.8.3 NMAC, 5/1/2018; A, 7/1/2024]

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 HCA contracted managed care organization (MCO) or HCA. 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 their rights and responsibilities.

A. These include the right:

(1) to be treated with respect and with due consideration for their dignity and privacy;

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

(3) to make and have honored their 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 their 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 their 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 their 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 their authorized representative or authorized provider believes is erroneous;

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

(13) to choose from among contracted providers in accordance with their 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 their 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 their 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 email 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 their 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 their 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 email 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 their 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 HCA.
[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.

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

8.308.9.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.9.1 NMAC - Rp, 8.308.9.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.9.2 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. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.9.3 NMAC - Rp, 8.308.9.3 NMAC, 5/1/2018; A, 7/1/2024]

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 HCA 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 they have a qualifying condition is evaluated by the MCO's utilization management for determination if they meet the qualifying condition. An ABP exempt member utilizes their benefits described in 8.308.9 NMAC and in 8.308.12 NMAC.

C. Early childhood home visiting program: A program that uses home visiting as a primary service delivery strategy and offers services on a voluntary basis to eligible pregnant individuals and their children from birth up to kindergarten entry, according to the program standard.

D. Evidence-based, early childhood home visiting program: A home visiting program that is recognized by the U.S. department of health & human services maternal, infant, and early childhood home visiting (MIECHV) project and:

(1) is grounded in relevant, empirically-based best practice and knowledge that:

(a) is linked to and measures the following outcomes:

(i) babies that are born healthy;

(ii) children that are nurtured by their parents and caregivers;

(iii) children that are physically and mentally healthy;

(iv) children that are ready for school;

(v) children and families that are safe; and

(vi) families that are connected to formal and informal supports in their communities;

(b) has comprehensive home visiting standards that ensure high-quality service delivery and continuous quality improvement; and

(c) has demonstrated significant, sustained positive outcomes;

(2) follows program standards that specify the purpose, outcomes, duration and frequency of services that constitute the program;

(3) follows the curriculum of an evidence-based home visiting model;

(4) employs well-trained and competent staff and provides continual professional supervision and development relevant to the specific program and model being delivered;

(5) demonstrates strong links to other community-based services;

(6) operates within an organization that ensures compliance with home visiting standards;

(7) continually evaluates performance to ensure fidelity to the program standards;

(8) collects data on program activities and program outcomes; and

(9) is culturally and linguistically appropriate.

[8.308.9.7 NMAC - Rp, 8.308.9.7 NMAC, 5/1/2018; A, 1/1/2019; A, 4/5/2022]

8.308.9.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.308.9.8 NMAC - Rp, 8.308.9.8 NMAC, 5/1/2018; A, 4/5/2022]

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 HCA. 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, HCA 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 HCA 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 HCA;

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

(1) providing a member or their 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 HCA; 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 their authorized representative shall have the right to seek a second opinion from a qualified health care professional within their 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 their 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; A, 4/5/2022]

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 their 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 their 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 HCA 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 individuals 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; A, 4/5/2022]

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 HCA 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 HCA.

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 their 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 their 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 their 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; A, 4/5/2022]

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 HCA which define how a member is educated about their 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 them 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; A, 4/5/2022]

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 HCA 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;

(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; and

(8) referral to a home visiting pilot program for eligible pregnant individuals and children residing in the HCA-designated counties for services as outlined at 8.308.9.23 NMAC.

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 (greater than 10 mm of induration) must be referred to the local DOH public health office in their 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 (greater than twenty percent over desired body weight or BMI greater than 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 (greater than 140/90 mmHg); HDL cholesterol level greater than 35 mg/dl and triglyceride level greater than 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 their 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; A, 1/1/2019; A, 4/5/2022]

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 HCA 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 HCA, 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 HCA 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 eligible recipients who have a well-documented medical diagnosis of autism spectrum disorder (ASD), and for eligible recipients who have well-documented risk for the development of ASD. As part of a three-

stage comprehensive approach consisting of evaluation, assessment, and treatment, ABA services may be provided in coordination with other medically necessary services (e.g., family infant toddler program (FIT) services, occupational therapy, speech language therapy, medication management, developmentally disabled waiver services, etc.). ABA services are part of the early periodic screening, diagnosis and treatment (EPSDT) program (CFR 42 section 441.57). There is no age requirement to receive ABA services and ABA is a covered benefit for medicaid-enrolled adults.

(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 their 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 their family and the interactive effect through a variety of informational and supportive activities that assists the member and their family develop patterns of interaction that promote wellness and recovery over time. The positive interactive effect between the member and their 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 themselves 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 their 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; A, 4/5/2022]

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 HCA 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 they have a qualifying condition is evaluated by their MCO for determination if they meet an ABP qualifying condition. An ABP exempt member may select to no longer utilize their ABP benefits package. Instead, the ABP exempt member will utilize their 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 HCA 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; A, 4/5/2022]

8.308.9.23 CENTENNIAL HOME VISITING (CHV) PILOT PROGRAM SERVICES: Beginning January 1, 2019, the benefit is available to approximately 300 eligible pregnant medicaid managed care enrolled members and their children who reside in Bernalillo County (other HCA-designated counties may be included at a later time and with a distinct enrollment limit) in accordance with the program standard. The MCO shall contract with agencies operating in the HCA-designated counties that provide services that are in alignment with one of the two following evidence-based early childhood home visiting delivery models:

A. Nurse Family Partnership (NFP): The services to be delivered under the NFP national program standards are for first-time parents only. In Bernalillo County, the program is anticipated to serve up to 132 families by the end of the first year of implementation using one NFP team and to approximately 240 eligible members (annual average at full implementation) thereafter using two NFP teams. The number of families served will be determined based on the number of active NFP teams in any program year. HCA may expand this program to other counties at HCA's discretion dependent upon provider capacity. The NFP services will be suspended once the child reaches two years of age.

B. Parents as Teachers (PAT): The PAT evidence-based program services will adhere to the national model and curriculum and serve approximately 60 families (annual average at full implementation) in Bernalillo County. Services will begin during pregnancy and may continue until the child reaches five years of age or kindergarten entry. HCA may expand this program to other counties at HCA's discretion dependent upon provider capacity. The number of families served in other counties will be determined based on the number of active PAT teams in the program year. The MCO may propose other evidence-based early childhood home visiting delivery models with similar services in lieu of the PAT model if available in the HCA-designated service areas.

C. Description of Services: The services available under the CHV pilot program are described below:

(1) Prenatal home visits: the benefit package includes the following services for eligible pregnant individuals during their pregnancy:

(a) monitoring for high blood pressure or other complications of pregnancy (only covered under the NFP model);

(b) diet and nutritional education;

(c) stress management;

(d) sexually transmitted disease (STD) prevention education;

(e) tobacco use screening and cessation education;

(f) alcohol and other substance misuse screening and counseling;

(g) depression screening; and

(h) domestic and intimate partner violence screening and education.

(2) Postpartum home visits: the benefit package includes the following services that may be delivered as part of a postpartum home visit, when provided during the 12-month postpartum period to an eligible member:

(a) diet and nutritional education;

(b) stress management;

(c) sexually transmitted disease (STD) prevention education;

(d) tobacco use screening and cessation education;

(e) alcohol use and other substance misuse screening and counseling;

(f) depression screening;

(g) domestic and intimate partner violence screening and education;

(h) breastfeeding support and education. Members may be referred to a lactation specialist, but lactation consultant services are not covered as a home visiting service;

(i) guidance and education regarding wellness visits to obtain recommended preventive services;

(j) medical assessment of the postpartum mother and infant (only covered under the NFP model);

(k) maternal-infant safety assessment and education, such as safe sleep education for sudden infant death syndrome (SIDS) prevention;

(l) counseling regarding postpartum recovery, family planning, and needs of a newborn;

(m) assistance to the family in establishing a primary source of care and a primary care provider, including help ensuring that the mother/infant has a postpartum/newborn visit scheduled; and

(n) parenting skills and confidence building.

(3) Infant and children home visits: the benefit package includes the following services that may be delivered to newborn infants born to CHV Pilot Project members until the child reaches two years of age for NFP and five years of age or kindergarten entry for PAT, as part of an infant home visit:

(a) breastfeeding support and education. Members may be referred to a lactation specialist, but lactation consultant services are not covered as a home visiting service;

(b) child developmental screening at major developmental milestones from birth to age two for NFP according to the model standard practice, and age five or kindergarten entry for PAT; and

(c) parenting skills and confidence building.

[8.308.9.23 NMAC - N, 1/1/2019; A, 4/5/2022]

8.308.9.24 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; A and Rn, 1/1/2019]

8.308.9.25 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 individual, the health of the individual or their 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 NMAC - Rn, 8.308.9.24 NMAC, 1/1/2019; A, 4/5/2022]

8.308.9.26 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 their 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; 8.308.9.26 NMAC - Rn, 8.308.9.25 NMAC, 1/1/2019]

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.

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

8.308.10.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.10.1 NMAC - Rp, 8.308.10.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.10.2 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. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.10.3 NMAC - Rp, 8.308.10.3 NMAC, 5/1/2018; A, 7/1/2024]

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 their 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. Managed care organizations (MCOs) may delegate care coordination functions through a full delegation model or a shared functions model, while retaining oversight of all care coordination activities.

(a) Full delegation model allows the MCO to delegate the full set of care coordination functions to a provider/health system (delegate) through a value-based purchasing (VBP) arrangement.

(b) Shared functions model allows the MCO to delegate some care coordination functions such as conducting health risk assessments, conducting comprehensive needs assessments, conducting periodic touch points, coordinating referrals to community services, and locating and engaging difficult to engage medicaid members.

(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) or MCO delegate will document the refusal in the member's file and report it to HCA. 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 or MCO delegate 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 or MCO delegate 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 or MCO delegate shall conduct a HCA approved health risk assessment (HRA) either by telephone, in person or as otherwise approved by HCA. The HRA is conducted for the purpose of:

(1) introducing the MCO or MCO delegate 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 HCA managed care policy manual (section 04 care coordination).

C. Assignment to care coordination levels two and three: The MCO or MCO delegate shall conduct a HCA 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 HCA 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 HCA managed care policy manual (section 04 care coordination).

E. Comprehensive care plan requirements: The MCO or MCO delegate shall develop a comprehensive care plan (CCP) for members in care coordination levels two and three. Requirements for CCP development are defined in the HCA managed care policy manual (section 04 care coordination).

F. On-going reporting: The MCO or MCO delegate 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, other behavioral health services, or release from incarceration; and

(5) all LOC transitions.

[8.308.10.9 NMAC - Rp, 8.308.10.9 NMAC, 5/1/2018; A, 1/1/2019]

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.

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

8.308.11.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.11.1 NMAC - Rp, 8.308.11.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.11.2 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. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.11.3 NMAC - Rp, 8.308.11.3 NMAC, 5/1/2018; A, 7/1/2024]

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 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.308.11.8 NMAC - Rp, 8.308.11.8 NMAC, 5/1/2018; A, 4/5/2022]

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 their 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 their 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 HCA'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 HCA prescribed timeframes, processes and tools to identify their 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 HCA. 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 HCA 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 their 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 HCA.

(8) The receiving MCO shall continue providing services previously authorized by HCA, 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 HCA approval, either through fee-for-service (FFS) or any other HCA contractor, the receiving MCO shall reimburse the HCA 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, HCA 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 their MCO for durable medical equipment (DME) costing $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 $2,000 or more, and prior to the delivery of the DME item, they are enrolled in a MCO, HCA 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, HCA will pay for prescription drug refills for the first 30 calendar days of their 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 HCA 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 HCA 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, HCA 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 individuals:

(1) When a member is in their second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to their 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 12-month postpartum period without any form of prior approval.

(2) When a newly enrolled member is in their first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to their 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 they 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, their 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 12-month postpartum period.

(4) When a member is receiving services from a non-contracted provider, their MCO will be responsible for the costs of continuation of medically necessary covered prenatal services, delivery, through the 12-month postpartum period, without any form of prior approval, until such time when their MCO determines it can reasonably transfer them to a contracted provider without impeding service delivery that might be harmful to their 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 their 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 they are a candidate for transition to the community, their 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) their physical and behavioral health needs;

(b) the selection of providers in their community;

(c) continuation of MAP eligibility;

(d) their housing needs;

(e) their financial needs;

(f) their interpersonal skills; and

(g) their safety.

(3) The MCO shall conduct an additional assessment within 75 calendar days of the member's transition to their 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 they have uninterrupted access to medically necessary services when transitioning between a MCO and their 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 12-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; A, 4/5/2022]

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.

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 13 MEMBER REWARDS

8.308.13.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.13.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.13.2 SCOPE: This rule applies to the general public.
[8.308.13.2 NMAC - N, 1/1/2014]

8.308.13.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.13.3 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.13.4 DURATION: Permanent.
[8.308.13.4 NMAC - N, 1/1/2014]

8.308.13.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.13.5 NMAC - N, 1/1/2014; A, 5/1/2018]

8.308.13.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.308.13.6 NMAC - N, 1/1/2014]

8.308.13.7 DEFINITIONS: [**RESERVED**]

8.308.13.8 [RESERVED]
[8.308.13.8 NMAC - N, 1/1/2014; Repealed, 5/1/2018]

8.308.13.9 ELIGIBLE MEMBERS: A member of a HCA contracted managed care organization (MCO) is eligible to participate in 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 HCA contracted MCO, and retains MAP category of eligibility, they no longer will earn reward credits as of the last day of enrollment in their MCO.

B. Upon losing eligibility for continued enrollment in a HCA contracted MCO, the individual no longer will earn member reward credits.
[8.308.13.9 NMAC - N, 1/1/2014; A, 5/1/2018]

8.308.13.10 REWARD CREDITS: A member may earn reward credits when engaging in healthy behaviors included in the member rewards program. Reward credits are determined for specific member healthy behaviors. Details on the requirements to earn a healthy behavior reward credit are made available to a member on MAD's website and provided in writing to a member through their MCO.

A. Maximum amount of a member's reward credit balance: A member must use credits earned during the calendar year by the end of the following calendar year. Any credits that are not used by the end of the following calendar year in which they are earned are lost.

B. Portability of reward credits: A member may carry their reward credits when transitioning from one HCA contracted MCO to another HCA contracted MCO. When a member earns reward credits for a specific healthy behavior, they may not earn reward credits for the same healthy behavior within the same calendar year with their new MCO.

C. Retention of reward credits: A member's reward credit balance will be accessible for the member's use up to 365 days after they lose MAP eligibility. For a native American who was a member of a HCA

contracted MCO, and later opts in to fee-for-service (FFS) administration of benefits, the previously earned MCO reward credits are accessible up to 365 days after the close of their HCA contracted MCO membership.

D. Reward credit disputes: If a member believes there is a discrepancy in the way their HCA contracted MCO has determined a reward credit or balance, the member shall contact their MCO for resolution.

[8.308.13.10 NMAC - N, 1/1/2014]

HISTORY OF 8.308.13 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 14 CO-PAYMENTS

8.308.14.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.14.1 NMAC - Rp, 8.308.14.1 NMAC, 10/1/2017; A, 7/1/2024]

8.308.14.2 SCOPE: This rule applies to the general public.
[8.308.14.2 NMAC - Rp, 8.308.14.2 NMAC, 10/1/2017]

8.308.14.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.14.3 NMAC - Rp, 8.308.14.3 NMAC, 10/1/2017; A, 7/1/2024]

8.308.14.4 DURATION: Permanent.
[8.308.14.4 NMAC - Rp, 8.308.14.4 NMAC, 10/1/2017]

8.308.14.5 EFFECTIVE DATE: October 1, 2017, unless a later date is cited at the end of a section.
[8.308.14.5 NMAC - Rp, 8.308.14.5 NMAC, 10/1/2017]

8.308.14.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.14.6 NMAC - Rp, 8.308.14.6 NMAC, 10/1/2017]

8.308.14.7 DEFINITIONS: Co-payment: A co-payment is a fixed dollar amount that a medicaid recipient must pay directly to a provider for a service, visit or item. A co-payment is to be paid at the time of service or receipt of the item.
[8.308.14.5 NMAC - Rp, 8.308.14.7 NMAC, 10/1/2017]

8.308.14.8 [RESERVED]
[8.308.14.8 NMAC - Rp, 8.308.14.8 NMAC, 10/1/2017]

8.308.14.9 CO-PAYMENTS IN THE MEDICAID MANAGED CARE PROGRAM: The medical assistance division (MAD) imposes co-payment provisions on certain members, certain categories of eligibility and on certain services. The member's HCA contracted managed care organization (MCO) is required to impose co-payments as directed by MAD at 8.302.2 NMAC and in accordance with federal regulations.

A. General requirements regarding co-payments:

(1) The MCO or its contracted providers may not deny services for a member's failure to pay the co-payment amounts.

(2) The MCO must take measures to educate and train both its contracted providers and members on co-payment requirements.

(3) The MCO shall not impose co-payment provisions on certain services that, in accordance with federal regulations, are always exempt from co-payment provisions. See 42 CFR 447.56, *limitations on premiums and cost sharing* and 8.302.2 NMAC.

(4) The MCO shall not impose co-payment provisions on certain member categories of eligibility that, in accordance with federal and state regulations and rules, are exempt from cost-sharing provisions.

(5) Payments to MCO contracted providers: In accordance with 42 CFR 447.56, *limitations on premiums and cost sharing*, the MCO must reduce the payment it makes to a contracted provider by the amount of the member's applicable co-payment obligation, regardless of whether the provider has collected the payment.

(6) At the direction of MAD, the MCO must report all co-payment amounts collected.

(7) The MCO may not impose more than one type of co-payment for any service, in accordance with 42 CFR 447.52.

(8) The MCO must track, by month, all co-payments collected from each individual member in the household to ensure that the household does not exceed the aggregate limit (cap). The cap is five percent of countable household income for all individual members in a household, calculated as applicable for a quarter. The MCO must be able to provide each household member, at their request, with information regarding co-payments that have been applied to claims for the member.

(9) The MCO must report to the provider when a co-payment has been applied to the provider's claim and when a co-payment was not applied to the provider's claim. The MCO shall be responsible for assuring the provider is aware that:

(a) the provider shall be responsible for refunding to the member any co-payments the provider collects after the member has reached the co-payment cap (five percent of the member's household income, calculated on a quarterly basis) which occurs because the MCO was not able to inform the provider of the exemption from co-payment due to the timing of claims processing;

(b) the provider shall be responsible for refunding to the member any co-payments the provider collects for which the MCO did not deduct the payment from the provider's payment whether the discrepancy occurs because of provider error or MCO error; and

(c) failure to refund a collected co-payment to a member and to accept full payment from the MCO may result in a credible allegation of fraud, see 8.351.2 NMAC.

[8.308.14.9 NMAC - Rp, 8.308.14.9 NMAC, 10/1/2017]

8.308.14.10 MEMBER RIGHTS AND RESPONSIBILITIES:

A. When a MAD benefit has a co-payment assigned for a MAP category of eligibility, the eligible recipient will at the time of service make payment or make arrangements with the provider for payment at a later date.

B. A member shares the responsibility to track their co-payments for each quarter. The member has the right to request from their MCO at any time an account of their household's co-payment total per quarter. If the member believes they have met the household's out-of-pocket (OOP) limit, they may request that the provider wait to charge future co-payments if the member has contacted their MCO to determine if the OOP limit has been met.

C. If a member had reached their household OOP limit but was not aware of it at the time the member paid a co-payment, the provider must refund the member the co-payment.

(1) The provider must refund the member within 10 working days after the member requests a reimbursement of the paid co-payment or the member's MCO notifies the provider that the member's OOP limit has been met.

(2) The member may notify verbally or in writing their MCO of the provider's failure to refund the co-payment within the required timeframe.

(3) Failure of the MCO to intervene to have its contracted provider refund the co-payment within 10 working days of the member notifying the MCO constitutes a MCO adverse action and the member may file a MCO appeal and if applicable, a HCA administrative hearing. See 8.308.15 and 8.352.2 NMAC for detailed information.

(4) The member may also contact the HCA office of inspector general after they have complied with Paragraph (2) and (3) above to report the provider's refusal to refund the member's co-payment as such action may result in a credible allegation of fraud.

[8.308.14.10 NMAC - N, 10/1/2017]

8.308.14.11 CO-PAYMENT AMOUNTS IN MANAGED CARE PROGRAMS: Medicaid co-payment amounts and the application of co-payments are determined by MAD. See 42 CFR 447.56, *limitations on premiums and cost sharing*, and 8.302.2 NMAC.

[8.308.14.11 NMAC - Rp, 8.308.14.11 NMAC, 10/1/2017]

HISTORY OF 8.308.14 NMAC: [**RESERVED**]

History of Repealed Material:

8.308.14 NMAC, Cost Sharing, filed 12/17/2013 - Repealed effective 10/1/2017.

NMAC History:

8.308.14 NMAC, Cost Sharing, filed 12/17/2013 was replaced by 8.308.14 NMAC, Co-Payments effective 10/1/2017.

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

8.308.15.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.15.1 NMAC - Rp, 8.308.15.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.15.2 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. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.15.3 NMAC - Rp, 8.308.15.3 NMAC, 5/1/2018; A, 7/1/2024]

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 HCA 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 HCA managed care organization (MCO) intends or has taken action against a member of their 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, their 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 HCA PASRR administrative hearing governed by 8.354.2 NMAC instead of a MCO member appeal or a HCA 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, their 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 their 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 their 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. **"HCA expedited administrative hearing"** means an expedited informal evidentiary hearing conducted by the HCA 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 their authorized representative may request a HCA expedited administrative hearing only after exhausting their MCO expedited or standard member appeal process and unless the request for a HCA 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 HCA expedited administrative hearing process and Subsection B of 8.308.15.13 NMAC.

G. **"HCA PASRR administrative hearing"** means a HCA 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 HCA PASRR administrative hearing process.

H. **"HCA 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 their authorized representative may request a HCA standard administrative hearing only after exhausting their MCO expedited or standard member appeal process. See 8.352.2 NMAC for a detailed description of the HCA standard administrative hearing process.

I. **"MAD"** means the medical assistance division, which administers medicaid and other medical assistance programs under HCA.

J. **"MAP"** means the medical assistance programs administered under MAD.

K. **"MCO"** means the member's HCA contracted managed care organization.

L. **"MCO expedited member appeal"** means the process open to a member or their 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, their 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 their 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 their 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 their 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 HCA expedited or standard administrative hearing, unless the reason for the request is based on the assertion by the member or their 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 their 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 their 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 HCA 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 HCA 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 their rights and responsibilities to be designated by a member or the member's authorized representative to act as their 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 their 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 HCA 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 their 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, their authorized representative any changes to these procedures and processes. The description shall include:

(a) information on how the member or their authorized representative or authorized provider can request a MCO expedited or standard appeal, or how the member or their 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 their 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 HCA 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 their authorized representative that files a MCO member grievance or any member, their 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 HCA 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 their authorized representative may file a MCO member grievance concerning dissatisfaction with the MCO's operation.

(b) The member or their authorized representative may choose a relative, friend or other spokesperson to advocate or assist them through the MCO member grievance process; however, the spokesperson is limited to a supporting role and cannot act on behalf of the member or their authorized representative. The member or their 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 their authorized representative during the MCO's member grievance process. A member or their authorized representative may elect not to sign such a release, but utilize the spokesperson during the MCO member grievance process.

(2) The member or their authorized representative may have legal counsel assist them during the MCO member grievance process.

(3) Grievance: A member or their authorized representative shall have the right to file a grievance with their MCO to express dissatisfaction about any matter or aspect of their 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 HCA administrative hearing process. If the member or their authorized representative or the authorized provider wishes to appeal an intended or taken adverse action against the member, the member, their 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 their 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 their authorized representative may file a MCO member grievance at any time when they wishe to register their dissatisfaction.

(c) The MCO will provide the member or their 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 their authorized representative or the authorized provider has the right to request a MCO standard member appeal orally and in

writing in accordance with their 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, their 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 their authorized representative or the authorized provider may have legal counsel to assist them during the MCO expedited or standard member appeal process.

(b) Standing to request a MCO expedited or standard member appeal:

(i) The member or their authorized representative may request a MCO expedited or standard member appeal concerning their disputed benefit.

(ii) The member, their authorized representative or authorized provider may choose a relative, friend or other spokesperson to advocate or assist them 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 their authorized representative. The member or their 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 their authorized representative during the MCO expedited or standard member appeal process.

(c) If a member or their authorized representative or authorized provider elects to request a continuation of the disputed current benefit, the member, their 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 their authorized representative or authorized provider does not have the right to request a HCA expedited or standard administrative hearing related to a value-added services offered by the MCO. If the member or their authorized representative or authorized provider chooses to request a MCO expedited or standard member appeal, the following apply.

(i) The member, their 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 their authorized representative may request a HCA expedited or standard administrative hearing concerning their disputed benefit. Once the member or their authorized representative requests a HCA expedited or standard administrative hearing, they are referred to as the claimant. The authorized provider is not eligible to request a HCA 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 HCA 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 their 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 their 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 their 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 their ability to attain, maintain, or regain maximum function. Once a member or their authorized representative or authorized provider requests a MCO expedited member appeal and the member or their 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 their 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, their authorized representative or authorized provider elects to request a continuation of the member's disputed current benefit, the member or their 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 their 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 their authorized representative may request a HCA expedited or standard administrative hearing concerning the member's disputed benefit.

(c) Once the member or their authorized representative request a HCA expedited or standard administrative hearing, they are referred to as the claimant.

(4) The member or their authorized representative or the authorized provider may have legal counsel or a spokesperson assist them during the MCO expedited member appeal process.

(5) The member or their authorized representative or the authorized provider does not have the right to request a MCO expedited or standard member appeal or a HCA 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 HCA 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 HCA 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 their 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 their authorized representative may then request a HCA 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 HCA 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, their 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 their 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, their 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, their 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 their 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 their 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 their 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 their 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 their 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 their 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 their 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 their 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 their 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 their 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, their 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, their 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, their 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 their authorized representative may request a HCA 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 their 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 their authorized representative or authorized provider elects to request a continuation of the member's disputed current benefit, the member or their 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 their authorized representative or the authorized provider requests a MCO standard member appeal, the following apply.

(a) If the member or their 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 their authorized representative may request a HCA expedited or standard administrative hearing concerning the member's disputed benefit.

(c) If a member or their authorized representative elects not to request a HCA 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 their authorized representative requests a HCA expedited or standard administrative hearing, they are referred to as the claimant.

(3) The member or their authorized representative or the authorized provider may have legal counsel or a spokesperson assist them during the MCO standard member appeal process.

(4) The member or their authorized representative or the authorized provider does not have the right to request a MCO expedited or standard member appeal or a HCA 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 HCA 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 HCA 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 their 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 their 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 their 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 their 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 their 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 their 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 their authorized representative or authorized provider requests the extension; or

(ii) the MCO determines it requires additional information and provides to the member or their 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 their authorized representative or the authorized provider its MCO standard member appeal final decision.

(2) If the member or their 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 their 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 their 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 their 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 their 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 their 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 their 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 their 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, their 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 their 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, their 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 their authorized representative elects not to request a HCA 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 their authorized representative may request a HCA 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 their authorized representative has now exhausted the MCO expedited or standard member appeal process. The authorized provider cannot request a HCA expedited or standard administrative hearing on their own; this right is accorded only to the member or their authorized representative, unless the provider has been designated as the member's authorized representative.

F. A member or their authorized representative must request a HCA expedited administrative hearing within 30 calendar days of the date of the MCO member appeal final decision letter or request a HCA standard administrative hearing within 90 days of the date of the MCO member appeal final decision.

(1) A member or their 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 their disputed current benefit during the MCO member appeal process, the member or their authorized representative does not need to request another continuation of the disputed current benefit when requesting a HCA expedited or standard administrative hearing. It is automatically continued by the member's MCO.

(3) If the member or their 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 HCA expedited or standard administrative hearing process, the member or their 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 their 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 their authorized representative elects to continue the member's disputed current benefit during the member's HCA expedited or standard administrative hearing process, the MCO must in writing inform the member or their authorized representative that if the HCA 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 HCA expedited or standard administrative hearing process.

H. If the member or their authorized representative requests a HCA expedited or standard administrative hearing and the member or their 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 HCA 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 their authorized representative wants to continue the disputed current benefit during the HCA 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 HCA 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 HCA 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.

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 20 REIMBURSEMENT

8.308.20.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.20.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.20.2 SCOPE: This rule applies to the general public.
[8.308.20.2 NMAC - N, 1/1/2014]

8.308.20.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.20.3 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.20.4 DURATION: Permanent.
[8.308.20.4 NMAC - N, 1/1/2014]

8.308.20.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.20.5 NMAC - N, 1/1/2014]

8.308.20.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.20.6 NMAC - N, 1/1/2014]

8.308.20.7 DEFINITIONS: [**RESERVED**]

8.308.20.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.308.20.8 NMAC - N, 1/1/2014; A, 4/5/2022]

8.308.20.9 REIMBURSEMENT FOR MANAGED CARE:

A. Payment for services: HCA shall make actuarially sound payments, in accordance with 42 C.F.R. 438.6(c), for the provision of the managed care medicaid benefit package, under capitated risk contracts to the designated managed care organizations (MCOs). Rates whether set by HCA or negotiated between HCA and the MCO are confidential.

(1) At the sole discretion of HCA, rates shall be appropriate for the medicaid populations to be covered and the services to be furnished under the contract. Rates may be adjusted based on factors, including but not limited to, changes in the scope of work; CMS requiring a modification of the 1115(a) waiver; new or amended federal or state statutes, regulations or rules; inflation; significant changes in the demographic characteristics of the member population; or the disproportionate enrollment selection of the MCO by members in certain rate cohorts.

(2) The MCO shall be responsible for the provision of services for members during the month of capitation. A medicaid eligible recipient shall not be liable for debts or costs incurred by an MCO under the MCO's managed care contract for providing health care to them. This includes but is not limited to:

(a) the MCO's debts in the event of its insolvency;

(b) services provided to the member that are not included in the medicaid benefit package and for which HCA does not pay the MCO, e.g., value added services;

(c) instances when the MCO does not pay the health care provider who furnishes the services under contractual, referral, or other arrangement;

(d) payments for covered services furnished under contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the service directly; and

(e) if a MCO member loses eligibility for any reason and is reinstated as eligible by HCA before the end of the month, the MCO shall accept a retroactive capitation payment for that month of eligibility and assume financial responsibility for all medically-necessary covered benefit services supplied to the member.

(3) Retroactive capitation payments may not be issued for a member for the same coverage month in which fee-for-service claims have already been paid by HCA except in special situations determined by HCA.

B. Capitation disbursement requirements: HCA shall pay a capitated amount to the MCO for the provision of the managed care benefit package at specified rates. The monthly rate is based on actuarially sound capitation rate cells. The MCO shall accept the capitation rate paid each month by HCA as payment in full for all services including all administrative costs associated therewith, including gross receipts tax payable to the provider. The MCO is at risk of incurring losses if the cost of providing the managed care medicaid benefit package exceeds its capitation payment. HCA shall not provide retroactive payment adjustments to the MCO to reflect the actual cost of services furnished by the MCO.

C. Capitation recoupments: HCA shall have the discretion to recoup capitations or payments as provided for in its contract with the MCO.

(1) Instances when HCA shall recoup payments for members include, but are not limited to:

(a) member incorrectly enrolled with more than one MCO;

(b) member who dies prior to the enrollment month for which payment was made; or

(c) member who HCA later determines was not eligible for medicaid during the enrollment month, including retroactive months for which payment was made.

(2) HCA acknowledges and agrees that in the event of any recoupment pursuant to this rule, the MCO shall have the right to recoup from a provider or another person to whom the MCO has made payment during this period of time; however, may not recoup payments for any value added services provided. Recouped payments to a provider is subject to the time periods governed by the MCO provider agreement.

(3) Any duplicate payment identified by either the MCO or HCA shall be recouped upon identification.

(4) The MCO has the right to dispute any recoupment action in accordance with contractual provisions.

D. Patient liability: HCA monthly capitation payments will be net of patient liability. The capitation payments are developed on "gross" cost and will be reduced by the amount of average patient member responsibility each month. The MCO shall delegate the collection of patient member liability to the nursing facility or community-based residential alternative facility and shall pay the facility net of the applicable patient member liability amount. The MCO shall submit patient member liability information associated with claim payments in their encounter data submissions.

E. Payment time frames: A clean claim shall be paid by the MCO to contracted and non-contracted providers according to the following timeframe: ninety percent within 30 calendar days of the date of receipt and ninety-nine percent within 90 calendar days of the date of receipt, as required by federal guidelines in the code of federal regulations Section 42 CFR 447.45. The date of receipt is the date the MCO first receives the claim either manually or electronically. The MCO is required to date stamp all claims on the date of receipt. The date of payment is the date of the check or other form of payment. An exception to this requirement may be made if the MCO and its providers by mutual agreement establish an alternative payment schedule. However, any such alternative payment schedule shall first be incorporated into the contract between HCA and the MCO. The MCO shall be financially responsible for paying all claims for all covered, emergency and post-stabilization services that are furnished by non-contracted providers, at no more than the medicaid fee-for-service rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists.

(1) The MCO shall pay a contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating provider and not paid within 30 calendar days of the date of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. Interest shall accrue from the 31st calendar day for electronic claims and from the 46th calendar day for manual claims. The MCO shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HCA/MAD.

(2) No contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

(3) If the MCO is unable to determine liability for or refuses to pay a claim of a participating provider within the times specified above, the MCO shall make a good-faith effort to notify the participating provider by fax, electronically or via other written communication within 30 calendar days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim.

F. Special payment requirements: This section lists special payment requirements by provider type.

(1) Reimbursement to a federally qualified health center (FQHC) and a rural health clinic (RHC): a contracted and non-contracted FQHC or RHC shall be reimbursed at a minimum of the prospective payment system (PPS) as determined by HCA or its designee or an alternative payment methodology in compliance with Section 1905(a)(2)(C) of the 1902 Social Security Act, as established by HCA.

(2) Reimbursement to Indian health service (IHS), tribal health providers, and urban Indian providers authorized to provide services as defined in the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.

(a) The MCO shall reimburse IHS and tribal compact contracted and non-contracted provider as identified by HCA, at a minimum of one hundred percent of the rate established for an IHS facility or federally-leased facility by the office of management and budget (OMB). For services designated by HCA to be paid at fee schedule rates rather than OMB rates, the MCO shall reimburse the IHS or tribal contract provider at not less than the MAD fee schedule rate.

(b) IHS facilities, tribal health providers and urban Indian providers shall have up to two years from a claim's first date of service to submit a claim; claims not submitted within two years of the first date of service are not eligible for reimbursement.

(c) With the exception of residential treatment center services, services provided by IHS or a tribal 638 facility is not subject to prior authorization.

(3) Reimbursement for family planning services: the MCOs shall reimburse an out-of-network family planning provider for services provided to a MCO member at a rate that is at least equal to the MAD fee-schedule rate for the provider type.

(4) Reimbursement for an individual in their second or third trimester of pregnancy: If an individual is in the second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to their enrollment in the MCO, the receiving MCO will be responsible for providing continued access to their prenatal care provider (whether a contracted or non-contracted provider) through the 12-month postpartum period without any form of prior approval.

5) Reimbursement for a MCO member who disenrolls transitions while hospitalized: If an eligible recipient is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, the relinquishing MCO shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico department of health (DOH). The payer at the date of admission remains responsible for the services until the date of discharge. Upon discharge, the member will then become the financial responsibility of the receiving MCO receiving capitation payments. The relinquishing MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from the MCO**.**

[8.308.20.9 NMAC - N, 1/1/2014; A, 4/5/2022]

HISTORY OF 8.308.20 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 21 QUALITY MANAGEMENT

8.308.21.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.21.1 NMAC - Rp, 8.308.21.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.21.2 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. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.21.3 NMAC - Rp, 8.308.21.3 NMAC, 5/1/2018; A, 7/1/2024]

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 HCA 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, or their authorized representative, will receive information on their 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 their 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 the member;

(b) the neglect of the member;

(c) the exploitation of the member;

(d) any incident involving their utilization of emergency services;

(e) the hospitalization of the member;

(f) their involvement with law enforcement;

(g) their exposure to or the potential of exposure to environmental hazards that compromise their 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 HCA 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 HCA or its designee access to a member's medical and behavioral health records;

E. include provisions in contracts with providers for MCO and HCA 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.

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 22 FRAUD, WASTE AND ABUSE

8.308.22.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.22.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.22.2 SCOPE: This rule applies to the general public.
[8.308.22.2 NMAC - N, 1/1/2014]

8.308.22.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.22.3 NMAC - N, 1/1/2014; A, 7/1/2024]

8.308.22.4 DURATION: Permanent.
[8.308.22.4 NMAC - N, 1/1/2014]

8.308.22.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.22.5 NMAC - N, 1/1/2014]

8.308.22.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.22.6 NMAC - N, 1/1/2014]

8.308.22.7 DEFINITIONS:

A. "Abuse" is provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in unnecessary costs to the medicaid program, or in reimbursement of services that fail to meet professionally recognized standards for health care.

B. "Credible allegation of fraud" means an allegation, which has been verified by the state, from any source, including but not limited to the following:

(1) fraud hotline complaint;
(2) claims data mining;
(3) patterns identified through provider audits;
(4) civil false claims cases; or
(5) law enforcement investigations; see 42 CFR 455.2.

C. "Fraud" means an intentional deception or misrepresentation by a person or an entity, with knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes fraud under applicable federal or state statutes, regulations and rules.

D. "MFEAD" is the medicaid fraud and elder abuse division of the New Mexico attorney general's office

E. "Overpayment" means any funds that a person or entity receives or retains in excess of the medicaid allowable amount; however, for purposes of this rule, an overpayment does not include funds that have been subject to a payment suspension or that have been identified as third-party liability.

F. "Provider" means a network provider and non-network provider.

G. "Recovery" means money received by HCA or MFEAD for fraud or credible allegations of fraud from a provider.

H. "Refund" means money returned by a provider for overpayment(s).

I. "Waste" is the overutilization of services or other practices that result in unnecessary costs.
[8.308.22.7 NMAC - N, 1/1/2014]

8.308.22.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

[8.308.22.8 NMAC - N, 1/1/2014]

8.308.22.9 FRAUD, WASTE AND ABUSE: HCA is committed to aggressive prevention, detection, monitoring, and investigation to reduce provider or member fraud, waste and abuse. This rule applies to all individuals and entities participating in or contracting with HCA or a MCO for provision or receipt of medicaid services. If fraud, waste or abuse is discovered, HCA shall seek all remedies available to it under federal and state statutes, regulations, rules.

A. Program integrity requirements: the MCO shall have a comprehensive internal program integrity and overpayment prevention program to prevent, detect, preliminarily investigate and report potential and actual program violations including detecting potential overutilization of services, drugs, medical supply items and equipment. The MCO shall:

(1) be responsible for preventing and identifying overpayments or improper payments made to its providers;

(2) have specific internal controls for prevention, such as claim edits, prepayment and post-payment reviews, and provider profiling; and

(3) verify that services are actually provided utilizing "explanation of medicaid benefits" (EOB) notices and performing audits, reviews, and preliminary investigations.

B. Investigations and referrals: The MCO shall perform preliminary investigations of alleged fraud. The MCO shall:

(1) after conducting its preliminary investigation, submit to HCA for review all facts, supporting documentation and evidence of alleged fraud;

(2) upon request from MFEAD, release its preliminary investigation, including all supporting documentation and evidence to MFEAD and cease its investigation until otherwise advised by HCA or MFEAD;

(3) upon receipt of notification by HCA, and as directed, impose a suspension of payments to providers pending investigations of credible allegations of fraud and non release the payment suspension until notified in writing by HCA.

C. Overpayments: Are funds that a person or entity receives or retains in excess of the medicaid allowable amount; however, for purposes of this rule, an overpayment does not include funds that have been subject to a payment suspension or that have been identified as third-party liability.

(1) An overpayment shall be deemed to have been identified by a provider when:

(a) the provider reviews billing or payment records and learns that it incorrectly coded certain services or claimed incorrect quantities of services, resulting in increased reimbursements;

(b) the provider learns that a recipient's death occurred prior to the service date on which a claim that has been submitted for payment;

(c) the provider learns that services were provided by an unlicensed or excluded individual on its behalf;

(d) the provider performs an internal audit and discovers that an overpayment exists;

(e) the provider is informed by a governmental agency or its designee of an audit that discovered a potential overpayment;

(f) the provider is informed by the MCO of an audit that discovered a potential overpayment;

(g) the provider experiences a significant increase in medicaid revenue and there is no apparent reason for the increase, such as a new partner added to a group practice or new focus on a particular area of medicine;

(h) the provider has been notified that the MCO or a governmental agency or its designee has received a hotline call or email; or

(i) the provider has been notified that the MCO or a governmental agency or its designee has received information alleging that a member had not received services or been supplied goods for which the provider submitted a claim for payment.

(2) The MCO shall require its contracted providers to report to their MCO by the later of:

(a) the date which is 60 calendar days after the date on which the overpayment was identified; or

(b) the date any corresponding cost report is due, if applicable;

(3) The MCO shall require its providers to complete a self-report of the overpayment within 60 calendar days from the date on which the provider identifies an overpayment and require that the provider send an "overpayment report" to the MCO and HCA which includes:

(a) the provider's name;

(b) the provider's tax identification number and national provider number;

(c) how the overpayment was discovered;

(d) the reason(s) for the overpayment;

(e) the health insurance claim number, as appropriate;

(f) the date(s) of service;

(g) the medicaid claim control number, as appropriate;

(h) the description of a corrective action plan to ensure the overpayment does not occur again;

(i) whether the provider has a corporate integrity agreement (CIA) with the United States department of health and human services (HHS) office of inspector general (OIG) or is under the HHS/OIG self-disclosure protocol;

(j) the specific dates (or time span) within which the problem existed that caused the overpayments;

(k) whether a statistical sample was used to determine the overpayment amount and, if so, a description of the statistically valid methodology used to determine the overpayment; and

(l) the refund amount;

(4) The MCO shall notify its providers of the provision that overpayments identified by a provider but not self-reported by a provider within the 60-day timeframe are presumed to be false claims and are subject to referrals as credible allegations of fraud;

(5) The MCO shall report claims identified for overpayment recovery:

(a) in a format requested by HCA; and

(b) make 837 encounter adjustments with an identifier specified by HCA for recoveries identified by a governmental entity or its designee.

(6) Provide all records pertaining to overpayment recovery efforts as requested by HCA.

D. Refunds of overpayments:

(1) All self-reported refunds for overpayments shall be made by the provider to their MCO and are property of the MCO, unless:

(a) a governmental entity or its designee independently notified the provider that an overpayment existed; or

(b) the MCO fails to initiate recovery within 12 months from the date the MCO first paid the claim;

(c) the MCO fails to complete the recovery within 15 months from the date it first paid the claim; or

(d) provisions in the HCA agreement with the MCO otherwise provide for all or part of the recovery to go to MAD or HCA.

(2) In situations where the MCO and a governmental entity, or its designee, jointly audit its provider, the MCO and the governmental entity or designee shall agree upon a distribution of any refund.

(3) Unless otherwise agreed to by the MCO and HCA, the MCO shall not be entitled to any refund or recovery if the refund or recovery is part of a resolution of a state or federal investigation, lawsuit, including but not limited to False Claims Act cases.

E. Member fraud, abuse and overutilization:

(1) Cases involving one or more of the following situations constitute sufficient grounds for a member fraud referral:

(a) the misrepresentation of facts in order to become or to remain eligible to receive benefits under New Mexico medicaid or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined;

(b) the transferring by a member of a medicaid member identification (ID) card to a person not eligible to receive services under New Mexico medicaid or to a person whose benefits have been restricted or exhausted, thus enabling such a person to receive unauthorized medical benefits; and

(c) the unauthorized use of a medicaid member ID card by a person not eligible to receive medical benefits under a medical assistance program or is a high utilizer of services without apparent medical justification.

(2) HCA and the MCO shall possess the authority to restrict or lock-in a member to a specified and limited number of providers if they are involved in potential fraudulent activities or is identified as abusing services provided under their medicaid program.

(a) Prior to placing a member on a provider lock-in, the MCO shall inform them of the intent to lock-in, including the reasons for imposing the provider lock-in.

(b) The restriction does not apply to emergency services furnished to this member.

(c) The MCO's grievance procedure shall be made available to the member disagreeing with the provider lock-in.

(d) The member shall be removed from provider lock-in when their MCO has determined that the member's utilization problems or detrimental behavior has ceased and that recurrence of the problems is judged to be improbable.

(e) HCA shall be notified of provider lock-ins and provider lock-in removals.

[8.308.22.9 NMAC - N, 1/1/2014]

HISTORY OF 8.308.22 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 309 ALTERNATIVE BENEFIT PROGRAM
PART 4 MAD ADMINISTERED BENEFITS AND LIMITATION OF SERVICES

8.309.4.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.309.4.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.309.4.2 SCOPE: This rule applies to the general public.
[8.309.4.2 NMAC - N, 1/1/2014]

8.309.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.309.4.3 NMAC - N, 1/1/2014; A, 7/1/2024]

8.309.4.4 DURATION: Permanent.
[8.309.4.4 NMAC - N, 1/1/2014]

8.309.4.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.309.4.5 NMAC - N, 1/1/2014]

8.309.4.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.309.4.6 NMAC - N, 1/1/2014]

8.309.4.7 DEFINITIONS: [RESERVED]

8.309.4.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.309.4.8 NMAC - N, 1/1/2014]

8.309.4.9 ALTERNATIVE BENEFITS PLAN SERVICES WITH LIMITATIONS (ABP): The medical assistance division (MAD) category of eligibility "other adults" has an alternative benefit plan (ABP). MAD covers ABP specific services for an ABP eligible recipient. 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 eligible recipient: (1) has limitations on specific benefits; (2) does not have all standard medicaid state plan benefits available; and (3) has some benefits, primarily preventive services, that are available only to an ABP eligible recipient. All early and periodic screening, diagnosis and treatment (EPSDT) program services are available to an ABP eligible recipient under 21 years. ABP services for an ABP eligible recipient 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. A MAD ABP provider and ABP eligible recipient have rights and responsibilities as described in chapters 349 through 352 of Title 8 NMAC, Social Services. Long term care in a nursing facility (NF), mi via and community benefits are not available to an ABP eligible recipient.
[8.309.4.9 NMAC - N, 1/1/2014]

8.309.4.10 ALTERNATIVE BENEFITS PLAN GENERAL BENEFITS FOR ABP-EXEMPT ELIGIBLE RECIPIENTS (ABP-exempt): An ABP eligible recipient who self-declares they have a qualifying condition is evaluated by the MAD utilization review (UR) contractor for determination of whether they meet the qualifying condition. An ABP-exempt eligible recipient may select to no longer utilize their ABP benefits package. Instead, the ABP-exempt eligible recipient would then utilize the standard medicaid state plan benefit package. See Section 19 of this rule for detailed descriptions of the standard medicaid state plan benefits. Long term care in a nursing facility (NF), mi via and community benefits are available to an eligible ABP-exempt recipient when all conditions for accessing those services are met.

[8.309.4.10 NMAC - N, 1/1/2014]

8.309.4.11 MAD ABP GENERAL PROGRAM DESCRIPTION: The ABP benefits and services are detailed in Sections 12 through 17 of this rule. The ABP-exempt benefits and services are detailed in Section 19 of this rule.
[8.309.4.11 NMAC - N, 1/1/2014]

8.309.4.12 GENERAL ABP 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 eligible recipient 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 for an ABP recipient.

D. ABP eligible recipient transportation: The benefit package covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health services for an ABP eligible recipient in or out of their home community as detailed in 8.310.2 NMAC.

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

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

G. Dialysis services: The benefit package includes medically necessary dialysis services as detailed in 8.310.2 NMAC. A dialysis provider shall assist an ABP eligible recipient in applying for and pursuing final medicare eligibility determination.

H. Durable medical equipment and medical supplies: The benefit package includes:

(1) durable medical equipment as detailed in 8.310.2 NMAC;

(2) covered prosthetic and orthotic services as detailed in 8.310.2 NMAC and 8.324.5 NMAC; and

(3) medical supplies as detailed in 8.310.2 NMAC with some limitations; for an ABP eligible recipient 21 years of age and older the only medical supplies that are covered:

(a) diabetic supplies, such as reagents, test strips, needles, test tapes, and alcohol swabs; and

(b) medical supplies that are a necessary component of durable medical equipment, medical supplies applied as part of a treatment in a practitioner's office, outpatient hospital, residential facility, as a home health service and in other similar settings are covered as part of a service (office visit), which are not reimbursed separately; and

(c) family planning supplies.

I. Emergency and non-emergency transportation services: The benefit package includes transportation service such as ground ambulance, or air ambulance in an emergency and when medically necessary, 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. Non-emergency transportation is covered only when an ABP eligible recipient does not have a source of transportation available and when the ABP eligible recipient does not have access to alternative free sources. MAD or its UR contractor shall coordinate efforts when providing transportation services for an ABP eligible recipient requiring physical or behavioral health services.

J. Home health services: The benefit package for an ABP eligible recipient as detailed in 8.325.9 NMAC with some limitations. For an ABP eligible recipient 21 years of age and older, home health services are limited to 100 visits annually that do not exceed four hours-per-visit.

K. Hospice services: The benefit package for an ABP eligible recipient as detailed in 8.325.4 NMAC.

L. 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 and 8.321.2 NMAC.

M. Inpatient hospital services: The benefit package includes hospital inpatient acute care, procedures and services for the eligible recipient as detailed in 8.311.2 NMAC and inpatient rehabilitation hospitals detailed in 8.311.2 NMAC. Long-term acute care hospitals (extended care hospitals) are covered only as a

temporary step-down level of care (LOC) following the eligible recipient's discharge from a hospital prior to being discharged to home.

N. 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. Additionally, ABP diagnostic testing coverage includes physical measurements and performance testing, such as cardiac stress tests and sleep studies.

O. Physical health services: The benefit package includes primary, primary care in a school-based setting, family planning and specialty physical health services provided by a licensed practitioner performed within the scope of practice; see 8.310.2 and 8.310.3 NMAC. Benefits also include:

(1) an out of hospital birth and 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 or validly contracted with HCA and participates in MAD birthing options program as detailed in 8.310.2 NMAC; and

(2) bariatric surgery is limited to one per lifetime; meeting additional criteria to assure medical necessity may be required prior to accessing services.

P. Rehabilitation and habilitation services: The benefit package includes rehabilitative and habilitative services as detailed in 8.323.5 NMAC. For an eligible recipient 21 years and older there are service limitations listed below:

(1) cardiac rehabilitation is limited to 36 visits per cardiac event;

(2) pulmonary rehabilitation is limited to short-term therapy as defined in Paragraph (3) below; and

(3) physical and occupational therapies and speech and language pathology:

(a) are short-term therapies that produce significant and demonstrable improvement within the two-month period of the initial date of treatment; and

(b) the short-term therapy may be extended beyond the initial two month period for one additional period of up to two months dependent upon the MAD UR contractor, only if such services can be expected to result in continued significant improvement of the ABP eligible recipient's physical condition within the extension period.

(4) nursing facility (NF) and acute long term care facility stays only as a temporary step-down LOC from a hospital prior to the eligible recipient's discharge to home.

Q. Private duty nursing: For an eligible recipient under 21 years of age, private duty nursing services are covered under EPSDT program. See Section 18 of this rule for a detailed description. For recipients age 21 and older, private duty nursing is only available through the home health benefit. See Subsection J of this section and 8.325.9 NMAC.

R. Tobacco cessation services: The benefit package includes cessation sessions as described in 8.310.2 NMAC but is not limited to EPSDT or pregnant women.

S. Transplant services: The following transplants are covered in the benefit package as long as the indications are not considered experimental or investigational: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allogeneic bone marrow transplants and corneal transplants. For an ABP eligible recipient 21 years or older, there is a lifetime limitation two transplants. See 8.325.6 NMAC for guidance whether MAD has determined if a transplant is experimental or investigational.

T. Vision: The benefit package includes specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for an ABP eligible recipient 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 or older, the service limitations are:

(1) coverage is limited to one routine eye exam in a 36-month period; and

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

[8.309.4.12 NMAC - N, 1/1/2014; A, 10-15-14]

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

[8.309.4.13 NMAC - N, 1/1/2014]

8.309.4.14 REPRODUCTIVE HEALTH SERVICES: The benefit package includes reproductive health services as detailed in 8.310.2 NMAC.
[8.309.4.14 NMAC - N, 1/1/2014]

8.309.4.15 PREVENTATIVE PHYSICAL HEALTH SERVICES: The benefit package includes the current national standards for preventive health services including behavioral health preventive services. Standards are derived from several sources, including the United States preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Unless an ABP eligible recipient refuses and the refusal is documented, MAD shall make available the preventive health services or screens or document that the services (with the results) were provided by other means. The MAD provider shall document medical reasons not to perform these services for an individual ABP eligible recipient. ABP eligible recipient refusal is defined to include refusal to consent to and refusal to access care.

A. Initial assessment: A MAD ABP provider may assist the ABP eligible recipient with inquires to the MAD UR contractor for a NF assessment.

B. Prenatal care and screenings: The benefit package includes prenatal care and related services, as detailed in 8.310.2 NMAC.

C. Preventive medicine and supplements:

(1) An ABP eligible recipient can receive supplements detailed below as medically indicated:

(a) aspirin to prevent cardiovascular disease for a female between the ages of 45 to 79 years when the potential benefit of a reduction of ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage;

(b) aspirin to prevent cardiovascular disease for a male between the ages of 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage;

(c) vitamin D supplementation to prevent falls in a community-dwelling for an ABP eligible recipient 65 years of age and older who is at increased risk for falls;

(d) folic acid supplementation for all female ABP eligible recipients who are planning or are capable of pregnancy to take a daily supplement containing 0.4 to 0.8 mg of folic acid;

(e) iron supplementation for all asymptomatic ABP eligible recipients between the ages of six to 12 months who are at increased risk for iron deficiency anemia; and

(f) breast cancer preventive medication, such as chemoprevention, is made available.

(2) The MAD provider will discuss with a female ABP eligible recipient who is at high risk for breast cancer and at low risk for adverse effects of chemoprevention. The PCP will provide information to the ABP eligible recipient of the potential benefits and harms of chemoprevention.

D. Screens and preventative screens: screens and preventative screens include in the recommendation of the United States preventative services task force A and B recommendations are included in the benefit package.
[8.309.4.15 NMAC - N, 1/1/2014]

8.309.4.16 TELEMEDICINE SERVICES: The benefit package includes telemedicine services as detailed in 8.310.2 NMAC.
[8.309.4.16 NMAC - N, 1/1/2014]

8.309.4.17 BEHAVIORAL HEALTH SERVICES: The benefit package includes the behavioral health services as detailed in 8.321.2 NMAC.
[8.309.4.17 NMAC - N, 1/1/2014]

8.309.4.18 EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT SERVICES (EPSDT): The benefit package includes the delivery of the federally mandated EPSDT program services [42 CFR Section 441.57] provided by a primary care provider (PCP) as detailed in 8.320.2 NMAC. These include the ABP benefit services found in Sections 12 through 17 of this rule.

A. General physical health EPSDT services: MAD makes available access to early intervention programs and services for an ABP eligible recipient 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, ESPDT services are for an ABP eligible recipient under 21 years of age. For detailed description of each service,

see 8.320.2 and for school based health services, see 8.320.6 NMAC. Additional NMAC citations may be included as reference.

B. Behavioral health EPSDT services: The benefit package includes services provided by a behavioral health practitioner for an ABP eligible recipient. See 8.321.2 NMAC for a detailed description of each service. MAD makes available access to early intervention programs and services for an ABP eligible recipient identified in their EPSDT screen as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder.

[8.309.4.18 NMAC - N, 1/1/2014]

8.309.4.19 ABP-EXEMPT ELIGIBLE RECIPIENT GENERAL BENEFIT DESCRIPTION: An ABP eligible recipient with a qualifying condition may select ABP-exempt utilizing the standard medicaid state plan benefits. All services, services limitations and co-payments that apply to full benefit medicaid recipients are available to APB-exempt recipients. An ABP-exempt recipient does not have access to the benefits that are 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 following chapters of Title 8 Social Services NMAC provide more detailed descriptions of services.

A. Chapter 301 *medicaid general benefit description*;
B. Chapter 302 *medicaid general provider policies*;
C. Chapter 310 *health care professional services*;
D. Chapter 311 *hospital services*;
E. Chapter 312 *long term care-nursing services*, with the exceptions detailed in Section 10 of this rule);
F. Chapter 313 *long-term care facilities -intermediate care facilities*;
G. Chapter 314 *long-term care services-waivers*;
H. Chapter 320 *early and periodic screening, diagnosis and treatment (EPSDT)*;
I. Chapter 321 *behavioral health services*;
J. Chapter 324 *adjunct services*;
K. Chapter 325 *specialty services*; and
L. Chapter 326 *case management services*.

[8.309.4.19 NMAC - N, 1/1/2014]

8.309.4.20 ABP AND ABP-EXEMPT ELIGIBLE PROVIDERS: Health care to an ABP eligible recipient is furnished by a variety of providers and provider groups. Refer to the MAD NMAC specific service rules for detailed description of unique provider requirements. For general information, see 8.310.2 and 8.310.3 NMAC.

[8.309.4.20 NMAC - N, 1/1/2014]

8.309.4.21 ABP AND ABP-EXEMPT NONCOVERED SERVICES: MAD does not cover certain procedures, services, or miscellaneous items. Refer to the NMAC specific service rules for detailed description of unique noncovered services. For general information, see 8.310.2 NMAC for physical health noncovered services, 8.320.2 NMAC for EPSDT noncovered services, 8.320.6 for noncovered school-based health services, and 8.321.2 NMAC for behavioral health noncovered services.

[8.309.4.21 NMAC - N, 1/1/2014]

8.309.4.22 ABP AND ABP-EXEMPT PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to UR for medical necessity and program compliance. Refer to the NMAC specific service rule for detailed description of the service's prior authorization and utilization review requirements. For general information, see 8.310.2 and 8.310.3 NMAC.

[8.309.4.22 NMAC - N, 1/1/2014]

8.309.4.23 ABP AND ABP-EXEMPT RECIPIENT RESPONSIBILITIES: Services provided may be subject to cost sharing requirements. Please see 8.302.2 NMAC for more information on any required recipient co-payments.

[8.309.4.23 NMAC - N, 1/1/2014]

HISTORY OF 8.309.4 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 2 GENERAL BENEFIT DESCRIPTION

8.310.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.310.2.1 NMAC - Rp, 8.310.2.1 NMAC, 1/1/2014; A, 7/1/2024]

8.310.2.2 SCOPE: The rule applies to the general public.
[8.310.2.2 NMAC - Rp, 8.310.2.2 NMAC, 1/1/2014]

8.310.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.310.3.3 NMAC - Rp, 8.310.3.3 NMAC, 1/1/2023; A, 7/1/2024]

8.310.2.4 DURATION: Permanent.
[8.310.2.4 NMAC - Rp, 8.310.2.4 NMAC, 1/1/2014]

8.310.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.310.2.5 NMAC - Rp, 8.310.2.5 NMAC, 1/1/2014]

8.310.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.2.6 NMAC - Rp, 8.310.2.6 NMAC, 1/1/2014]

8.310.2.7 DEFINITIONS: [**RESERVED**]

8.310.2.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.310.2.8 NMAC - Rp, 8.310.2.8 NMAC, 1/1/2014; A, 8/10/2021]

8.310.2.9 GENERAL PROGRAM DESCRIPTION:

A. The New Mexico medical assistance division (MAD) pays for medically necessary health care services furnished by a MAD enrolled medical provider. See 42 CFR 440.210; Section 27-2-16 NMSA 1978 (Repl. Pamp. 1991).

B. MAD pays for medically necessary behavioral health professional services including assessments, evaluations, and therapy required by the condition of the medical assistance program (MAP) eligible recipient. See 42 CFR Sections 440.40, 440.60(a) and 441.571.

C. MAD covers services which are medically necessary for the diagnosis or treatment of illnesses, injuries or conditions of a MAP eligible recipient, as determined by MAD or its designee. All services must be furnished within the limits of the MAD New Mexico administrative code (NMAC) rules policies and instructions within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority. Any claim submitted for reimbursement is subject to review by MAD or its designee to verify the medical necessity of the service. All claims are subject to pre-payment or post-payment review and recoupment.

D. HCA, through MAD, is responsible for the administration of the medicaid program and other health care programs. This joint federal and state program provides payment for medically necessary health services furnished to MAP eligible recipients.

E. A provider must be eligible for participation as a MAD approved provider at the time services are furnished. MAD does not cover services performed during a time period when the provider or facility did not meet required licensing or certification requirement.

F. If a MAP eligible recipient is enrolled with a MAD managed care organization (MCO), the provider must contact that member's MCO for specific reimbursement information. A MCO contracted with the

state of New Mexico is not required to follow the MAD fee-for-service (FFS) fee schedules or reimbursement methodologies unless otherwise instructed by MAD. Reimbursement arrangements are determined contractually between the MCO and the provider.
[8.310.2.9 NMAC - N, 1/1/2014]

8.310.2.10 RELATIONSHIP TO MEDICARE: MAD covers medically necessary health services furnished to a MAP eligible recipient who meets specific income, resource and eligibility standards. Medicare is a federal program which offers health insurance coverage to MAP eligible recipient 65 years of age and older, to those who have received disability benefits for 24 consecutive months, to those who have end stage renal disease, and to other MAP eligible recipients as specified by other provisions of the Social Security Act.

A. New Mexico has entered into an agreement with the social security administration to pay a medicaid MAP eligible recipient's premium for medicare part B, and under some circumstances, medicare part A premiums.

B. After medicare has made payment for services, MAD pays for the medicare co-insurance, deductible and copayment amounts for a MAP eligible recipient subject to the following reimbursement limitations.

(1) Medicaid payment for the co-insurance, deductible, copayment or other patient responsibility is limited such that the payment from medicare, plus the amount allowed by MAD for the co-insurance, copayment and deductible, shall not exceed the MAD allowed amount for the service. When the medicare payment exceeds the amount that medicaid would have allowed for the service, no payment is made for the co-insurance, copayment, deductible or other patient responsibility. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare co-insurance, copayment or deductible from the MAP eligible recipient or their authorized representative. For services for which medicare part B applies a 50 percent co-insurance rate, medicare co-insurance, copayment and deductible amounts are paid at an amount that allows the provider to receive more than MAD allowed amount, not to exceed a percentage determined by HCA.

(2) MAD will pay toward the medicare co-insurance and deductible to the extent that the amount paid by medicare and the allowed medicare co-insurance, deductible and copayment together do not exceed the MAD allowable amount. MAD will pay the full medicare co-insurance and deductible when MAD does not have a specific amount allowed for the service. When MAD does not use an equivalent payment methodology for a service, the full coinsurance, deductible and copayment amounts will be paid. This occurs when providers are paid at encounter rates, percent of billed charges followed by cost settlements, or when providers are entitled to a full reimbursement rate such as for federally qualified health centers and hospital outpatient prospective payment system reimbursement.
[8.310.2.10 NMAC - Rp, 8.300.1.10 NMAC, 1/1/2014]

8.310.2.11 SERVICE LIMITATIONS AND RESTRICTIONS: MAD covers the following services with the frequency limits indicated. For purpose of this rule, a provider is considered part of the same provider group if they practice in the same office or clinic or has direct access to the MAP eligible recipient's medical or behavioral health records. Exceeding these limits requires prior authorization.

A. Office visits in a practitioner's office: Visits are limited to one-per-day from the same provider or provider group, unless the claim documents a change in the MAP eligible recipient's condition that could not have been anticipated at the first visit.

B. Physical medicine modalities in a professional practitioner's office: These modalities are limited to three-per-month. The limit is met when the same modality is performed three times during a calendar month, when three different modalities are performed during a month, or when three different modalities are performed during one visit.

C. Physical medicine procedures and kinetic activities in a professional practitioner's office: These services are limited to three-per-month from the same provider or provider group. The limit is met when the same procedure is performed three times during a calendar month, when three different procedures are performed during a month, or when three procedures are performed during one visit.

D. Manipulation, osteo-manipulative therapy, or myofacial release in a professional practitioner's office: These services are limited to three manipulations per calendar month, regardless of the area or areas manipulated. The limit is met when a manipulation of three different areas or of the same area at three different visits is performed during a month.

E. Medically necessary services: All services are limited to those that are medically necessary, including the length of time and the frequency of service.
[8.310.2.11 NMAC - Rp, 8.310.2.13 NMAC, 1/1/2014; A, 4/5/2022]

8.310.2.12 **SERVICES:** MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of provider program rules and within the scope of their practice board and licensure.

A. **Medical practitioner services:**

(1) Second surgical opinions: MAD covers second opinions when surgery is considered.

(2) Services performed in an outpatient setting: MAD covers procedures performed in the office, clinic or as outpatient institutional services as alternatives to hospitalization. These procedures are those for which an overnight stay in a hospital is seldom necessary.

(a) A MAP eligible recipient may be hospitalized if they have existing medical conditions that predispose them to complications even with minor procedures.

(b) Claims may be subject to pre-payment or post-payment review.

(c) Medical justification for performance of these procedures in a hospital must be documented in the MAP eligible recipient's medical record.

(3) Noncovered therapeutic radiology and diagnostic imaging services: MAD does not pay for kits, films or supplies as separate charges. All necessary materials and minor services are included in the service or procedure charge. Reimbursement for imaging procedures includes all materials and minor services necessary to perform the procedure. MAD does not pay an additional amount for contrast media except in the following instances:

(a) radioactive isotopes;

(b) non-ionic radiographic contrast material; or

(c) gadolinium salts used in magnetic resonance imaging.

(4) Midwives services: MAD covers services furnished by certified nurse midwives or licensed midwives within the scope of their practice, as defined by state laws and rules and within the scope of their practice board and licensure. Reimbursement for midwife services is based on one global fee, which includes prenatal care, delivery and postpartum care.

(a) Separate trimesters completed and routine vaginal delivery can be covered if a MAP eligible recipient is not under the care of one provider for the entire prenatal, delivery and postpartum periods.

(b) MAD covers laboratory and diagnostic imaging services related to pregnancy. These services can be billed separately.

(c) MAD covers gynecological or obstetrical ultrasounds without requiring a prior authorization of any kind.

(d) MAD covers a MAP eligible pregnant recipient's labor and delivery services at a New Mexico department of health (DOH) licensed birth center through the "Birthing Options Program" (BOP). MAD reimburses the birth center facility and the rendered services of a midwife separately. BOP services are provided by an eligible midwife that enrolls as a BOP provider with the health care authority/medical assistance division (HCA/MAD). The facility must comply with all DOH licensing requirements, including limiting licensure. The facility must maintain all clinical documentation, including schedules, for the period of time as required under 8.302.1 NMAC. The program does not cover the full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

(e) Non-covered midwife services: Midwife services are subject to the limitation and coverage restrictions which exist for other MAD services. MAD does not cover the following specific services furnished by a midwife:

(i) oral medications or medications, such as ointments, creams, suppositories, ophthalmic and otic preparations which can be appropriately self-administered by the MAP eligible recipient;

(ii) services furnished by an apprentice; unless billed by the supervising midwife;

(iii) an assistant at a home birth unless necessary based on the medical condition of the MAP eligible recipient which must be documented in the claim.

B. **Pharmaceutical, vaccines and other items obtained from a pharmacy:** MAD does not cover drug items that are classified as ineffective by the food and drug administration (FDA) and antitubercular drug items that are available from the public health department. In addition, MAD does not cover personal care items or pharmacy items used for cosmetic purposes only. Transportation to a pharmacy is not a MAD allowed benefit with the exception for justice-involved MAP eligible recipients who are released from incarceration at a correctional facility within the first seven days of release.

C. Laboratory and diagnostic imaging services: MAD covers medically necessary laboratory and diagnostic imaging services ordered by primary care provider (PCP), physician assistant (PA), certified nurse practitioner (CNP), or clinical nurse specialists (CNS) and performed in the office by a provider or under their supervision by a clinical laboratory or a radiology laboratory, or by a hospital-based clinical laboratory or radiology laboratory that are a enrolled MAD provider. See 42 CFR Section 440.30.

(1) MAD covers interpretation of diagnostic imaging with payment as follows: when diagnostic radiology procedures, diagnostic imaging, diagnostic ultrasound, or non-invasive peripheral vascular studies are performed in a hospital inpatient or outpatient setting, payment is made only for the professional component of the service. This limitation does not apply if the hospital does not bill for any component of the radiology procedures and does not include the cost associated with furnishing these services in its cost reports.

(2) A provider may bill for the professional components of imaging services performed at a hospital or independent radiology laboratory if the provider does not request an interpretation by the hospital radiologist.

(3) Only one professional component is paid per radiological procedure.

(4) Radiology professional components are not paid when the same provider or provider group bills for professional components or interpretations and for the performance of the complete procedure.

(5) Professional components associated with clinical laboratory services are payable only when the work is actually performed by a pathologist who is not billing for global procedures and the service is for anatomic and surgical pathology only, including cytopathology, histopathology, and bone marrow biopsies, or as otherwise allowed by the medicare program.

(6) Specimen collection fees are payable when obtained by venipuncture, arterial stick, or urethral catheterization, unless a MAP eligible recipient is an inpatient of a nursing facility or hospital.

(7) Noncovered laboratory services: MAD does not cover laboratory specimen handling, mailing, or collection fees. Specimen collection is covered only if the specimen is drawn by venipuncture, arterial stick, or collected by urethral catheterization from a MAP eligible recipient who is not a resident of a NF or hospital. MAD does not cover the following specific laboratory services:

(a) clinical laboratory professional components, except as specifically described under covered services above;

(b) specimens, including pap smears, collected in a provider's office or a similar facility and conveyed to a second provider's office, office laboratory, or non-certified laboratory;

(c) laboratory specimen handling or mailing charges;

(d) specimen collection fees other than those specifically indicated in covered services; and

(e) laboratory specimen collection fees for a MAP eligible recipient in NF or inpatient hospital setting.

D. Reproductive health services: MAD pays for family planning and other related health services (see 42 CFR Section 440.40(c)) and supplies furnished by or under the supervision of a MAD enrolled provider acting within the scope of their practice board or licensure.

(1) Prior to performing medically necessary surgical procedures that result in sterility, providers must complete a "*sterilization consent*" or a "*hysterectomy acknowledgment/consent*" form. MAD covers a medically necessary sterilization under the following conditions. See 42 CFR Section 441.251 et seq:

(a) a MAP eligible recipient 21 years and older at the time consent is obtained;

(b) a MAP eligible recipient is not mentally incompetent; mentally incompetent is a declaration of incompetency as made by a federal, state, or local court; a MAP eligible recipient can be declared competent by the court for a specific purpose, including the ability to consent to sterilization;

(c) a MAP eligible recipient is not institutionalized; for this section, institutionalized is defined as:

(i) an individual involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a psychiatric hospital or an intermediate care facility for the care and treatment of mental illness;

(ii) confined under a voluntary commitment in a psychiatric hospital or other facility for the care and treatment of mental illness;

(d) a MAP eligible recipient seeking sterilization must be given information regarding the procedure and the results before signing a consent form; this explanation must include the fact that sterilization is a final, irreversible procedure; a MAP eligible recipient must be informed of the risks and benefits associated with the procedure;

(e) a MAP eligible recipient seeking sterilization must also be instructed that their consent can be withdrawn at any time prior to the performance of the procedure and that they would not lose any other MAD benefits as a result of the decision to have or not have the procedure; and

(f) a MAP eligible recipient voluntarily gives informed consent to the sterilization procedure. See 42 CFR Section 441.257(a); and

(g) a MAP eligible recipient's informed consent to the sterilization procedure must be attached to the claim.

(2) Hysterectomies: MAD covers only a medically necessary hysterectomy. MAD does not cover a hysterectomy performed for the sole purpose of sterilization. See 42 CFR Section 441.253.

(a) Hysterectomies require a signed, voluntary informed consent which acknowledges the sterilizing results of the hysterectomy. The form must be signed by the MAP eligible recipient prior to the operation.

(b) Acknowledgement of the sterilizing results of the hysterectomy is not required from a MAP eligible recipient who has been previously sterilized or who is past child-bearing age as defined by the medical community. In this instance, the PCP signs the bottom portion of the hysterectomy form which states the MAP eligible recipient has been formerly sterilized, and attaches it to the claim.

(c) An acknowledgement can be signed after the fact if the hysterectomy is performed in an emergency.

(3) Birthing options services (BOP): MAD covers a MAP eligible pregnant recipient's labor and delivery services at a New Mexico department of health (DOH) licensed birth center through BOP. The BOP is an out-of-hospital birthing option for pregnant individuals enrolled in the medicaid program who are at low-risk for adverse birth outcomes. BOP services are provided by an eligible midwife that enrolls as a BOP provider with health care authority/medical assistance division (HCA/MAD). The BOP services are specifically for basic obstetric care for uncomplicated pregnancies and childbirth, including immediate newborn care that is limited to stabilization of the baby during this transition. The program does not cover the full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

(4) Other covered services: MAD covers medically necessary methods, procedures, pharmaceutical supplies and devices to prevent unintended pregnancy or contraception.

(5) Noncovered reproductive health care: MAD does not cover the following specific services:

(a) sterilization reversal services;

(b) fertility drugs;

(c) in vitro fertilization;

(d) artificial insemination;

(e) hysterectomies performed for the sole purpose of family planning;

(f) induced vaginal deliveries prior to 39 weeks unless medically indicated;

(g) caesarean sections unless medically indicated; and

(h) elective procedures to terminate a pregnancy.

E. Nutritional services: MAD covers medically necessary nutritional services which are 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 MAP eligible recipient. MAD covers only those services furnished by PCP, licensed nutritionists or licensed dieticians. MAD covers the following services:

(1) Nutritional assessments for a pregnant MAP eligible recipient and for a MAP eligible recipient under 21 years of age through the early and periodic screening, diagnosis and treatment (EPSDT) program. Nutritional assessment is defined as an evaluation of the nutritional needs of the MAP eligible recipient based upon appropriate biochemical, anthropometric, physical and dietary data to determine nutrient needs and includes recommending appropriate nutritional intake.

(2) Nutrition counseling to or on behalf of a MAP eligible recipient under 21 years of age who has been referred for a nutritional need. Nutrition counseling is defined as advising and helping a MAP eligible recipient obtain appropriate nutritional intake by integrating information from the nutrition assessment with information on food, other sources of nutrients and meal preparation, consistent with cultural background and socioeconomic status.

(3) Noncovered nutritional services: MAD covers only those services furnished by a PCP, licensed nutritionist or licensed dietician. MAD does not cover the following specific services:

(a) services not considered medically necessary for the condition of the MAP eligible recipient as determined by MAD or its designee;

(b) dietary counseling for the sole purpose of weight loss;

(c) weight control and weight management programs; and

(d) commercial dietary supplements or replacement products marketed for the primary purpose of weight loss and weight management; see 8.324.4 NMAC.

F. Transplant services: Non-experimental transplant services are covered. MAD covered transplantation services include hospital, a PCP, laboratory, outpatient surgical, and other MAD covered services necessary to perform the selected transplantation for the MAP eligible recipient and donor.

(1) Due to special medicare coverage available for individuals with end-stage renal disease, medicare eligibility must be pursued by the provider for coverage of a kidney transplant before requesting MAD reimbursement.

(2) MAD covers the MAP eligible recipient's and donor's related medical, transportation, meals and lodging services for non-experimental transplantation.

(3) MAD does not cover transplant procedures, treatments, use of a drug, biological product, a product or a device which are considered unproven, experimental, investigational or not effective for the condition for which they are intended or used.

(4) A written prior authorization must be obtained for any transplant, with the exception of a cornea and a kidney. The prior authorization process must be started by the MAP eligible recipient's attending PCP contacting the MAD UR contractor. Services for which prior approval was obtained remain subject to UR at any point in the payment.

G. Dental services: Dental services are covered as an optional medical service for a MAP eligible recipient. Dental services are defined as those diagnostic, preventive or corrective procedures to the teeth and associated structures of the oral cavity furnished by, or under the supervision of, a dentist that affect the oral or general health of the MAP eligible recipient. See 42 CFR Section 440.100(a). MAD also covers dental services, dentures and special services for a MAP eligible recipient who qualifies for services under the EPSDT program. See 42 CFR Section 441.55.

(1) Emergency dental care: MAD covers emergency care for all MAP eligible recipients. Emergency care is defined as services furnished when immediate treatment is required to control hemorrhage, relieve pain or eliminate acute infection. For a MAP eligible recipient under 21 years of age, care includes operative procedures necessary to prevent pulpal death and the imminent loss of teeth, and treatment of injuries to the teeth or supporting structures, such as bone or soft tissue contiguous to the teeth.

(a) Routine restorative procedures and root canal therapy are not emergency procedures.

(b) Prior authorization requirements are waived for emergency care, but the claim can be reviewed prior to payment to confirm that an actual emergency existed at the time of service.

(2) Diagnostic services: MAD coverage for diagnostic services is limited to the following:

(a) for a MAP eligible recipient under 21 years of age, diagnostic services are limited to one clinical oral examination every six months and upon referral one additional clinical oral examination by a different dental provider every six months;

(b) one clinical oral examination every 12 months for a MAP eligible recipient 21 years and older; and

(c) MAD covers emergency oral examinations which are performed as part of an emergency service to relieve pain and suffering.

(3) Radiology services: MAD coverage of radiology services is limited to the following:

(a) one intraoral complete series every 60 months per MAP eligible recipient; this series includes bitewing x-rays;

(b) additional bitewing x-rays once every 12 months per MAP eligible recipient; and

(c) panoramic films performed can be substituted for an intraoral complete series, which is limited to one every 60 months per MAP eligible recipient.

(4) Preventive services: MAD coverage of preventive services is subject to certain limitations.

(a) Prophylaxis: MAD covers for a MAP eligible recipient under 21 years of age one prophylaxis service every six months. MAD covers for a MAP eligible recipient 21 years of age and older who has a developmental disability, as defined in 8.314.6 NMAC, one prophylaxis service every six months. For a MAP eligible recipient 21 years of age and older without a developmental disability, as defined in 8.314.6 NMAC, MAD covers one prophylaxis service once in a 12 month-period.

(b) Fluoride treatment: MAD covers for a MAP eligible recipient under 21 years of age, one fluoride treatment every six months. For a MAP eligible recipient 21 years of age and older MAD, covers one fluoride treatment once in a 12-month period.

(c) Fluoride varnish: MAD covers for a MAP eligible recipient under 21 years of age, one fluoride varnish treatment every six months.

(d) Molar sealants: MAD only covers for a MAP eligible recipient under 21 years of age, sealants for permanent molars. Each MAP eligible recipient can receive one treatment per tooth every 60 months. MAD does not cover sealants when an occlusal restoration has been completed on the tooth. Replacement of a sealant within the 60-month period requires a prior authorization. For a MAP eligible recipient 21 years of age and older, MAD does not cover sealant services.

(e) Space maintenance: MAD covers for a MAP eligible recipient under 21 years of age fixed unilateral and fixed bilateral space maintainers (passive appliances). For a MAP eligible recipient 21 years of age and older, MAD does not cover space maintenance services.

(5) Restorative services: MAD covers the following restorative services:

(a) amalgam restorations (including polishing) on permanent and deciduous teeth;

(b) resin restorations for anterior and posterior teeth;

(c) one prefabricated stainless steel crown per permanent or deciduous tooth;

(d) one prefabricated resin crown per permanent or deciduous tooth; and

(e) one recementation of a crown or inlay.

(6) Endodontic services: MAD covers therapeutic pulpotomy for a MAP eligible recipient under 21 years of age if performed on a primary or permanent tooth and no periapical lesion is present on a radiograph.

(7) Periodontic services: MAD covers for a MAP eligible recipient certain periodontics surgical, non-surgical and other periodontics services subject to certain limitations:

(a) a collaborative practice dental hygienist may provide periodontal scaling and root planning, per quadrant after diagnosis by a MAD enrolled dentist; and

(b) a collaborative practice dental hygienist may provide periodontal maintenance procedures with prior authorization.

(8) Removable prosthodontic services: MAD covers two denture adjustments per every 12 months per MAP eligible recipient. MAD also covers repairs to complete and partial dentures.

(9) Fixed prosthodontics services: MAD covers one recementation of a fixed bridge.

(10) Oral surgery services:

(a) simple and surgical extractions: MAD coverage includes local anesthesia and routine post-operative care; erupted surgical extractions are defined as extractions requiring elevation of mucoperiosteal flap and removal of bone, or section of tooth and closure;

(b) autogenous tooth reimplantation of a permanent tooth: MAD covers for a MAP eligible recipient under 21 years of age; and

(c) the incision and the drainage of an abscess for a MAP eligible recipient.

(11) Adjunctive general services: MAD covers emergency palliative treatment of dental pain for a MAP eligible recipient. MAD also covers general anesthesia and intravenous sedation for a MAP eligible recipient. Documentation of medical necessity must be available for review by MAD or its designee. For a MAP eligible recipient under 21 years of age, MAD covers the use of nitrous oxide analgesia. For a MAP eligible recipient 21 years of age and older, MAD does not cover the use of nitrous oxide analgesia.

(12) Hospital care: MAD covers dental services normally furnished in an office setting if they are performed in an inpatient hospital setting only with a prior authorization, unless one of the following conditions exist:

(a) the MAP eligible recipient is under 21 years of age; or

(b) the MAP eligible recipient under 21 years of age has a documented medical condition for which hospitalization for even a minor procedure is medically justified; or

(c) any service which requires a prior authorization in an outpatient setting must have a prior authorization if performed in an inpatient hospital.

(13) Behavioral management: Dental behavior management as a means to assure comprehensive oral health care for persons with developmental disabilities is covered. This code allows for additional compensation to a dentist who is treating persons with developmental disabilities due to the increased time, staffing, expertise, and adaptive equipment required for treatment of a special needs MAP eligible recipient. Dentists who have completed the training and received their certification from DOH are eligible for reimbursement.

(14) Noncovered dental services: MAD does not cover dental services that are performed for aesthetic or cosmetic purposes. MAD covers orthodontic services only for a MAP eligible recipient under 21 years of age and only when specific criteria are met to assure medical necessary. MAD does not cover the following specific services:

(a) surgical tray is considered part of the surgical procedure and is not reimburse separately for tray;

(b) sterilization is considered part of the dental procedure and is not reimbursed separately for sterilization;

(c) oral preparations, including topical fluorides dispensed to a MAP eligible recipient for home use;

(d) permanent fixed bridges;

(e) procedures, appliances or restorations solely for aesthetic, or cosmetic purposes;

(f) procedures for desensitization, re-mineralization or tooth bleaching;

(g) occlusal adjustments, disking, overhang removal or equilibration;

(h) mastique or veneer procedures;

(i) treatment of TMJ disorders, bite openers and orthotic appliances;

(j) services furnished by non-certified dental assistants, such as radiographs;

(k) implants and implant-related services; or

(l) removable unilateral cast metal partial dentures.

H. Podiatry and procedures on the foot: MAD covers only medically necessary podiatric services furnished by a provider, as required by the condition of the MAP eligible recipient. All services must be furnished within the scope and practice of the podiatrist as defined by state law, the New Mexico board of podiatry licensing requirements, and in accordance with applicable federal, state, and local laws and rules. MAD covers routine foot care if certain conditions of the foot, such as corns, warts, calluses and conditions of the nails, post a hazard to a MAP eligible recipient with a medical condition. MAD covers the treatment of warts on the soles of the feet (plantar warts). Medical justification for the performance of routine care must be documented in the MAP eligible recipient's medical record. MAD covers the following specific podiatry services.

(1) Routine foot care: Routine foot care services that do not meet the coverage criteria of medicare part B are not covered by MAD. MAD covers services only when there is evidence of a systemic condition, circulatory distress or areas of diminished sensation in the feet demonstrated through physical or clinical determination. A MAP eligible recipient with diagnoses marked by an asterisk(*) in the list below must be under the active care of a physician or physician assistant (PA). to qualify for covered routine foot care, and must have been assessed by that provider for the specified condition within six months prior to or 60-calendar days after the routine foot care service. A CNP, PA and a CNS do not satisfy the coverage condition of "active care by a PCP".

(2) Common billed diagnoses: The following list of systemic diseases is not all-inclusive and represents the most commonly billed diagnoses which qualify for medically necessary foot care:

(a) diabetes mellitus*;

(b) arteriosclerosis obliterans;

(c) buerger's disease;

(d) chronic thrombophlebitis*;

(e) neuropathies involving the feet associated with:

(i) malnutrition and vitamin deficiency*;

(ii) malnutrition (general, pellagra);

(iii) alcoholism;

(iv) malabsorption (celiac disease, tropical sprue);

(v) pernicious anemia;

(vi) carcinoma*;

(vii) diabetes mellitus*;

(viii) drugs or toxins*;

(ix) multiple sclerosis*;

(x) uremia (chronic renal disease)*;

(xi) traumatic injury;

(xii) leprosy or neurosyphilis;

(xiii) hereditary disorders;

(xiv) hereditary sensory radicular neuropathy;

(xv) fabry's disease; and

(xvi) amyloid neuropathy.

(3) Routine foot care services: MAD covers routine foot care services for a MAP eligible recipient who has a systemic condition and meets the severity in the class findings as follows: one of class A findings; or two of class B findings; or one of the class B findings and two of the following class C findings:

(a) class A findings: non-traumatic amputation of foot or integral skeletal portion thereof;

(b) class B findings:

(i) absent posterior tibial pulse;

(ii) absent dorsalis pedis pulse; and

(iii) advanced trophic changes as evidenced by any three of the following: hair growth (decrease or increase); nail changes (thickening); pigmentary changes (discoloring); skin texture (thin, shiny); or skin color (rubor or redness);

(c) class C findings:

(i) claudication;

(ii) temperature changes (e.g., cold feet);

(iii) edema;

(iv) paresthesias (abnormal spontaneous sensations in the feet); or

(v) burning.

(4) Subluxated foot structure: Non-surgical and surgical correction of a subluxated foot structure that is an integral part of the treatment of foot pathology or that is undertaken to improve the function of the foot or to alleviate an associated symptomatic condition, including treatment of bunions, is covered when medical necessity has been documented. Treatment for bunions is limited to capsular or bony surgery. The treatment of subluxation of the foot is defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles in the foot.

(5) Foot warts: MAD covers the treatment of warts on the feet.

(6) Asymptomatic mycotic nails: MAD covers the treatment of asymptomatic mycotic nails in the presence of a systemic condition that meets the clinical findings and class findings as required for routine foot care.

(7) Mycotic nails: MAD covers the treatment of mycotic nails in the absence of a covered systemic condition if there is clinical evidence of mycosis of the toenail and one or more of the following conditions exist and results from the thickening and dystrophy of the infected nail plate:

(a) marked, significant limitation;

(b) pain; or

(c) secondary infection.

(8) Orthopedic shoes and other supportive devices: MAD only covers these items when the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics who is a MAP eligible recipient.

(9) Hospitalization: If the MAP eligible recipient has existing medical condition that would predispose them to complications even with minor procedures, hospitalization for the performance of certain outpatient podiatric services may be covered.

(10) Noncovered podiatric services: A provider is subject to the limitations and coverage restrictions that exist for other medical services. MAD does not cover the following specific services or procedures.

(a) Routine foot care is not covered except as indicated under "covered services" for a MAP eligible recipient with systemic conditions meeting specified class findings. Routine foot care is defined as:

(i) trimming, cutting, clipping and debriding toenails;

(ii) cutting or removal of corns, calluses, or hyperkeratosis;

(iii) other hygienic and preventative maintenance care such as cleaning and soaking of the feet, application of topical medications, and the use of skin creams to maintain skin tone in either ambulatory or bedfast MAP eligible recipient; and

(iv) any other service performed in the absence of localized illness, injury or symptoms involving the foot.

(b) Services directed toward the care or the correction of a flat foot condition are not covered. Flat foot is defined as a condition in which one or more arches of the foot have flattened out.

(c) Orthopedic shoes and other supportive devices for the feet are generally not covered. This exclusion does not apply if the shoe is an integral part of a leg brace or therapeutic shoes furnished to a diabetic MAP eligible recipient.

(d) Surgical or nonsurgical treatments undertaken *for the sole purpose* of correcting a subluxated structure in the foot as an isolated condition are not covered. Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot.

(e) MAD will not reimburse for services that have been denied by medicare for coverage limitations.

I. Anesthesia: MAD covers anesthesia and monitoring services which are medically necessary for performance of surgical or diagnostic procedures, as required by the condition of the MAP eligible recipient. All services must be provided within the limits of MAD benefit package, within the scope and practice of anesthesia as defined by state law and in accordance with applicable federal and state and local laws and rules.

(1) When a provider performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, payment for this service is considered to be part of the underlying medical or surgical service and will not be covered in addition to the procedure.

(2) An anesthesia service is not covered if the medical or surgical procedure is not a MAD covered service.

(3) Separate payment is not allowed for qualifying circumstances. Payment is considered bundled into the anesthesia allowance.

(4) Separate payment is not allowed for the anesthesia complicated by the physical status of the MAP eligible recipient.

J. Vision: MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for a MAP eligible recipient. MAD pays for the correction of refractive errors required by the condition of the MAP eligible recipient. All services must be furnished within the limits of the MAD benefits package, 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.

(1) Vision exam: MAD covers routine eye exams. Coverage for an eligible adult recipient 21 years of age and older of age is limited to one routine eye exam in a 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma, will be covered for required follow-up and treatment. The medical condition must be clearly documented on the MAP eligible recipient's visual examination record and indicated by diagnosis on the claim. Exam coverage for a MAP eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period.

(2) Noncovered vision services: MAD does not cover vision services that are performed for aesthetic or cosmetic purposes. MAD covers orthoptic assessments and treatments only when specific criteria are met to assure medical necessity.

K. Hearing: All audiology screening, diagnostic, preventive or corrective services require medical clearance. Audiologic and vestibular function studies are rendered by an audiologist or a PCP. Hearing aid dealers and dispensers are not reimbursed for audiological, audiometric or other hearing tests. Only licensed audiologists and PCPs are reimbursed for providing these testing services.

L. Client medical transportation: MAD covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health examination and treatment for a MAP eligible recipient in or out of their home community. See 42 CFR 440.170. Travel expenses include the cost of transportation by long distance common carrier, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the MAP eligible recipient. When medically necessary, MAD covers similar expenses for an attendant who accompanies the MAP eligible recipient to the medical or behavioral health examination or treatment. MAD reimburses a MAP eligible recipient or the transportation provider for medically necessary transportation subject to the following.

(1) Free alternatives: Alternative transportation services which may be provided free of charge include volunteers, relatives or transportation services provided by a nursing facility (NF) or another residential center. A MAP eligible recipient must certify in writing that they do not have access to free alternatives.

(2) Least costly alternatives: MAD covers the most appropriate and least costly transportation alternatives suitable for the MAP eligible recipient's medical or behavioral health condition. If a MAP eligible recipient can use a private vehicle or public transportation, those alternatives must be used before the MAP eligible recipient can use more expensive transportation alternatives.

(3) Non-emergency transportation service:

(a) MAD covers non-emergency transportation services for a MAP eligible recipient who does not have primary transportation to a MAD covered service and who is unable to access a less costly form of public transportation.

(b) MAP eligible recipients released from incarceration at a correctional facility may be transported by a New Mexico medicaid transportation provider to a pharmacy to fill and retrieve prescribed medication. The eligible recipient must have a valid prescription that is qualified to be filled or re-filled at the time of their release from incarceration.

(4) Long distance common carriers: MAD covers long distance services furnished by a common carrier if the MAP eligible recipient must leave their home community to receive medical or behavioral health services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through the MAP eligible recipient's local county income support division (ISD) office.

(5) Ground ambulance services: MAD covers services for a MAP eligible recipient provided by ground ambulances when:

(a) an emergency which requires ambulance service is certified by the attending provider or is documented in the provider's records as meeting emergency medical necessity as defined as:

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

(ii) medical necessity for ambulance services is established if the MAP eligible recipient's condition is such that the use of any other method of transportation is contraindicated and would endanger the MAP eligible recipient's health.

(b) Scheduled, non-emergency ambulance services: These services are covered when ordered by the MAP eligible recipient's attending provider who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's medical or behavioral condition.

(c) Reusable items and oxygen: MAD covers non-reusable items and oxygen required during transportation. Coverage for these items is included in the base rate reimbursement for a ground ambulance;

(6) Air ambulance services: MAD covers services for a MAP eligible recipient provided by an air ambulance, including a private airplane, if an emergency exists and the medical necessity for the service is certified by their attending provider.

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

(b) MAD covers the following services for air ambulances:

(i) non-reusable items and oxygen required during transportation;

(ii) professional attendants required during transportation; and

(iii) detention time or standby time up to one hour without provider documentation; if the detention or standby time is more than one hour, a statement from the attending provider or flight nurse justifying the additional time is required.

(7) Lodging services: MAD covers lodging services if a MAP eligible recipient is required to travel to receive medical or behavioral health services and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, in-state lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15-calendar days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the attending provider's statement of need. Authorization forms for direct payment to a MAD approved lodging provider by MAD are available through local county ISD offices. In addition, overnight lodging could include the following situations:

(a) a MAP eligible recipient who is required to travel more than four hours each way to receive medical or behavioral health services; or

(b) a MAP eligible recipient who is required to travel less than four hours each way and is receiving daily medical or behavioral health services and is not sufficiently stable to travel or must be near a facility because of the potential need for emergency or critical care.

(8) Meal services: MAD covers meals if a MAP eligible recipient is required to leave their home community for eight hours or more to receive medical or behavioral health services. Authorization forms for direct payment to a meal provider by MAD are available through local county ISD offices.

(9) Coverage for attendants: MAD covers transportation, meals and lodging in the same manner as for a MAP eligible recipient for one attendant if the medical necessity for the attendant is certified in writing by the MAP eligible recipient's attending provider or the MAP eligible recipient who is receiving medical service is under 18 years of age. MAD only covers transportation services or related expenses for a MAP eligible recipient and as certified, their attendant. Transportation services and related expenses will not be reimbursed by MAD for any other individual accompanying the MAP eligible recipient to a MAD covered medical or behavioral health service.

(10) Coverage for a MAP eligible waiver recipient: Transportation of a MAP eligible waiver recipient to a provider of a waiver service is only covered when the service is occupational therapy, physical therapy, speech therapy or an outpatient behavioral health therapy.

(11) Out-of-state transportation and related expenses: All out-of-state transportation, meals and lodging must be prior approved by MAD or its designee. Out-of-state transportation is approved only if the out-of-state medical or behavioral health service is approved by MAD or its designee. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in the state of New Mexico.

(a) Requests for out-of-state transportation must be coordinated through MAD or its designee;

(b) Authorization for lodging and meal services by an out-of-state provider can be granted for up to 30-calendar days by MAD or its designee. Re-evaluation authorizations are completed prior to expiration and every 30-calendar days, thereafter.

(c) Border cities: A border city is a city within 100 miles of a New Mexico border (Mexico excluded). Transportation to a border city is treated as in-state provider service. A MAP eligible recipient who receives a MAD reimbursable service from a border area provider is eligible for transportation services to that provider. See 8.302.4 NMAC, to determine when a provider is considered an out-of-state provider or a border area provider.

(12) Client medical transportation fund: In a non-emergency situation, a MAP eligible recipient can request reimbursement from the client medical transportation (CMT) fund through their local county ISD office for money spent on transportation, meals and lodging by the MAP eligible recipient; for reimbursement from the CMT fund, a MAP eligible recipient must apply for reimbursement within 30-calendar days from the date of appointment or the date they are discharged from the hospital.

(a) Information requirements: The following information must be furnished to the ISD CMT fund custodian within 30-calendar days of the MAD approved provider visit to receive reimbursement:

(i) submit a letter on the provider's stationary which indicates that the MAP eligible recipient kept the appointment for which the CMT fund reimbursement is requested; for medical or behavioral health services, written receipts confirming the date of service must be given to the MAP eligible recipient for submission to the local county ISD office;

(ii) proper referral with original signatures and documentation stating that the MAD services are not available within the community from the MAD requesting provider, when a referral is necessary;

(iii) verification of current eligibility of the recipient for a MAD service for the month the appointment and travel is made;

(iv) certification that free alternative transportation services are not available and that the MAP eligible recipient is not enrolled in a HCA contracted managed care organization (MCO);

(v) verification of mileage; and

(vi) documentation justifying a medical attendant.

(b) Preparation of referrals for travel outside the home community: If a MAP eligible recipient must travel over 65 miles from their home community to receive medical care, the transportation provider must obtain a written verification from the referring provider or from the service provider containing the following information for the provider to retain with their billing records:

(i) the medical, behavioral health or diagnostic service for which the MAP eligible recipient is being referred;

(ii) the name of the out of community medical or behavioral health provider; and

(iii) justification that the medical or behavioral health care is not available in the home community.

(c) Fund advances in emergency situations: Money from the CMT fund is advanced for travel only if an emergency exists. An emergency is defined in this instance as a non-routine, unforeseen accident, injury or acute illness demanding immediate action and for which transportation arrangements could not be made five calendar days in advance of the visit to the provider. Advance funds must be requested and disbursed prior to the medical or behavioral health appointment.

(i) The ISD CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate utilization review (UR) contractor verifies that the recipient is eligible for a MAD service and has a medical or behavioral health appointment prior to advancing money from the CMT fund and that the MAP eligible recipient is not enrolled in a HCA contracted MCO;

(ii) written referral for out of community service must be received by the CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate UR contractor no later than 30-calendar days from the date of the medical or behavioral health appointment for which the advance funds were requested. If a MAP eligible recipient fails to provide supporting documentation, recoupment proceedings are initiated; see Section OIG-900, Restitutions.

(d) MAP Eligible recipients enrolled in a HCA contracted MCO: A member enrolled in HCA contracted MCO on the date of service is not eligible to use the client medical transportation fund for services that are the responsibility of the MAP eligible recipient's MCO.

(13) Noncovered transportation services: Transportation services are subject to the same limitations and coverage restrictions which exist for other services. A payment for transportation to a non-covered MAD service is subject to retroactive recoupment. MAD does not cover the following services or related costs of travel:

(a) an attendant where there is not the required certification from the MAP eligible recipient's medical or behavioral health provider;

(b) minor aged children of the MAP eligible recipient that are simply accompanying them to medical or behavioral health services;

(c) transportation to a non-covered MAD service;

(d) transportation to a pharmacy provider with the exception for justice-involved MAP eligible recipients who are released from incarceration at a correctional facility within the first seven days of release; see 8.324.7 NMAC.

M. Telehealth services:

(1) Telemedicine visits: An interactive HIPAA compliant telecommunication system must include both interactive audio and video and be delivered on a real-time basis at the originating and distant sites. If real-time audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person as a face to face encounter. Coverage for services rendered through telemedicine shall be determined in a manner consistent with medicaid coverage for health care services provided through in person consultation. For telemedicine services, when the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and regulations or meet federal requirements for providing services to IHS facilities or tribal contract facilities. Provision of telemedicine services does not require that a certified medicaid healthcare provider be physically present with the MAP eligible recipient at the originating site unless the telemedicine consultant at the distant site deems it necessary.

(a) Telemedicine originating-site: The location of a MAP eligible recipient at the time the service is being furnished via an interactive telemedicine communications system. The origination-site can be any of the following medically warranted sites where services are furnished to a MAP eligible recipient.

(i) The office of a physician or practitioner.

(ii) A critical access hospital (as described in section 1861 (mm)(1) of the Act).

(iii) A rural health clinic (as described in 1861 (mm)(2) of the Act).

(iv) A federally qualified health center (as defined in section 1861 (aa)(4) of the Act).

(v) A hospital (as defined in section 1861 (e) of the Act).

(vi) A hospital-based or critical access hospital-based renal dialysis center (including satellites).

(vii) A skilled nursing facility (as defined in section 1819(a) of the Act).

(viii) A community mental health center (as defined in section 1861(ff)(3)(B) of the Act).

(ix) A renal dialysis facility (only for the purposes of the home dialysis monthly ESRD-related clinical assessment in section 1881(b)(3)(B) of the Act).

(x) The home of an individual (only for purposes of the home dialysis ESRD-related clinical assessment in section 1881(b)(3)(B) of the Act).

(xi) A mobile stroke unit (only for the purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke provided in accordance with section 1834(m)(6) of the Act).

(xii) The home of an individual (only for the purposes of treatment of a substance use disorder or a co-occurring mental health disorder), furnished on or after July 1, 2019, to an individual with a substance use disorder diagnosis.

(xiii) The home of an individual when an interactive audio and video telecommunication system that permits real-time visit is used between the eligible provider and the MAP eligible recipient.

(xiv) A School Based Health Center (SBHC) as defined by section 2110(c)(9) of the Act.

(b) Telemedicine distant-site: The location where the telemedicine provider is physically located at the time of the telemedicine service. All services are covered to the same extent the service and the provider are covered when not provided through telemedicine. For these services, use of the telemedicine communications system fulfills the requirement for a face-to-face encounter.

(c) Telemedicine reimbursement: MAD covers both distant (where the eligible provider is located) as well as the originating sites (where the MAP eligible recipient is located, if another eligible provider accompanies the patient). If audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person and no additional reimbursement is made.

(d) Telemedicine providers: Reimbursement for professional services at the originating-site and the distant-site are made at the same rate as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for a real-time interactive audio/video technology telemedicine system fee (where the MAP eligible recipient is located, if another eligible provider accompanies the patient) at the lesser of the provider's billed charge, or the maximum allowed by MAD for the specific service of procedure. If the originating site is the patient's home, the originating site fee should not be billed if the eligible provider does not accompany the MAP eligible recipient. The MAP eligible recipient is not reimbursed for their computer/internet.

(e) A telemedicine originating-site communication system fee is covered if the MAP eligible recipient was present at and participated in the telemedicine visit at the originating-site and the system that is used meets the definition of a telemedicine system.

(2) Telephone visits: MAD will reimburse eligible providers for limited professional services delivered by telephone without video. No additional reimbursement is made to the originating-site for an interactive telemedicine system fee.

(3) MAD will reimburse for services delivered through store-and-forward. To be eligible for payment under store-and-forward, the service must be provided through the transference of digital images, sounds, or previously recorded video from one location to another; to allow a consulting provider to obtain information, analyze it, and report back to the referring physician providing the telemedicine consultation. Store-and-forward telemedicine includes encounters that do not occur in real time (asynchronous) and are consultants that do not require face-to-face live encounter between patient and telemedicine provider.

(4) Noncovered telemedicine services: A service provided through telemedicine is subject to the same program restrictions, limitations and coverage which exist for the service when not provided through telemedicine. Telemedicine services are not covered when audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting.

N. Pregnancy termination services: MAD does not cover the performance of 'elective' pregnancy termination procedures. MAD will only pay for services to terminate a pregnancy when certain conditions are met.

(1) Prior to performing pregnancy termination services providers must complete and file in the MAP eligible recipient medical record, a consent for pregnancy termination that includes written certification of a provider that the procedure meets one of the following conditions:

(a) the procedure is necessary to save the life of the MAP eligible recipient as certified in writing by a provider;

(b) the pregnancy is a result of rape or incest, as certified by the treating provider, the appropriate reporting agency, or if not reported, the MAP eligible recipient is not physically or emotionally able to report the incident; or

(c) the procedure is necessary to terminate an ectopic pregnancy; or

(d) the procedure is necessary because the pregnancy aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical, emotional or mental health of the MAP eligible recipient.

(2) Psychological services: MAD covers behavioral health services for a pregnant MAP eligible recipient.

(3) Oral medications: MAD covers oral medications approved by the FDA have been determined a benefit by MAD for pregnancy termination. MAD will cover oral medications when administered by a provider acting within the scope of their practice board and licensure.

(4) Informed consent: Under New Mexico law, the provider may not require any MAP eligible recipient to accept any medical service, diagnosis, or treatment or to undergo any other health service provided under the plan if the MAP eligible recipient objects on religious grounds or in the case of a non-emancipated MAP eligible recipient, the legal parent or guardian of the non-emancipated MAP eligible recipient objects.

(a) Consent: Voluntary, informed consent by a MAP eligible recipient 18 years of age and older, or an emancipated minor MAP eligible recipient must be given to the provider prior to the procedure to terminate pregnancy, except in the following circumstances:

(i) in instances where a medical emergency exists; a medical emergency exists in situations where the attending PCP certifies that, based on the facts of the case presented, in their best clinical judgment, the life or the health of the MAP eligible recipient is endangered by the pregnancy so as to require an immediate pregnancy termination procedure;

(ii) in instances where the MAP eligible recipient is unconscious, incapacitated, or otherwise incapable of giving consent; in such circumstances, the consent shall be obtained as prescribed by New Mexico law;

(iii) in instances where pregnancy results from rape or incest or the continuation of the pregnancy endangers the life of the MAP eligible recipient;

(iv) consent is valid for 30-calendar days from the date of signature, unless withdrawn by the MAP eligible recipient prior to the procedure.

(b) Required acknowledgements: In signing the consent, the MAP eligible recipient must acknowledge that they have received, at least, the following information:

(i) alternatives to pregnancy termination;

(ii) medical procedure(s) to be used;

(iii) possibility of the physical, mental, or both, side effects from the performance of the procedure;

(iv) right to receive pregnancy termination behavioral health services from an independent MAD provider; and

(v) right to withdraw consent up until the time the procedure is going to be performed.

(c) Record retention: A dated and signed copy of the consent, with counseling referral information, if requested, must be given to the MAP eligible recipient. The provider must keep the original signed consent with the MAP eligible recipient's medical records.

(d) Consent for a MAP eligible recipient under 18 years of age who is not an emancipated minor, in instances not involving life endangerment, rape or incest: Informed written consent for an non-emancipated minor to terminate a pregnancy must be obtained, dated and signed by a parent, legal guardian, or another adult acting 'in loco parentis' to the minor. An exception is when the minor objects to parental involvement for personal reasons or the parent, guardian or adult acting 'in loco parentis' is not available. The treating PCP shall note the minor's objections or the unavailability of the parent or guardian in the minor's chart, and:

(i) certify in their best clinical judgment, the minor is mature enough and well enough informed to make the decision about the procedure; in the circumstance where sufficient maturity and information is not present or apparent, certify that the procedure is in the minor's best interests based on the information provided to the treating PCP by the minor; or

(ii) refer the minor to an independent MAD behavioral health provider in circumstances where the treating PCP believes behavioral health services are necessary before a clinical judgment can be rendered on the criteria established in Paragraph (1) above; the referral shall be made on the same day of the visit between the minor and the treating PCP where consent is discussed; the independent MAD behavioral health provider shall meet with the minor and confirm in writing to the treating PCP whether or not the minor is mature enough and sufficiently informed to make the decision about the procedure; in the circumstance where sufficient maturity and information is not present or apparent, that the procedure is in the minor's best interests based on the information provided to the independent MAD behavioral health provider by the minor; this provider's written report is due to the treating PCP within 72 hours of initial referral;

(iii) a minor shall not be required to obtain behavioral health services referenced in Paragraph (2) above; however, if the treating PCP is unable or unwilling to independently certify the requirements established in Paragraph (1) above, the minor must be informed by the treating PCP that written consent must be obtained by the parent, legal guardian or parent 'in loco parentis' prior to performing the procedure; or, that the minor must obtain a court order allowing the procedure without parental consent.

O. Behavioral health professional services: Behavioral health services are addressed specifically in 8.321.2 NMAC.

P. Experimental or investigational services: MAD covers 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. MAD does not cover experimental or investigational medical, surgical or health care procedures or treatments, including the use of drugs, biological products, other products or devices, except the following:

(1) Phase I, II, III or IV: MAD may approve coverage for routine patient care costs incurred as a result of the MAP eligible recipient's participation in a phase I, II, III, or IV cancer trial that meets the following criteria. The cancer clinical trial is being conducted with the approval of at least one of the following:

(a) one of the federal national institutes of health;

(b) a federal national institutes of health cooperative group or center;

(c) the federal department of defense;

(d) the FDA in the form of an investigational new drug application;

(e) the federal department of veteran affairs; or

(f) a qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility.

(2) Review and approval: The clinical trial has been reviewed and approved by an institutional review board that has a multiple project assurance contract approved by the office of protection from research risks of the federal national institutes of health.

(3) Experimental or investigational interventions: Any medical, surgical, or other healthcare procedure or treatment, including the use of a drug, a biological product, another product or device, is considered experimental or investigational if it meets any of the following conditions:

(a) current, authoritative medical and scientific evidence regarding the medical, surgical, or other health care procedure or treatment, including the use of a drug, a biological product, another product or device for a specific condition shows that further studies or clinical trials are necessary to determine benefits, safety, efficacy and risks, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting;

(b) the drug, biological product, other product, device, procedure or treatment (the "technology") lacks final approval from the FDA or any other governmental body having authority to regulate the technology;

(c) the medical, surgical, other health care procedure or treatment, including the use of a drug, a biological product, another product or device is the subject of ongoing phase I, II, or III clinical trials or under study to determine safety, efficacy, maximum tolerated dose or toxicity, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting.

(4) Review of conditions: On request of MAD or its designee, a provider of a particular service can be required to present current, authoritative medical and scientific evidence that the proposed technology is not considered experimental or investigational.

(5) Reimbursement: MAD does not reimburse for medical, surgical, other health care procedures or treatments, including the use of drugs, biological products, other products or devices that are considered experimental or investigational, except as specified as follows. MAD will reimburse a provider for routine patient care services, which are those medically necessary services that would be covered if the MAP

eligible recipient were receiving standard cancer treatment, rendered during the MAP eligible recipient's participation in phase I, II, III, or IV cancer clinical trials.

(6) Experimental or investigational services: MAD does not cover procedures, technologies or therapies that are considered experimental or investigational.

Q. Smoking/Tobacco cessation: MAD covers tobacco cessation services for all MAP eligible recipients.

(1) Eligible medical, dental, and behavioral health practitioner: Cessation counseling services may be provided by one of the following:

(a) by or under the supervision of a physician; or

(b) by any other MAD enrolled health care professional authorized to provide other MAD services who is also legally authorized to furnish such services under state law;

(c) generally, eligible practitioners would be medical practitioners, including independently enrolled CNPs, behavioral health and dental practitioners; physician assistants and CNPs not enrolled as independent MAD providers, and registered nurses and dental hygienists may bill for counseling services through the enrolled entity under which their other services are billed, when under the supervision of a dentist or physician;

(d) counseling service must be prescribed by a MAD enrolled licensed practitioner.

(2) Eligible pharmacy providers: For rendering tobacco cessation services, eligible pharmacists are those who have attended at least one continuing education course on tobacco cessation in accordance with the federal public health guidelines found in the United States department of health and human services; public health services' *quick reference guide for clinicians*, and *treating tobacco use and dependence*.

(3) Tobacco cessation drug items: MAD covers all prescribed tobacco cessation drug items for a MAP eligible recipient as listed in this section when ordered by a MAD enrolled prescriber and dispensed by a MAD enrolled pharmacy. MAD does not require prior authorization for reimbursement for tobacco cessation products, but the items must be prescribed by a MAD enrolled practitioner. Tobacco cessation products include, but are not limited to the following:

(a) sustained release buproprion products;

(b) varenicline tartrate tablets; and

(c) prescription and over-the-counter (OTC) nicotine replacement drug products, such as lozenges, patches, gums, sprays and inhalers.

(4) Covered services: MAD makes reimbursement for assessing all MAP eligible recipient's tobacco dependence including a written tobacco cessation treatment plan of care as part of an evaluation and management (E&M) service, and may bill using the E&M codes. MAD covers face-to-face counseling when rendered by an appropriate provider. The effectiveness of counseling is comparable to pharmacotherapy alone. Counseling plus medication provides additive benefits. Treatment may include prescribing any combination of tobacco cessation products and counseling. Providers can prescribe one or more modalities of treatment. Cessation counseling session refers face-to-face MAP eligible recipient contact of either

(a) intermediate session (greater than three minutes up to 10 minutes); or

(b) intensive session (greater than 10 minutes).

(5) Documentation for counseling services: Ordering and rendering practitioners must maintain sufficient documentation to substantiate the medical necessity of the service and the services rendered, which may consist of documentation of tobacco use. The rendering practitioner must maintain documentation that face-to-face counseling was prescribed by a practitioner, even if the case is a referral to self, consistent with other NMAC rules and other materials.

(6) Limitations on counseling sessions: The services do not have any limits on the length of treatment or quit attempts per year. The program also allows participants to try multiple treatments and does not impose any requirement to enroll into counseling. During the 12-month period, the practitioner and the MAP eligible recipient have flexibility to choose between intermediate or intensive counseling modalities of treatment for each session.

R. Screening, brief intervention and referral to treatment (SBIRT) service: SBIRT is a community-based practice designed to identify, reduce and prevent problematic substance use or misuse and co-occurring mental health disorders as an early intervention. Through early identification in a medical setting, SBIRT services expand and enhance the continuum of care and reduce costly health care utilization. The primary objective is the integration of behavioral health with physical health care. SBIRT is delivered through a process consisting of universal screening, scoring the screening tool and a warm hand-off to a SBIRT trained professional who conducts a face-to-face brief intervention for positive screening results. If the need is identified for behavioral health treatment, the certified SBIRT staff, with the eligible recipient's approval, assists in securing behavioral health services. Only

a physical health office, clinic, or facility who has been certified by a HCA approved SBIRT trainer and uses the approved healthy lifestyle questionnaire (HLQ) can complete the screen. The physical office, clinic or facility must be the billing provider, not the individual practitioner. All practitioners must be SBIRT certified and are employees or contractors of a SBIRT physical health office, clinic or facility. See the SBIRT policy and billing manual for detailed description of the service and billing requirements.

S. Other services: Other covered and noncovered services including hospitalization and other residential facilities, devices for hearing and vision correction, behavioral health services, home and community based services, EPSDT services, case management and other adjunct and specialty services are described in other NMAC rules.

[8.310.2.12 NMAC - Rp, 8.310.2.12 NMAC, 1/1/2014; A, 8/10/2021; A, 4/5/2022]

8.310.2.13 GENERAL NONCOVERED SERVICES

A. General noncovered services: MAD does not cover certain procedures, services, or miscellaneous items. See specific provider or service rules or sections of this rule for additional information on service coverage and limitations. A provider cannot turn an account over to collections or to any other factor intending to collect from the MAP eligible recipient or their authorized representative; see 8.302.2 NMAC. A provider cannot bill a MAP eligible recipient or their authorized representative for the copying of the MAP eligible recipient's records, and must provide copies of the MAP eligible recipient's records to other providers upon request of the MAP eligible recipient.

B. Appointment, interest and carrying charges: MAD does not cover penalties on payments for broken or missed appointments, costs of waiting time, or interest or carrying charges on accounts. A provider may not bill a MAP eligible recipient or their authorized representative for these charges or the penalties associated with missed or broken appointments or failure to produce eligibility cards, with the exception of MAP recipient eligibility categories of CHIP or WDI who may be charged up to $5 for a missed appointment.

C. Contract services: Services furnished by a contractor, an organization, or an individual who is not the billing provider must meet specific criteria for coverage as stated in MAD or its designee's NMAC rules, billing instructions, policy manuals; see 8.302.2 NMAC.

D. Cosmetic services and surgeries: MAD does not cover cosmetic items or services that are prescribed or used for aesthetic purposes. This includes items for aging skin, for hair loss, and personal care items such as non-prescription lotions, shampoos, soaps or sunscreens. MAD does not cover cosmetic surgeries performed for aesthetic purposes. "*Cosmetic surgery*" is defined as a procedure performed to improve the appearance of physical features that may or may not improve the functional ability of the area of concern. MAD covers only a surgery that meets specific criteria and is approved as medically necessary reconstructive surgery.

E. Postmortem examinations: MAD does not cover postmortem examinations.

F. Education or vocational services: MAD does not cover literature, booklets, and other educational materials. Dietary counseling is covered only for a MAP eligible recipient under 21 years of age, as part of the EPSDT program and for a pregnant MAP eligible recipient. MAD does not cover formal educational or vocational training services, unless those services are included as active treatment services for a MAP eligible recipient in intermediate care facility for individuals with intellectual disabilities (ICF-IID)or for a MAP eligible recipient under 21 years of age receiving inpatient psychiatric services [42 CFR 441.13(b)]. "*Formal educational services*" relate to training in traditional academic subjects. Vocational training services relate to organized programs directly related to the preparation of a MAP eligible recipient for paid or unpaid employment.

G. Hair or nail analysis: MAD does not cover hair or nail analysis.

H. Preparations dispensed for home use: MAD does not cover oral, topical, otic, or ophthalmic preparations dispensed to a MAP eligible recipient by a PCP, a CNP, a P.A., or an optometrist for home use or self administration unless authorized by MAD to assure the availability of medications.

I. Routine physical examinations: MAD only covers a routine physical examination for:

(1) a MAP eligible recipient residing in a NF or an ICF-IID facility.

(2) a MAP eligible recipient under 21 years of age through the tot to teen health check screen, New Mexico's EPSDT screening program. Included in the coverage is the physical examinations, screenings and treatment.

J. Screening services: MAD does not cover screening services that are not used to make a diagnosis, such as chromosome screening, hypertension screening, diabetic screening, general health panels, executive profiles, paternity testing, or premarital screens. MAD covers screening services for a MAP eligible recipient under 21 years of age through the tot to teen healthcheck program. MAD covers screening services

ordered by a provider for cancer detection such as pap smears and mammograms for a MAP eligible recipient when medically appropriate.

K. Services not covered by medicare: MAD does not cover services, procedures, or devices that are not covered by medicare due to their determination that the service is not medically necessary or that the service is experimental or not effective.

L. Bariatric surgery services: Bariatric surgery services are covered only when medically indicated and alternatives are not successful.

M. Services and tests which are not routinely warranted due to the MAP eligible recipient's age: MAD does not reimburse for routine screening, tests, or services which are not medically necessary due to the age of the MAP eligible recipient:

(1) Papanicolaou test (pap smear) for women under 21 years of age unless prior history or risk factors make the test medically warranted; and

(2) prostate specific antigen (PSA) test for men under age 40 unless prior history or risk factors make the test medically warranted.

N. Services for surrogate mothers: MAD does not pay for services for pregnancy, complications encountered during pregnancy related conditions, prenatal care and postpartum care, or delivery for services to a surrogate mother for which an agreement or contract between the surrogate mother and another party exists.
[8.310.2.13 NMAC - Rp, 8.310.2.14 NMAC, 1/1/2014; A, 8/10/2021; A, 4/5/2022]

8.310.2.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. The provider must contact HCA or its authorized agents to request UR instructions. It is the provider'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 HCA, the provider must follow that contractor's instructions for authorization of services.

A. Prior authorization: Procedures or services may require a prior authorization from MAD or its designee. Services for which a prior authorization was obtained remain subject to UR at any point in the payment process, including after payment has been made. It is the provider'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.

(1) Dental services: MAD covers certain services, including some diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, maxillofacial prosthetic, oral surgery, and orthodontic services only when a prior authorization is received from MAD or its designee. MAD covers medically necessary orthodontic services to treat handicapping malocclusions for a MAP eligible recipient under 21 years of age by prior authorization.

(2) Transplantation services**:** A written prior authorization must be obtained for any transplant, with the exception of a cornea and a kidney. The prior authorization process must be started by the MAP eligible recipient's attending PCP contacting the MAD UR contractor. Services for which prior approval was obtained remain subject to UR at any point in the payment process.

(3) Pregnancy termination services: Services to terminate a pregnancy do not require a prior authorization from MAD or its designee.

(4) Eligibility determination: The prior authorization of a service does not guarantee that an individual is eligible for MAD or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if a MAP eligible recipient has other health insurance.

(5) Reconsideration: A provider who disagrees with a prior authorization -request denial or another review decision can request reconsideration; see 8.350.2 NMAC.

B. Prior authorization and UR: MAD has developed a UR process to regulate provider compliance with MAD quality control and cost containment objectives. See 42 CFR Section 456. Specific details pertinent to a service or a provider are contained in NMAC rules or UR instructions for that specific service or provider type. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instruction, UR instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these

instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of their MAD provider participation agreement (PPA) and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. A provider must supply necessary information in order for payment to be made.

C. Medical necessity requirements: MAD reimburses a provider for furnishing MAD covered service to a MAP eligible recipient only when the service is medically necessary. Medical necessity is required for the specific service, level of care (LOC), and service setting, if relevant to the service. A provider must verify that MAD covers a specific service and that the service is medically necessary prior to furnishing the service. Medical necessity determinations are made by professional peers based on established criteria, appropriate to the service that are reviewed and approved by MAD. MAD denies payment for services that are not medically necessary and for services that are not covered by MAD. The process for determining medical necessity is called UR. The UR of a MAD service may be performed directly by MAD or its designee, or another state agency designated by MAD.

D. Timing of UR:

(1) A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD PPA, a provider agrees to cooperate fully with MAD or its designee in their performance of any review and agree to comply with all review requirements. The following are examples of the reviews that may be performed:

(a) prior authorization review (review occurs before the service is furnished);

(b) concurrent review (review occurs while service is being furnished);

(c) pre-payment review (claims review occurring after service is furnished but before payment);

(d) retrospective review (review occurs after payment is made); and

(e) one or more reviews may be used by MAD to assess the medical necessity and program compliance of any service.

(2) Prior authorization reviews: A claim for a service that requires a prior authorization are paid only if the prior authorization was obtained and approved by MAD or MAD's UR contractor, prior to services being furnished. A prior authorization specifies the approved number of service units that a provider is authorized to furnish to a MAP eligible recipient and the date the service must be provided.

(a) A prior authorization does not guarantee that an individual is eligible for a specific MAD service. A provider must verify that individuals are eligible for a specific MAD service at the time the service is furnished.

(b) Information on the specific service or procedure that requires a prior authorization for a specific provider type are contained in the applicable MAD rules and the UR instructions for that provider type or service.

(c) A service that has been approved by MAD or its designee does not prevent a later denial of payment if the service has been determined to be not medically necessary or if the individual was not eligible for the service.

(d) A prior authorization review is used to authorize service for a MAP eligible recipient before a service is furnished. A request for a retroactive prior authorization may be approved only under the following circumstances:

(i) approval is made as part of the process of determining MAD eligibility for certain categories, such as a MAD institutional care or home and community-based services waiver (HCBSW) programs. In these situations, the determination of medical necessity for an institutional LOC of the service is a factor in establishing MAD eligibility and may be made after the MAP eligible recipient receives NF or HCBSW services;

(ii) the service is furnished before the determination of the effective date of the recipient's MAP eligibility for a MAD service or the servicing provider's MAD PPA; a retrospective request for a prior authorization is based on retrospective recipient or provider eligibility must be received in writing by MAD or its designee within 30 calendar days of the date of the eligibility determination;

(iii) in cases of medical emergency; a medical emergency is defined as a medical condition, manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could be reasonably expected to result in one of the following: an individual's death; placement of an individual's health in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part;

(iv) a service that is furnished to a medicare recipient who is also eligible for a MAD service and medicare has denied payment for a reason that is not based on medical necessity; requests for a retroactive prior authorization must be accompanied by a copy of the document from medicare that denied payment and states the reason for denial; a service denied payment by medicare because of lack of medical necessity is not covered by MAD.

(3) Concurrent review: A concurrent review is conducted while the service is being furnished. A continued stay or continued service review is concurrent review for medical necessity.

(4) Prepayment review: A prepayment review is conducted after a service has been furnished and a claim for payment has been filed by the provider. If a service is not a covered MAD benefit or not medically necessary, payment for that service will be denied.

(5) Retrospective review: A retrospective review is conducted after the claim has been processed and payment is made. Information from the paid claim is compared with the provider records detailing the service and medical necessity.

(a) If MAD determines the service specified on the claim was not performed or, was not a covered benefit or was not medically necessary, the MAD payment is recouped.

(b) Retrospective review involves the review of a specific portion or the entire record of service. Depending on the service, validation of either or both the diagnosis or procedure, validation of diagnostic related groups (DRGs), and quality of care are examples of indicators or issues which may be reviewed.

(c) A retrospective review may be conducted by MAD or its designee on a random or selective basis. In addition to reviews performed by a MAD staff or its designee, MAD analyzes statistical data to determine utilization patterns. Specific areas of overutilization may be identified that result in recoupment or repayment from either or both a provider or the assignment of a MAP eligible recipient to a MAD medical management designated provider.

(d) A selective or scheduled review is conducted to focus on the overutilization and underutilization of a specific service or provider. The service or procedure selected for this focused retrospective review is identified by MAD as potential or actual problems.

E. Denial of payment: If a service or procedure is not medically necessary or not a covered MAD service, MAD may deny a provider'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.

F. Review of decisions: A provider who 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 who is not satisfied with the reconsideration determination may request a HCA provider administrative hearing; see 8.352.3 NMAC.
[8.310.2.14 NMAC - Rp, 8.310.2.15 NMAC, 1/1/2014]

HISTORY OF 8.310.2 NMAC:
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ISD 310.0100, Physician Services, filed 1/9/1980.
ISD 310.0100, Physician Services, filed 6/16/1980.
ISD 310.0100, Physician Services, filed 4/2/1982.
ISD-Rule-310.0100, Physician Services, filed 9/2/1983.
ISD-Rule-310.0100, Physician Services, filed 3/30/1984.
ISD-Rule-310.0100, Physician Services, filed 4/26/1984.
ISD-Rule-310.0100, Physician Services, filed 2/25/1986.
MAD Rule 310.01, Physician Services, filed 12/15/1987.
MAD Rule 310.01, Physician Services, filed 4/27/1988.
MAD Rule 310.01, Physician Services, filed 4/20/1992.
MAD Rule 310.01, Physician Services, filed 3/10/1994.
SP-004.0400, Section 4, General Program Administration Medicaid Quality Control, filed, 1/23/1981
SP-003.0103, Standards and Methods for Assuring High Quality Care, filed 1/27/1981.
SP-004.1400, Section 4, General Program Administration Utilization Control, filed 3/3/1981.
MAD Rule 310.27, Anesthesia Services, filed 7/2/1990.
ISD 310.1000, Vision Care Services, filed 2/13/1980.
ISD 310.1000, Vision Care Services, filed 7/8/1982.

ISD Rule 310.1000, Vision Care Services, filed 2/28/1983.
ISD Rule 310.1000, Vision Care Services, filed 8/23/1984.
MAD Rule 310.10, Vision Care Services, filed 12/15/1987.
MAD Rule 310.10, Vision Care Services, filed 10/26/1988.
MAD Rule 310.10, Vision Care Services, filed 4/20/1992.
ISD 310.0900, Dental Services, filed 2/13/1980.
ISD 310.0900, Dental Services, filed 6/8/1981.
ISD 310.0900, Dental Services, filed 10/14/1983.
MAD Rule 310.09, Dental Services, filed 4/20/1992.
MAD Rule 310.09, Dental Services, filed 11/12/1993.
ISD 310.1500, Psychiatric and Psychological Services, filed 2/13/1980.
ISD Rule 310.1500, Psychiatric and Psychological Services, filed 2/7/1986.
MAD Rule 310.15, Psychiatric and Psychological Services, filed 12/15/1987.
ISD Rule 310.1900, Certified Nurse Midwife Services, filed 9/19/1983.
MAD Rule 310.19, Certified Nurse Midwife Services, filed 12/15/1987.
MAD Rule 310.19, Midwife Services, filed 8/31/1989.
ISD 310.1100, Podiatry Services, filed 2/13/1980.
ISD 310.1100, Podiatry Services, filed 10/14/1981.
ISD Rule 310.1100, Podiatry Services, filed 2/28/1983.
ISD Rule 310.1100, Podiatry Services, filed 2/21/1986.
MAD Rule 310.11, Podiatry Services, filed 12/15/1987.
MAD Rule 310.11, Podiatry Services, filed 4/27/1988.
MAD Rule 310.11, Podiatry Services, filed 4/20/1992.
ISD-Rule 310.2100, Dialysis Services, filed 4/8/1985.
SP-003.0400, Section 3, Services: General Provisions Special Requirements Applicable to Sterilization Procedures, filed 1/23/1981.
ISD 310.1300, Family Planning Services, filed 2/18/1980.
MAD Rule 310.13, Family Planning Services, filed 12/15/1987.
ISD 310.0200, Hospital Services, filed 1/9/1980.
ISD 310.0200, Hospital Services, filed 12/8/1980.
ISD 310.0200, Hospital Services, filed 12/30/1981.
ISD 310.0200, Hospital Services, filed 4/2/1982.
ISD 310.0200, Hospital Services, filed 7/8/1982.
ISD Rule 310.0200, Hospital Services, filed 4/5/1983.
ISD Rule 310.0200, Hospital Services, filed 2/15/1984.
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ISD Rule 310.0200, Hospital Services, filed 2/21/1986.
MAD Rule 310.02, Hospital Services, filed 12/1/1987.
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MAD Rule 310.02, Hospital Services, filed 7/2/1990.
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MAD Rule 310.02, Hospital Services, filed 7/14/1993.
MAD Rule 310.02, Hospital Services, filed 3/10/1994.
MAD Rule 310.02, Hospital Services, filed 6/15/1994.
MAD Rule 310.02, Hospital Services, filed 12/8/1994.
MAD Rule 766, Pregnancy Termination Procedures, filed 11/30/1994.

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MAD Rule 310.01, Physician Services, filed 3/10/1994 - Repealed effective 2/1/1995.
MAD Rule 310.27, Anesthesia Services, field 7/2/1990 - Repealed effective 2/1/1995.
MAD Rule 310.10, Vision Care Services, filed 4/20/1992 - Repealed effective 2/1/1995.

MAD Rule 310.09, Dental Services, filed 11/12/1993 - Repealed effective 1/8/1985.
MAD Rule 310.15, Psychiatric and Psychological Services, filed 12/15/1987 - Repealed effective 2/1/1995.
MAD Rule 310.11, Podiatry Services, filed 4/20/1992 - Repealed effective 2/1/1995.
ISD-Rule 310.2100, Dialysis Services, filed 4/8/1985 - Repealed effective 2/1/1995.
MAD Rule 310.13, Family Planning Services, filed 12/15/1987 - Repealed effective 2/1/1995.
MAD Rule 310.02, Hospital Services, filed 12/8/1994 - Repealed effective 2/1/1995.
MAD Rule 310.01, Physician Services, filed 3/10/1994 - Repealed effective 2/1/1995 and 5/1/1995.
8 NMAC 4.MAD.718.1, Midwife Services, filed 1/8/1985 - Repealed effective 1/1/2014.
8 NMAC 4.MAD.718.2, Podiatry Services, filed 1/8/1985 - Repealed effective 7/1/2004.
8 NMAC 4.MAD.762, Reproductive Health Services, filed 1/8/1985 0 Repealed effective 1/1/2014.
8.310.2 NMAC, Medical Services Providers, filed 2/16/2004 - Repealed effective 1/1/2014.
8.301.2 NMAC, General Benefit Description, filed 2/13/2006 - Repealed effective 1/1/2014.
8.301.3 NMAC, General Noncovered Services, filed 2/13/2006 - Repealed effective 1/1/2014.
8.301.6 NMAC, Client Medical Transportation, filed 2/14/2011 - Repealed effective 1/1/2014.
8.302.5 NMAC, Prior Authorization and Utilization Review, filed 12-11-03 - Repealed effective 1/1/2014.
8.310.5 NMAC, Anesthesia Services, filed 5/12/2003 - Repealed effective 1/1/2014.
8.310.6 NMAC, Vision Care Services, filed 11/2/2003 - Repealed effective 1/1/2014.
8.310.7 NMAC, Dental Services, filed 9/16/2002 - Repealed effective 1/1/2014.
8.310.8 NMAC, Behavioral Health Professional Services, filed 10-12-04 - Repealed effective 1/1/2014.
8.310.11 NMAC, Podiatry Services, field 6/16/2004 - Repealed effective 1/1/2014.
8.310.13 NMAC, Telehealth Services, filed 7/17/2007 - Repealed effective 1/1/2014.
8.324.9 NMAC, Nutrition Services, filed 2/17/2012 - Repealed effective 1/1/2014.
8.325.2 NMAC, Dialysis Services, filed 10/15/2004 - Repealed effective 1/1/2014.
8.325.5 NMAC, Transplant Services, filed 2/17/2012 - Repealed effective 1/1/2014.
8.325.6 NMAC, Experimental or Investigational Procedures, Technologies or Non-Drug Therapies, filed 5/12/2003 - Repealed effective 1/1/2014.
8.325.7 NMAC, Pregnancy Termination Procedures, filed 10/16/2003 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 3 PROFESSIONAL PROVIDERS, SERVICES AND REIMBURSEMENT

8.310.3.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.310.3.1 NMAC - Rp, 8.310.3.1 NMAC, 1/1/2023; A, 7/1/2024]

8.310.3.2 SCOPE: The rule applies to the general public.
[8.310.3.2 NMAC - Rp, 8.310.3.2 NMAC, 1/1/2023]

8.310.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.310.3.3 NMAC - Rp, 8.310.3.3 NMAC, 1/1/2023; A, 7/1/2024]

8.310.3.4 DURATION: Permanent.
[8.310.3.4 NMAC - Rp, 8.310.3.4 NMAC, 1/1/2023]

8.310.3.5 EFFECTIVE DATE: January 1, 2023, unless a later date is cited at the end of a section.
[8.310.3.5 NMAC - Rp, 8.310.3.5 NMAC, 1/1/2023]

8.310.3.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.3.6 NMAC - Rp, 8.310.3.6 NMAC, 1/1/2023]

8.310.3.7 DEFINITIONS: [**RESERVED**]

8.310.3.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high-quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.310.3.8 NMAC - Rp, 8.310.3.8 NMAC, 1/1/2023]

8.310.3.9 ELIGIBLE PROVIDERS:

A. Health care to eligible medical assistance program (MAP) recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by the HCA medical assistance division (MAD). Upon approval of a New Mexico MAD 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 a MAP eligible recipient. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including MAD New Mexico administrative code (NMAC) program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of their MAD PPA and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Upon approval of the New Mexico medical assistance PPA by MAD, the following practitioners and facilities may be enrolled as MAD providers:

(1) medical practitioners:

(a) a physician licensed to practice medicine or osteopathy;

(b) a licensed certified nurse practitioner under the supervision or in collaboration with a physician or as an independent practitioner;

(c) a licensed physician assistant certified by the national commission on certification of physician assistants under the supervision of a physician;

(d) a licensed pharmacist clinician under the supervision of a physician;

(e) a licensed clinical nurse specialist under the supervision or in collaboration with a physician or as an independent practitioner;

(f) a licensed nurse anesthetist certified by the American association of nurse anesthetists council on certification of nurse anesthetists;

(g) a licensed anesthesiologist assistant certified by the national commission for certification of anesthesiologist assistants (NCCAA);

(h) a licensed podiatrist;

(i) a licensed and certified nurse midwife;

(j) a licensed midwife;

(k) a licensed dietician or a licensed nutritionist under the direction of a licensed physician;

(l) a licensed optometrist;

(m) a licensed audiologist certified by the American speech and hearing association;

(n) a licensed chiropractor; or

(o) a licensed naturopathic doctor;

(2) dental practitioners:

(a) a licensed dentist; or

(b) a licensed dental hygienist certified for collaborative practice;

(3) therapists:

(a) a physical therapist licensed by the physical therapy board under the state of New Mexico regulations and licensing division (RLD);

(b) an occupational therapist licensed by the board of occupational therapy under RLD; or

(c) a speech pathologist licensed by the board of speech, language, hearing under RLD;

(4) clinical laboratory, radiology, and diagnostic facilities:

(a) an independent clinical laboratory having a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration applicable to the category of procedures performed by the laboratory;

(b) a licensed radiological facility; or

(c) a licensed diagnostic laboratory;

(5) transplant centers: practitioners and facilities licensed or certified to furnish specialized transplant medical or surgical services;

(6) other providers described in other rules found in NMAC rules eligible to provide services or receive reimbursement, such as behavioral health services, early and periodic screening, diagnostic and treatment (EPDST) services, institutional services, and other specialized services.

B. Upon approval of the New Mexico MAD PPA agreement by MAD or its designee, the clinic, professional association, or other legal entity may be enrolled as a MAD provider in order that payment may be made to the clinic, professional association, or other legal entity formed by one or more individual practitioners. The individual practitioners that are employed by or contracted by the clinic, professional practice or other legal entity must also be enrolled as individual providers. All requirements under state law and regulations or rules regarding supervision, direction, and approved supervisory practitioners must be met. Such entities include:

(1) professional components for inpatient and outpatient institutions;

(2) professional corporations and other legal entities;

(3) licensed diagnostic and treatment centers, including a birthing center licensed as a diagnostic and treatment center;

(4) licensed family planning clinics;

(5) public health clinics or agencies;

(6) Indian health services (IHS) facilities; and

(7) PL.93-638 tribal 638 facilities.

C. All services rendered must be within the legal scope of practice of the practitioner or provider and are limited to benefits and services covered by MAD including meeting requirements for medical necessity.

D. All providers must be licensed in New Mexico for services performed in New Mexico. For services performed by providers outside of New Mexico, a provider's out of state license may be accepted in lieu of licensure in New Mexico if the out of state licensure requirements are similar to those of the state of New Mexico. For services provided under the public health service including IHS, providers must meet the requirements of the public health service corps.

E. Additional licensure or certification requirements may be required for specialized services such as services provided to MAP special needs recipients. Transplantation providers are eligible for enrollment if licensed as state transplantation centers by the licensing and certification bureau of the New Mexico department of health (DOH); or if certified as transplantation centers by the centers for medicare and medicaid services (CMS).

F. For telemedicine services, when the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and NMAC rules or meet federal requirements for providing services to IHS facilities or tribal contract facilities.

[8.310.3.9 NMAC - Rp, 8.310.3.9 NMAC, 1/1/2023]

8.310.3.10 COVERED SERVICES: MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of NMAC rules and benefits and within the scope and practice of the provider's professional standards.

[8.310.3.10 NMAC - Rp, 8.310.3.10 NMAC, 1/1/2023]

8.310.3.11 REIMBURSEMENT: Providers must submit claims for reimbursement on the CMS-1500, American dental association (ADA), or universal billing (UB) claim form or their successor or their electronic equivalents, as appropriate to the provider type and service.

A. A provider is responsible for following coding manual guidelines and CMS national correct coding initiatives, including not improperly unbundling or upcoding services, not reporting services together inappropriately, and not reporting an inappropriate number or quantity of the same service on a single day. Bilateral procedures and incidental procedure are also subject to special billing payment policies. The payment for some services includes payment for other services. For example, payment for a surgical procedure may include hospital visits and follow up care or supplies which are not paid separately.

B. General reimbursement:

(1) reimbursement to professional service providers is made at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure;

(2) the billed charge must be the provider's usual and customary charge for the service or procedure.

(3) "usual and customary" charge refers to the amount that the provider charges the general public in the majority of cases for a specific procedure or service.

C. Reimbursement limitations:

(1) Nurses: Reimbursement to CNPs and CNSs who are in independent practice are limited to ninety percent of the MAD fee schedule amount allowed for physicians providing the same service.

(2) Midwife services: Reimbursement for a certified nurse midwife or a licensed midwife for maternity services is based on one global fee which includes prenatal care, delivery, postnatal and postpartum care. Services related to false labor are included as part of the global fee. Certified nurse midwives are reimbursed at the rate paid to physicians for furnishing similar services. Licensed midwives are reimbursed at seventy-seven percent of the rate paid to physicians for furnishing the global services and at one hundred percent of the rate paid to physicians for add-on services. Other services are paid according to the MAD fee schedule.

(3) Surgery: Surgical assistants are reimbursed at twenty percent of the allowed primary surgeon amount. Surgical assistants are paid only when the surgical code allows for assistants as determined by medicare, CMS, or MAD. Physician assistants (PA), pharmacist clinicians, CNP's, midwives, and CNS's can only be paid as surgical assistants when it is within the scope of their practice as determined by state statute and their licensing boards.

(4) Physician extenders: Physician assistants, pharmacist clinicians and other providers not licensed for independent practice are not paid directly. Reimbursement is made to the supervising provider or entity under which the extender works.

(5) Hospital settings: Reimbursement for services provided in hospital settings that are ordinarily furnished in a provider's office is made at sixty percent of the fee schedule allowed amount. MAD follows medicare principles in determining which procedures and places of service are subject to this payment reduction. For services not covered by medicare, the determination is made by MAD. For facility-based providers, costs billed separately as a professional component must be identified for exclusion from the facility cost report prior to cost settlement or rebasing.

(6) Dietician and nutrition services: For nutritional counseling services, physicians, physician extenders and clinics must include the charges for nutritional services in the office visit code when services are furnished by physicians or physician extenders. The level of the office visit reflects the length and complexity of the visit. For services furnished as part of prenatal or postpartum care, nutritional counseling services are included in the reimbursement fees for prenatal and postpartum care and are not reimbursed separately. Nutritional assessment and counseling services can be billed as a separate charge only when services are furnished to a MAP eligible recipient under age 21 by licensed nutritionists or licensed dieticians who are employed by eligible providers. Reimbursement is made to eligible providers and not directly to the nutritionists or dieticians.

(7) Laboratory and diagnostic imaging reimbursement limitations:

(a) Use of medicare maximums: The MAD payment does not exceed the amount allowed by medicare for any laboratory service. Medicare notifies MAD on an annual basis of its fee schedule for clinical laboratory services. These new fees become the maximums for reimbursement upon implementation by MAD.

(b) Referrals from providers: Physicians and other private practitioners cannot bill for laboratory tests which are sent to an outside laboratory or other facility. Payment for laboratory services cannot be made directly to a practitioner unless the tests were performed in their own office. Laboratories can bill for tests sent to other laboratories only if the CLIA number of the other laboratory is identified on the claim form. State facilities which contract for services with other state-operated laboratories, such as the state health laboratory, can bill for those services providing the amount billed for the service does not exceed the amount paid by the state facility to the contractor.

(c) Reimbursement for collection costs: MAD does not reimburse an independent clinical laboratory separately for associated collection costs such as office visits, home visits or nursing home visits.

(d) Services performed as profile or panel: Individual lab procedures that are routinely considered to be included in a profile or panel must be billed as a panel. MAD cannot be billed for individual lab procedures that are considered included in a profile or panel.

(8) Radiology:

(a) Non-profit licensed diagnostic and treatment centers and state facilities: Non-profit licensed diagnostic and treatment centers which contract for radiological services can bill for services provided that the charge does not exceed the amount paid to the contractor by the licensed diagnostic and treatment center.

(b) Reimbursement for additional charges: Reimbursement for performance of a radiology procedure is considered paid in full when payment is made for the procedure. Additional services such as office visits, home visits, and nursing home visits are not reimbursed separately.

(c) Reimbursement for inclusive procedures: Reimbursement for certain radiological procedures is included in the reimbursement for other procedures. Reimbursement for the lesser procedure is always considered to be included in the payment for the more comprehensive procedure for a specified group.

(d) Reimbursement for the professional component of a radiology service does not exceed forty percent of the amount allowed for the complete procedure.

(i) A professional component or interpretation is not payable to the same provider who bills for the complete procedure.

(ii) A claim for "supervision and interpretation only" is not payable in addition to a claim for the complete procedure.

(9) Telemedicine providers: Reimbursement for services at the originating-site (where the MAP eligible recipient is located) and the distant-site (where the provider is located) are made at the same amount as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for an interactive telemedicine system fee at the lesser of the provider's billed charge; or the maximum allowed by MAD for the specific service or procedure.

D. Reimbursement for services furnished by medical interns or residents: Reimbursement for services furnished by an intern or a resident in a hospital with an approved teaching program or services furnished in

another hospital that participates in a teaching program is only made through an institutional reimbursement process. Medical or surgical services performed by an intern or a resident that are unrelated to educational services, internship, or residency, are reimbursed according to the MAD fee schedule for physician services when all of the following provisions are met:

(1) services are identifiable physician services that are performed by the physician in person;

(2) services must contribute to the diagnosis or treatment of the MAP eligible recipient's medical condition;

(3) an intern or resident is fully licensed as a physician;

(4) services are performed under the terms of a written contract or agreement and are separately identified from services required as part of the training program; and

(5) services are excluded from outpatient hospital costs; when these criteria are met the services are considered to have been furnished by the practitioner in their capacity as a physician and not as an intern or resident.

E. Services of an assistant surgeon in an approved teaching program:

(1) MAD does not pay for the services of an assistant surgeon in a facility with approved teaching program since the resident is available to perform services unless the following exceptional medical circumstances exist:

(a) an assistant surgeon is needed due to unusual medical circumstances;

(b) the surgery is performed by a team of physicians during a complex procedure; or

(c) the presence of, and active care by, a physician of another specialty is necessary during the surgery due to the MAP eligible recipient's medical condition.

(2) This reimbursement rule may not be circumvented by private contractors or agreements entered into by a hospital with a physician or a physician group.

F. Reimbursement for dental residents: Reimbursement can be made for dental residents in an approved teaching program when all the following conditions are met:

(1) the resident is fully licensed as a dentist for independent practice;

(2) the costs of the dental residency program is not included in the direct or graduate medical education payments to a provider operating the teaching program; and

(3) only one dental claim is submitted for the service; the supervising dentist and the rendering dentist will not be both paid for the service or procedure.

G. Non-independent practitioners: Reimbursement for services furnished by a physician assistant, a pharmacist clinician, or another practitioner whose license is not for independent practice, is made only to the billing supervising practitioner or entity rather than directly to the supervised practitioner.

H. Surgical procedures: Reimbursement for surgical procedures is subject to certain restrictions and limitations.

(1) When multiple procedures that add significant time or complexity to care are furnished during the same operative session, the major procedure is reimbursed at one hundred percent of the allowable amount, the secondary procedure is reimbursed at fifty percent of the allowable amount and any remaining procedures are reimbursed at twenty-five percent of the allowable amount. Multiple procedures occurring in one incision are reimbursed similarly. "Multiple surgery" is defined as multiple surgical procedures billed by the same physician for the same MAP eligible recipient on the same date of service.

(2) Bilateral procedures that are furnished in the same operative session are billed as one service with a modifier. Reimbursement for bilateral procedures is one hundred fifty percent of the amount allowed for a unilateral procedure.

(3) Surgeons are not reimbursed for the performance of incidental procedures, such as incidental appendectomies, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernias, or tubal ligations done in conjunction with cesarean sections.

(4) Providers are not reimbursed for performing complete physical examinations or histories during follow-up treatment after a surgical procedure.

(5) Other health care related to a surgery is considered to be reimbursed in the payment for the surgery and is not paid as a separate cost. Surgical trays and local anesthesia are included in the reimbursement for the surgical procedure.

(6) Under certain circumstances, the skills of two surgeons, usually with different surgical specialties may be required in the management of a specific surgical problem. The total allowed value of the procedure is increased by twenty-five percent and each surgeon is paid fifty percent of that amount.

I. Maternity services: Reimbursement for maternity care is based on one global fee. Routine prenatal, delivery postnatal and postpartum care are included in the global fee. Services related to false labor and induced labor are also included in the global fee.

(1) If partial services are furnished by multiple providers, such as prenatal care only, one or two trimesters of care only, or delivery only, the procedure codes billed must reflect the actual services performed. The date of services must be the last day services were furnished for that specific procedure code.

(2) MAD pays based on a modifier for high-risk pregnancies or for complicated pregnancies. The determination of high risk is based on a claims review.

(3) If partial services are furnished by a certified nurse midwife or licensed midwife, such as prenatal care only, one or two trimesters of care only or delivery only, the procedure codes billed must reflect the actual services performed. The date of service must be the last day services were furnished for that specific code.

(4) If the services furnished include a combination of services performed by a certified nurse midwife or licensed midwife, and a physician in the same group practice, reimbursement for midwife services is based on trimesters of service furnished by the certified nurse midwife or licensed midwife.

(5) MAD pays supply fees only when a MAP eligible recipient is accommodated for two hours or more in the home or a birthing center prior to delivery. Payment for use of a licensed birthing center includes supplies.

(6) MAD covers postnatal and postpartum care by a certified nurse midwife or licensed midwife, as a separate service only when the midwife does not perform the delivery.

(7) Reimbursement for a single vaginal delivery assist is allowed when the assist service is furnished by licensed or certified midwives who are MAD providers. The need for the assistance based on the medical condition of the MAP eligible recipient must be documented.

(8) Reimbursement for cesarean sections and inductions is made only when the service is medically necessary. These services are not covered as elective procedures.

(9) MAD covers laboratory and diagnostic imaging services related to an essentially normal pregnancy. These services can be billed separately.

(10) Non/covered midwife services: Midwife services are subject to the limitation and coverage restrictions which exist for other MAD services. MAD does not cover the following specific services furnished by a midwife:

(a) oral medications or medications, such as ointments, creams, suppositories, ophthalmic and otic preparations which can be appropriately self/administered by the MAP eligible recipient;

(b) services furnished by an apprentice, unless billed by the supervising midwife;

(c) an assistant at a home birth unless necessary based on the medical condition of the MAP eligible recipient which must be documented in the claim.

(11) Birthing options program (BOP): The BOP is specifically for basic obstetric care for uncomplicated pregnancies and childbirth, including immediate newborn care that is limited to stabilization of the baby during this transition. The program does not cover full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

(a) The BOP out-of-hospital birth locations include a pregnant member's home or a licensed birth center.

(b) A BOP participant may elect to have a home birth or birth in a licensed birth center when she has BOP services provided by an eligible midwife that enrolls as a BOP provider with the health care authority/medical assistance division (HCA/MAD) and the New Mexico Department of Health/maternal health division (NMDOH/MHC).

J. Services limited by frequency:

(1) services furnished by another provider: where coverage of services provided to MAP eligible recipient is restricted or limited by frequency of services, procedures or materials, it is a provider's responsibility to determine if a proposed service has already been furnished by another provider, such that the MAP eligible recipient has exhausted the benefit. Examples include but are not limited to dental services, vision exams and eyeglasses.

(2) direct MAP eligible recipient payment for services: a provider can make arrangements for direct payment from a MAP eligible recipient or their authorized representative for noncovered services. A MAP eligible recipient or their authorized representative can only be billed for noncovered services if:

(a) a MAP eligible recipient or their authorized representative is advised by a provider of the necessity of the service and the reasons for the non-covered status;

(b) a MAP eligible recipient or their authorized representative is given options to seek treatment at a later date or from a different provider;

(c) a MAP eligible recipient or their authorized representative agrees in writing to be responsible for payment; and

(d) the provider fully complies with the NMAC rules relating to billing and claims filing limitations.

(3) services considered part of the total treatment: a provider cannot bill separately for the services considered included in the payment for the examination, another service, or for routine post-operative or follow-up care.

K. Anesthesia services:

(1) Reimbursement for anesthesia services is calculated using the MAD fee schedule anesthesia "base units" plus units for time.

(a) Each anesthesia procedure is assigned a specific number of relative value units which becomes the "base unit" for the procedure. Units of time are also allowed for the procedure. Reimbursement is calculated by multiplying the total number of units by the conversion factor allowed for each unit.

(b) The reimbursement per anesthesia unit may vary depending on who furnishes the service. Separate rates are established for a physician anesthesiologist, a medically-directed certified registered nurse anesthetist (CRNA), anesthesiologist assistant (AA) and a non-directed CRNA.

(c) For anesthesia provided directly by a physician anesthesiologist, CRNA, or an anesthesiologist assistant, one time unit is allowed for each 15-minute period a MAP eligible recipient is under anesthesia. For medical direction, one time unit is allowed for each 15-minute period.

(2) Medical direction: Reimbursement is made at fifty percent of the full anesthesia service amount for medical direction by a physician anesthesiologist who is not the surgeon or assistant surgeon, for directing an anesthesiology resident, a registered nurse anesthetist (CRNA) or an anesthesiologist assistant (AA). Reimbursement is made at fifty percent of the full anesthesia service amount for the anesthesia service provided by the medically directed anesthesiology resident, CRNA or AA. Medical direction occurs if the physician medically directs qualified practitioners in two, three, or four concurrent cases and the physician performs the activities described below. Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving a MAP eligible recipient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-MAP eligible recipients and the remaining is a MAP eligible recipient, this represents three concurrent cases.

(a) Time units for medical direction are allowed at one time unit for each 15-minute interval.

(b) Anesthesia claims are not payable if the surgery is not a MAD benefit or if any required documentation was not obtained.

(c) Medical direction is a covered service only if the physician:

(i) performs a pre-anesthesia examination and evaluation; and

(ii) prescribes the anesthesia plan; and

(iii) personally participates in the most demanding procedures of the anesthesia plan including induction and emergence; and

(iv) ensures that any procedures in the anesthesia plan that they do not perform are performed by a qualified anesthetist; and

(v) monitors the course of anesthesia administration at frequent intervals; and

(vi) remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) provides indicated post-anesthesia care.

(d) For medical direction, the physician must document in the medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and was present during the most demanding procedures, including induction and emergence, where indicated.

(e) A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients may not ordinarily be involved in furnishing additional services to other patients. Addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially

diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. Medical direction criteria are met even though the physician responds to an emergency of short duration.

(f) While directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

(g) If a physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patient, the physician's services to the surgical patients are supervisory in nature. Medical direction cannot be billed.

(3) Monitored anesthesia care: Medically necessary monitored anesthesia care (MAC) services are reimbursed at base units plus time units.

(a) "Monitored anesthesia care" is anesthesia care that involves the intraoperative monitoring by a physician or qualified practitioner under the medical direction of a physician, or of the MAP eligible recipient's vital physiological signs in anticipation of the need for administration of general anesthesia, or of the development of adverse physiological MAP eligible recipient reaction to the surgical procedure and includes:

(i) performance of a pre-anesthetic examination and evaluation;

(ii) prescription of the anesthesia care required;

(iii) continuous intraoperative monitoring by a physician anesthesiologist or qualified certified registered nurse anesthetist of the MAP eligible recipient's physiological signs;

(iv) administration of medication or other pharmacologic therapy as can be required for the diagnosis and treatment of emergencies; and

(v) provision of indicated postoperative anesthesia care.

(b) For MAC, documentation must be available to reflect pre- and post-anesthetic evaluations and intraoperative monitoring.

(c) Medical direction for monitored anesthesia is reimbursed if it meets the medical direction requirements.

(4) Medical supervision: If an anesthesiologist is medically directing more than four CRNAs, the service must be billed as medically supervised rather than medically directed anesthesia services. The MAD payment to the CRNA will be fifty percent of the MAD allowable amount for the procedure. Payment to the anesthesiologist will be based on three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedure.

(5) Obstetric anesthesia: Reimbursement for neuraxial labor anesthesia is paid using the base units plus one unit per hour for neuraxial analgesia management including direct patient contact time (insertion, management of adverse events, delivery, and removal).

(6) Unusual circumstances: When it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. Documentation supporting the medical necessity for both must be noted in the MAP eligible recipient's record.

(7) Pre-anesthetic exams and cancelled surgery: A pre-anesthetic examination and evaluation of a MAP eligible recipient who does not undergo surgery may also be considered for payment. Payment is determined under the physician fee schedule for the medical or surgical service.

(8) Performance of standard procedures: If an anesthesiologist performs procedures which are generally performed by other physicians without specific anesthesia training, such as local anesthesia or an injection, the anesthesiologist is reimbursed the fee schedule amount for performance of the procedure. Reimbursement is not made for base units or units for time.

(9) Add-on codes for anesthesia: Add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia are paid in addition to the primary anesthesia code. Anesthesia add-on codes are priced differently than multiple anesthesia codes. Only the base unit of the add-on code will be allowed. All anesthesia time must be reported with the primary anesthesia code. There is an exception for obstetrical anesthesia. MAD requires for the obstetrical add-on codes, that the anesthesia time be separately reported with each of the primary and the add-on codes based on the amount of time appropriately associated with either code. Both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes are recognized.

(10) Anesthesia services furnished by the same physician providing the medical and surgical service:

(a) A physician who both performs and provides moderate sedation for medical or surgical services will be paid for the conscious sedation consistent with CPT guidelines; however, a physician who

performs and provides local or minimal sedation for these procedures cannot bill and cannot be paid separately for the sedation services. The continuum of complexity in anesthesia services (from least intense to most intense) ranges from:

(i) local or topical anesthesia; to
(ii) moderate (conscious) sedation; to
(iii) regional anesthesia; to
(iv) general anesthesia.

(b) Moderate sedation is a drug-induced depression of consciousness during which a MAP eligible recipient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care. If the physician performing the procedure also provides moderate sedation for the procedure, payment may be made for conscious sedation consistent with CPT guidelines. However, if the physician performing the procedure provides local or minimal sedation for the procedure, no separate payment is made for the local or minimal sedation service.
[8.310.3.11 NMAC - Rp, 8.310.3.11 NMAC, 1/1/2023]

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ISD-Rule-310.0100, Physician Services, filed 9/2/1983.
ISD-Rule-310.0100, Physician Services, filed 3/30/1984.
ISD Rule-310.0100, Physician Services, filed 4/26/1984.
ISD Rule-310.0100, Physician Services, filed 2/25/1986.
MAD Rule 310.01, Physician Services, filed 12/15/1987.
MAD Rule 310.01, Physician Services, filed 4/27/1988.
MAD Rule 310.01, Physician Services, filed 4/20/1992.
MAD Rule 310.01, Physician Services, filed 3/10/1994.
MAD Rule 310.27, Anesthesia Services, filed 7/2/1990.

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MAD Rule 310.01, Physician Services, filed 3/10/1994 - Repealed effective 2/1/1995.
MAD Rule 310.27, Anesthesia Services, filed 7/2/1990 - Repealed effective 2/1/1995.
8.310.2 NMAC, Medical Services Providers, filed 2/16/2004 - Repealed effective 1/1/2014.
8.310.3 NMAC, Rural Health Clinic Services, filed 2/7/2012 - Repealed effective 1/1/2014. Replaced by 8.310.9 NMAC, Rural Health Clinic Services, effective 1/1/2014.
8.310.5 NMAC, Anesthesia Services, filed 5/12/2003 - Repealed effective 1/1/2014.
8.310.13 NMAC, Telehealth Services, filed 7/17/2007 - Repealed 1/1/2014.
8.324.2 NMAC, Laboratory Services, filed 2/7/2012 - Repealed 1/1/2014.
8.324.3 NMAC, Diagnostic Imaging and Therapeutic Radiology Services, filed 2/7/2012 - Repealed 1/1/2014.
8.324.9 NMAC, Nutrition Services, filed 2/7/2012 - Repealed 1/1/2014.
8.325.3 NMAC, Reproductive Services, filed 1/18/1995 - Repealed 1/1/2014.
8.310.3 NMAC, Professional Providers, Services And Reimbursement filed 12/17/2013 - Repealed 1/1/2023.

Other History: 8.310.3 NMAC, Professional Providers, Services And Reimbursement filed 12/17/2013, Replaced by 8.310.3 NMAC, Professional Providers, Services And Reimbursement effective 1/1/2023.

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 9 RURAL HEALTH CLINIC SERVICES

8.310.9.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.310.9.1 NMAC - Rp, 8.310.3.1 NMAC, 1/1/2014; A, 7/1/2024]

8.310.9.2 SCOPE: The rule applies to the general public.
[8.310.9.2 NMAC - Rp, 8.310.3.2 NMAC, 1/1/2014]

8.310.9.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.310.9.3 NMAC - Rp, 8.310.3.3 NMAC, 1/1/2014; A, 7/1/2024]

8.310.9.4 DURATION: Permanent
[8.310.9.4 NMAC - Rp, 8.310.3.4 NMAC, 1/1/2014]

8.310.9.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.310.9.5 NMAC - Rp, 8.310.3.5 NMAC, 1/1/2014]

8.310.9.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.310.9.6 NMAC - Rp, 8.310.3.6 NMAC, 1/1/2014]

8.310.9.7 DEFINITIONS: [**RESERVED**]

8.310.9.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.310.9.8 NMAC - Rp, 8.310.3.8 NMAC, 1/1/2014]

8.310.9.9 RURAL HEALTH CLINIC SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help rural New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for covered medicaid services provided in rural health clinics [42 CFR Section 440.20]. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.
[8.310.9.9 NMAC - Rp, 8.310.3.9 NMAC, 1/1/2014]

8.310.9.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following providers are eligible to be reimbursed for furnishing services as rural health clinics:

(1) clinics certified as non-hospital based rural health clinics by the health care financing administration (HCFA) following a survey and recommendation from the licensing and certification bureau; or

(2) clinics which are integral parts of institutional providers, such as hospitals, skilled nursing facilities or home health agencies, that have been certified as hospital-based rural health clinics.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
[8.310.9.10 NMAC - Rp, 8.310.3.10 NMAC, 1/1/2014]

8.310.9.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies*.
[8.310.9.11 NMAC - Rp, 8.310.3.11 NMAC, 1/1/2014]

8.310.9.12 COVERED SERVICES AND SERVICE LIMITATIONS: All services provided by the clinic must be furnished in accordance with applicable federal, state, and local laws and regulations and must be furnished within the limitations applicable to medicaid covered benefits.

A. The following are covered services:

(1) medically necessary diagnostic and therapeutic services, supplies, and treatment of medical conditions, including medically necessary family planning services; see Section MAD-762, *Reproductive Health Services*;

(2) laboratory and diagnostic imaging services for diagnosis and treatment; and

(3) surgical procedures, emergency room physician services, and inpatient hospital visits furnished at a different facility when performed by a physician under contract to a rural health clinic.

B. Visiting nurse services: Medicaid covers visiting nurse services through a rural health clinic if the following criteria are met [42 CFR Section 440.20(b)(4)]:

(1) the rural health clinic is located in an area in which there is a shortage of home health agencies, as determined by the secretary of the federal department of health and human services; the rural health clinic does not need separate or additional home health agency certification to furnish visiting nurse services;

(2) the services are furnished to homebound recipients;

(3) the services are furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by, or receives compensation for the services from the clinic;

(4) the services are furnished under a written plan of treatment that is:

(a) established and reviewed at least every 60 days by supervising physicians at the rural health clinics;

(b) established by certified nurse practitioners, certified physician assistants, certified nurse midwives, licensed nurse midwives, or specialized nurse practitioners and reviewed at least every sixty (60) days by supervising physicians; and

(c) signed by nurse practitioners, physician assistants, nurse midwives, specialized nurse practitioners, or supervisory physicians of the clinic;

(5) prior approval for nursing services must be obtained from the MAD utilization review contractor.

C. Primary care network restrictions: All rural health clinics are subject to the primary care network restrictions. See Section MAD-603, Primary Care Network.
[8.310.9.12 NMAC - Rp, 8.310.3.12 NMAC, 1/1/2014]

8.310.9.13 NON-CORE MEDICAL SERVICES: Core medical services, as defined in the Rural Health Clinic Act, performed at rural health clinics are included in the encounter rate for purposes of medicaid reimbursement. The following non-core services may be provided in rural clinics, however, reimbursement for these services is not included in the encounter rate:

A. optometric services, including vision examinations and eyeglasses dispensing;

B. hearing aid dispensing and related evaluations;

C. psychological services;

D. rural health drug services; and

(1) pharmacy services are covered by medicaid if the rural health clinic obtains a separate pharmacy provider number; a separate New Mexico medical assistance program provider participation application must be submitted for pharmacy services and be approved by MAD;.

(2) pharmacy dispensing services must be billed with the separate pharmacy provider number;.

(3) the rural health clinic pharmacy must be licensed by the state pharmacy board; see 8.324.4 NMAC, *Pharmacy Services*.

E. Rural health dental services:

(1) Certified rural health clinics may participate as rural health dental providers if they obtain a separate dental provider numbers. A separate New Mexico medical assistance program provider participation application must be submitted by a rural health center dental provider and be approved by MAD.

(2) Dental services must be billed under the separate dental provider number, not the rural health clinic provider number. See 8.310.7 NMAC, *Dental Services*.

[8.310.9.13 NMAC - Rp, 8.310.3.13 NMAC, 1/1/2014]

8.310.9.14 NONCOVERED SERVICES: Rural health clinic services are subject to the same limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*.

[8.310.9.14 NMAC - Rp, 8.310.3.14 NMAC, 1/1/2014]

8.310.9.15 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures or services may require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[8.310.9.15 NMAC - Rp, 8.310.3.15 NMAC, 1/1/2014]

8.310.9.16 REIMBURSEMENT: Rural health clinics must submit claims for reimbursement on the UB-92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

A. Reimbursement for non-hospital based rural health clinics: Interim reimbursement is made at an encounter rate established for the clinic by the medicare intermediary.

(1) An "encounter" means a face-to-face meeting between a recipient and any health professional whose services are reimbursed as a covered rural health clinic service.

(2) A final cost settlement based on the audit data is made in accordance with applicable medicare regulations following the medicare cost settlement.

(3) Multiple encounters with the same or different health professional(s) that take place on the same date at a single location are considered a single encounter.

(a) Exceptions exist for cases in which the recipient suffers illness or injury requiring additional diagnosis or treatment on the same day, after the first encounter.

(b) All medical, surgical, diagnostic imaging, supplies, and clinical laboratory services furnished during the encounter are considered reimbursed within the encounter rate.

B. Reimbursement for non-core services: Reimbursement to rural health clinics for drug services, dental services, vision services, hearing services, psychiatric or psychological services, and other non-core medical services is made according to the regulations applicable to each of these specific program areas. These services are not reimbursed on a reasonable cost basis, but instead are reimbursed as described in the applicable service sections.

C. Reimbursement for hospital based rural health clinics: Interim reimbursement to hospital, or other facility, based rural health clinics is made at the percentage determined by MAD. Adjustments and fiscal year reconciliations are made by MAD.

[8.310.9.16 NMAC - Rp, 8.310.3.16 NMAC, 1/1/2014]

HISTORY OF 8.310.9 NMAC:

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

ISD Rule 310.1800, Rural Health Clinic Services, filed 2/18/1980.

ISD-Rule 310.1800, Rural Health Clinic Services, filed 2/24/1986.
MAD Rule 310.18, Rural Health Clinic Services, filed 4/27/1988.
MAD Rule 310.18, Rural Health Clinic Services, filed 4/21/1992.

History of Repealed Material:
8.310.3 NMAC, Rural Health Clinic Services, filed 2/17/2012 - Repealed effective 1/1/2014. Replaced by 8.310.9 NMAC, Rural Health Clinic Services, effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 12 INDIAN HEALTH SERVICE AND TRIBAL 638 FACILITIES

8.310.12.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.310.12.1 NMAC - N, 11/1/2014; A, 7/1/2024]

8.310.12.2 SCOPE: This rule applies to the general public.
[8.310.12.2 NMAC - N, 11/1/2014]

8.310.12.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.310.12.3 NMAC - N, 11/1/2014; A, 7/1/2024]

8.310.12.4 DURATION: Permanent.
[8.310.12.4 NMAC - N, 11/1/2014]

8.310.12.5 EFFECTIVE DATE: November 1, 2014, unless a later date is cited at the end of a section.
[8.310.12.5 NMAC - N, 11/1/2014]

8.310.12.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.12.6 NMAC - N, 11/1/2014]

8.310.12.7 DEFINITIONS: [**RESERVED**]

8.310.12.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.310.12.8 NMAC - N, 11/1/2014]

8.310.12.9 INDIAN HEALTH SERVICE AND TRIBAL 638 FACILITIES: HCA, through the medical assistance division (MAD), pays for medically necessary health services furnished to an eligible recipient, including American Indian and Alaska native (AI/AN) eligible recipients. The Indian health service (IHS) is a federal agency within the United States department of health and human services (DHHS) that is responsible for providing health services to AI/ANs based on the unique government-to-government relationship between federally recognized tribes and nations and the federal government. The IHS health care delivery system consists of health facilities owned and operated by IHS, facilities owned by IHS and operated by tribes or tribal organizations under Title I or Title III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) agreements, and facilities owned and operated by tribes or tribal organizations under such agreements, hereafter referred to as "IHS and tribal 638 facilities". Pursuant to Section 1911 of the Social Security Act; see 42 U.S.C. 1369j and the 1996 memorandum of agreement between IHS and the centers for medicare and medicaid services (CMS), IHS and tribal 638 facilities are eligible to be reimbursed by MAD for furnishing covered healthcare services to a MAP eligible AI/AN recipient (eligible recipient). Specific to this rule, an eligible recipient includes a member enrolled in a HCA contracted managed care organization (MCO).
[8.310.12.9 NMAC - N, 11/1/2014]

8.310.12.10 ELIGIBLE PROVIDERS:

A. Health care to an eligible recipient is furnished by a variety of providers and provider groups. Reimbursement and billing for these services are administered by 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 an eligible recipient. Providers must be enrolled before submitting a claim for payment to the MAD claims processing

contractor. MAD makes available on the HCA website, on other program specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent material. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided therein and comply with the requirements. Providers must contact MAD for answers to billing questions or any of these materials. To be eligible for reimbursement, a provider must adhere to provisions of the MAD PPA and applicable statutes, regulations, rules and executive orders. MAD, or its selected claims processing contractor, issues payment to a provider using electronic funds transfer (EFT) only. Upon approval of the provider's PPA by MAD, the following practitioners and facilities may be enrolled as MAD providers:

(1) IHS facilities;
(2) Public Law 93-638 tribal facilities;
(3) urban Indian facilities (follows the rules for a federally qualified health center);
(4) IHS or tribal 638 facility pharmacies which follow 8.324.4 NMAC; and
(5) off site locations on federal land and facilities approved by MAD.

B. Practitioners contracted or employed by the above facilities are enrolled as individual providers for rendering services when appropriate.

C. Services rendered must be medically necessary and within the scope of practice of the practitioner or provider and are limited to benefits and services covered by MAD.

D. For services provided under the federal public health service, including IHS, rendering providers must meet the requirements of the public health service corp.

E. Additional provider numbers or NPI numbers may be required when necessary to assure that claiming of federal matching funds by MAD is accurate as per federal requirements to distinguish between 100% federal match rates and other match rates.

[8.310.12.10 NMAC - N, 11/1/2014]

8.310.12.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to an eligible recipient must comply with all applicable laws, regulations, rules, standards, and the provisions of the MAD PPA. A provider must adhere to MAD program rules as specified in the New Mexico administrative code (NMAC) and program policies that include, but are not limited to, supplements, billing instructions, and utilization review directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service. A provider must determine if an eligible recipient has other applicable health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act or regulatory authority, or as customarily provided under IHS or public health service administrative direction including the level of supervision required for services.

[8.310.12.11 NMAC - N, 11/1/2014]

8.310.12.12 COVERED SERVICES: MAD covers medically necessary services and procedures for the diagnosis and treatment of an illness or injury as indicated by the eligible recipient's condition. Services must be furnished within the limits of MAD rules and within the scope of practice of the provider's professional standards. Public health services including services by public health nurses are covered to the same extent their services would be covered for non-IHS public health facilities. Limitations on covered services based on age and category of eligibility also apply to services rendered at an IHS or tribal 638 facility. Examples include enhanced benefits only available to early and periodic screening, diagnostic and treatment (EPSDT) eligible recipients, and limitations and enhanced services for alternative benefit plan (ABP) eligible recipients, and eligible recipient pregnant women.

A. Outpatient encounters and visits: An outpatient encounter or visit is face-to-face contact between a practitioner and an eligible recipient as documented in the eligible recipient's physical or behavioral health record. An encounter or visit can occur at an IHS facility, tribal 638 facility, or a MAD recognized offsite location including IHS or tribal facility-based services that are provided in the home or in community centers or other locations but the medical records and the supervision or direction of the service comes from the eligible facility. To be billable as an encounter, the eligible recipient must be seen by a level of practitioner who would be

eligible to be enrolled as a MAD provider or a practitioner comparable to that required by other service and provider rules or the service must be supervised by a level of practitioner who would be eligible to be enrolled as a MAD provider or a practitioner comparable to that required by other service and provider rules. Examples include but are not limited to the following: audiologist, behavioral health professional, certified nurse midwife, certified nurse practitioner, clinical nurse specialist, clinical pharmacy specialist, dentist, dental hygienist, licensed dietician, occupational therapist, optometrist, pharmacist clinician, physician assistant, physician, physical therapist, podiatrist, speech therapist and other provider types within their scope of practice as designated by MAD; see 8.310.2 NMAC, 8.310.3 NMAC and 8.321.2 NMAC.

(1) Visits to the same facility, on the same day, for the same or related diagnosis constitutes a single encounter.

(2) Multiple encounters can occur on the same date of service when the services are distinct. The following are examples of types of separate encounters:

(a) an eligible recipient receives a service that is not associated with the initial encounter and the service provided is for a different principal diagnosis; or

(b) an eligible recipient is seen at two different facilities (different provider numbers) and one of the facilities is unable to provide the necessary services for the diagnosis or treatment of the eligible recipient's condition.

(3) An outpatient encounter may be billed when a visit consists of services that could be provided in a physician's office such as instructions to a diabetic, medication management, and anticoagulant management, when provided by a qualified individual as part of a facility-based outpatient program if no other related encounter occurs that day, similar to how services would be covered for other providers and clinics in other MAD service rules.

(4) An outpatient encounter may be billed when an eligible recipient returns at a later date for a follow up MAD service such as a laboratory, radiology, or therapy service which does not require an additional physician visit if no other related visit occurs that day.

(5) When a MAD service typically requires multiple visits such as orthodontia services, crowns, and dentures, the provider may bill an amount for the initial service that includes the standard number of encounters for the service are for the standard number of visits, similar to how services would be covered for other providers in other MAD service rules, or be paid at a fee schedule amounts that closely approximates the appropriate payment for multiple services.

B. Inpatient hospital stays: An inpatient hospital stay occurs when an eligible recipient is admitted and stays overnight.

C. Services not subject to office of management and budget (OMB) codes or rates: Some services are covered by MAD when occurring within an IHS or a tribal facility but are not included or billed at the OMB rate. These services are covered to the extent described under applicable rules for the service, and include:

(1) anesthesia (professional charges);

(2) ambulatory surgical center facility services;

(3) targeted case management;

(4) hearing appliances (hearing testing is reimbursed at the OMB rate);

(5) physician inpatient hospital visits and surgeries;

(6) smoking cessation;

(7) vision appliances, including frames, lenses, dispensing, and contacts (vision exams are at the OMB rate); and

(8) telemedicine's originating site facility fee; a telemedicine originating site fee is covered when the requirements of 8.310.2 NMAC are met; both the originating and distant sites may be IHS or tribal facilities at two different locations or if the distant site is under contract to the IHS or tribal facility and would qualify to be an enrolled provider; a telemedicine originating site fee is not payable if the telemedicine technology is used to connect an employee or staff member of a facility to the eligible recipient being seen at the same facility; however, even if the service does not qualify for a telemedicine originating site fee, the use of telemedicine technology may be appropriate thereby allowing the service provided to meet the standards to qualify as an encounter by providing the equivalent of face-to-face contact.

D. Behavioral health services:

(1) Outpatient behavioral health services billed using the outpatient OMB codes include assessments and evaluations, outpatient therapies, comprehensive community support services (CCSS), and other services as approved by MAD.

(2) Other specialized behavior health services may be reimbursed at the MAD fee for service (FFS) rate or at an OMB rate, as agreed between the facility and MAD.

(3) Prior to billing specialized behavioral health services including CCSS, the IHS or tribal 638 facility must submit documentation to MAD demonstrating the ability to adhere to the service definitions and standards for the specific service; see 8.321.2 NMAC.

E. Pharmacy services: See 8.324.4 NMAC for an IHS and a tribal 638 facility enrolled as a pharmacy. Pharmacy services are not part of the OMB rate. Pharmacy claims are not limited to a 30 or 90 day supply when the prescriber has written for a larger days supply of medication. Pharmacy claims may exceed the days supply limitations if the amounts dispensed at one time is reasonable. IHS and tribal 638 facility pharmacy claims are not subject to formularies or preferred drug lists or authorization as the facility maintains its own formulary.

F. Transportation services: For a detailed description of transportation services, see 8.324.7 NMAC.

[8.310.12.12 NMAC - N, 11/1/2014]

8.310.12.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: IHS and tribal 638 facilities need not obtain prior authorization for services, but must continue to follow standards of care within its scope of practice and retain documentation in the eligible recipient's physical and behavioral health record. MAD services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before or after services are furnished.

[8.310.12.13 NMAC - N, 11/1/2014]

8.310.12.14 NON-COVERED SERVICES: For a detailed description of general non-covered MAD services, see 8.310.2 NMAC and 8.321.2 NMAC. Other MAD service rules may have additional non-covered MAD service restrictions.

[8.310.12.14 NMAC - N, 11/1/2014]

8.310.12.15 REIMBURSEMENT: OMB rates are published annually in the federal register and are applicable to an IHS and a tribal 638 facility. These rates are applied retroactively to their effective date.

A. IHS OMB outpatient and inpatient reimbursement rates include facility fees and professional fees except as described in this rule.

(1) Outpatient encounters and visits: MAD reimburses outpatient encounters and visits at the OMB outpatient encounter rate. Reimbursement at OMB rates is retroactive to the dates of service for which the OMB rates are applicable.

(2) Inpatient hospital service: MAD reimburses covered inpatient hospital stays at the federally published OMB hospital inpatient per diem rate. The inpatient OMB rate applies when an eligible recipient has been under outpatient care observation or is receiving extended outpatient medical services, and the time period has been for 24 hours or more whether the eligible recipient has been formally admitted or not. Risk factors such as distance of the facility from the eligible recipient's residence for potential emergency follow up care, as well as lack of availability of step-down care providers (home health services, nursing facilities, and acute long term care hospital facilities) may be considered in making discharge decisions regarding the eligible recipient. Alternatively, the facility may elect to bill a daily outpatient OMB rate for an eligible recipient under observation. Reimbursement at OMB rates is retroactive to the date of service for which the federal OMB rates are applicable.

(3) Reimbursement following medicare payment is made at the full copayment, deductible and co-insurance amounts determined by medicare. Reimbursement following payment by other insurance is made at the OMB rate, is applicable, less the payment received from the other insurer.

B. Services not subject to the OMB rates are reimbursed according to MAD rules for the specific service. For services not reimbursable the facility at one hundred percent federal matching funds, the facility may be enrolled additionally for services to be paid at standard federal matching rates.

C. Electronic billing requirements: Electronic billing of claims is required unless an exemption has been allowed by MAD. Exemptions will be given on a case-by-case basis with consideration given to barriers faced by the provider in electronic billing, such as small volume for which developing electronic submission capability is impractical. The requirement for electronic submission of claims does not apply when paper attachments must accompany the claim form.

D. Responsibility for claims: A provider is responsible for all claims submitted under their national provider identifier (NPI) or provider number, including responsibility for accurate coding representing the services

provided without inappropriately upcoding, unbundling, or billing mutually exclusive codes as indicated by published coding manuals, directives, CMS correct coding initiatives, and NMAC MAD rules.
[8.310.12.15 NMAC - N, 11/1/2014]

HISTORY OF 8.310.12 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 311 HOSPITAL SERVICES
PART 3 METHODS AND STANDARDS FOR ESTABLISHING PAYMENT-INPATIENT HOSPITAL SERVICES

8.311.3.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.311.3.1 NMAC - Rp, 8.311.3.1 NMAC, 6/1/2016; A, 7/1/2024]

8.311.3.2 SCOPE: This rule applies to the general public.
[8.311.3.2 NMAC - Rp, 8.311.3.2 NMAC, 6/1/2016]

8.311.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.311.3.3 NMAC - Rp, 8.311.3.3 NMAC, 6/1/2016; A, 7/1/2024]

8.311.3.4 DURATION: Permanent.
[8.311.3.4 NMAC - Rp, 8.311.3.4 NMAC, 6/1/2016]

8.311.3.5 EFFECTIVE DATE: June 1, 2016, unless a later date is cited at the end of a section.
[8.311.3.5 NMAC - Rp, 8.311.3.5 NMAC, 6/1/2016]

8.311.3.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.311.3.6 NMAC - Rp, 8.311.3.6 NMAC, 6/1/2016]

8.311.3.7 DEFINITIONS: [RESERVED]

8.311.3.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.311.3.8 NMAC - N, 9/1/2021]

8.311.3.9 METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES: The New Mexico title XIX program reimburses appropriately licensed and certified acute care hospitals for inpatient services as outlined in this part. Procedures and policies governing state licensure, certification of providers, utilization review and any other aspect of state regulation of the title XIX program not relating to the method of computing payment rates for inpatient services are not affected by this part.
[8.311.3.9 NMAC - Rp, 8.311.3.9 NMAC, 6/1/2016]

8.311.3.10 GENERAL REIMBURSEMENT POLICY: The state of New Mexico health care authority (hereinafter called the HCA) will reimburse inpatient hospital services rendered on or after October 1, 1989, in the following manner:

A. Covered inpatient services provided to eligible recipients admitted to in-state acute care hospitals and acute care units on or after October 1, 1989 will be reimbursed at a prospectively set rate, determined by the methodology set forth in 8.311.3.12 NMAC, unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsection C through D below.

B. Covered inpatient services provided to eligible recipients admitted to acute care hospitals and acute care units within hospitals located out-of-state or in border areas (Mexico excluded) will be reimbursed at a prospectively set rate as described in Paragraph (16) of Subsection C of 8.311.12 NMAC, unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsections C through D below or at a negotiated rate not to exceed the rate paid by federal programs such as medicare. Negotiation of rates will only be allowed when the HCA determines that the hospital provides a unique service required by an

eligible recipient.

C. Inpatient services provided in rehabilitation and specialty hospitals and medicare PPS-exempt distinct part units within hospitals will be reimbursed using the provisions and principles of reimbursement set forth in Public Law 97-248. This legislation, which was effective October 1, 1982, is commonly referred to as TEFRA (Tax Equity and Finance Reduction Act) and is described in 8.311.3.11 NMAC.

D. Indian health services hospitals will be reimbursed using a per diem rate established by the federal government.

E. New Mexico providers entering the medical assistance division (MAD) program will be reimbursed at the peer group median rate for the applicable peer group, until such time as a distinct rate can be established, unless the hospital meets the criteria for prospective payment exemption as described in Subsections C through D above.

F. All hospitals which meet the criteria in Subsection A of 8.311.3.13 NMAC will be eligible for a disproportionate share adjustment.

G. Effective for discharges on or after April 1, 1992, and in accordance with Section 4604 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the HCA provides for an outlier adjustment in payment amounts for medically necessary inpatient services involving exceptionally high costs or long lengths of stay for children who have not attained the age of six years in disproportionate share hospitals, and for infants under one year of age in all hospitals, and for individuals of any age in the state teaching hospital. The outlier adjustment for these cases is described in Subsection F of 8.311.3.12 NMAC.

H. MAD covered inpatient services provided in specialty hospitals will be reimbursed at an interim rate established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals. If a provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost to charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration.

I. The reimbursement rates established by MAD using the reimbursement principles stated in 8.311.3 NMAC may be reduced or limited by budget availability at the HCA's discretion.

[8.311.3.10 NMAC - Rp, 8.311.3.10 NMAC, 6/1/2016; A, 1/1/2019]

8.311.3.11 PAYMENT METHODOLOGY FOR PPS-EXEMPT HOSPITALS AND EXEMPT UNITS WITHIN HOSPITALS:

A. Application of TEFRA principles of reimbursement:

(1) The principles and methods identified in Public Law 97-248 provision (TEFRA), effective October 1, 1982, regarding allowable payment for inpatient hospital services, and any subsequent changes to such provision shall be used to determine:

(a) the amount payable by the HCA through its fiscal agent for services covered under the MAD program and provided to eligible recipients; and

(b) the manner of payment and the manner of settlement or overpayments and underpayment for inpatient services provided by hospitals for MAD reimbursement purposes, effective for all accounting periods which begin on or after October 1, 1983.

(2) The inflation factor used in the calculations will be identical to that used by medicare to update payments to hospitals which are reimbursed using the TEFRA methodology, except for the period October 9, 1991 through September 30, 1992, for which the inflation factor will be half percent for urban hospitals and one and a half percent for rural hospitals.

(3) In accordance with Section 1902 (s)(3) of the Social Security Act effective July 1, 1991, the TEFRA rate of increase limit for inpatient hospital services will not apply to the delivery of such services to any individual who has not attained their first birthday, (or in the case of such an individual who is an inpatient on their first birthday until such individual is discharged).

B. Appeals:

(1) Hospitals may appeal the target rate and application of same, if circumstances beyond the hospitals' control have caused the reimbursement rates to fall at least five percent below actual allowable costs.

(2) Such appeals must be filed in writing within 180 calendar days of the notice of final settlement and must contain sufficient supporting documentation to demonstrate that the circumstances causing the situation were not within the control of the hospital and that the continued imposition of the target rate would cause a significant financial hardship.

(3) The HCA shall review the supporting documentation and, if appropriate, grant an

exemption from or modification of the target rate. The HCA's determination on the merits of the appeal will be made within 180 calendar days of receipt of the appeal request, although the state may make a determination to extend such period to a specified date as necessary.
[8.311.3.11 NMAC - Rp, 8.311.3.11 NMAC, 6/1/2016]

8.311.3.12 PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS: Payment for all covered inpatient services rendered to eligible recipients admitted to acute care hospitals (other than those identified in Subsections C through D of 8.311.3.10 NMAC) on or after October 1, 1989 shall be made based on a prospective payment approach which compensates hospitals an amount per discharge for discharges classified according to the diagnosis related group (DRG) methodology. The prospective rates for each hospital's MAD discharges will be determined by the HCA in the manner described in the following subsections.

A. Services included in or excluded from the prospective payment rate:

(1) Prospective payment rates shall constitute payment in full for each MAD discharge. Hospitals may not separately bill the eligible recipient or the MAD program for medical services rendered during an inpatient stay, except as described below. Hospitals may submit a claim for payment only upon the final discharge of an eligible recipient or upon completion of the transfer of the eligible recipient to another acute care hospital.

(2) The prospective payment rate shall include all services provided to hospital inpatients. These services shall include all items and non-physician services furnished directly or indirectly to hospital inpatients, such as:

(a) laboratory services;

(b) pacemakers and other prosthetic devices, including lenses and artificial limbs, knees and hips;

(c) radiology services, including computed tomography (CT) or magnetic resonance imaging (MRI) scans furnished to an eligible recipient by a physician's office, other hospital or radiology clinic;

(d) transportation (including transportation by ambulance) to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services.

(3) Services which may be billed separately include:

(a) ambulance service when the eligible recipient is transferred from one hospital to another and is admitted as an inpatient to the second hospital;

(b) physician services furnished to an individual eligible recipient.

B. Computation of DRG relative weights:

(1) Relative weights used for determining rates for cases paid by DRG under the state plan shall be derived, to the greatest extent possible, from New Mexico MAD hospital claim data. All such claims are included in the relative weight computation, except as described below.

(2) Hospital claim data for discharges occurring from January 1, 1985 through approximately the end of calendar year 1988 are included in the computation and prepared as follows:

(a) claims are edited to merge interim bills from the same discharge;

(b) all MAD inpatient discharges will be classified using the DRG methodology, a patient classification system that reflects clinically cohesive groupings of inpatient cases which consume similar amounts of hospital resources; claims are assigned to appropriate DRGs using DRG grouper software;

(c) claims included in the computation of DRG relative weights were restricted to those claims for cases to be included in the proposed PPS; claims for services provided in PPS-exempt hospitals or units (or for services otherwise exempt from the PPS) were not used to compute DRG relative weights.

(3) Charges for varying years are adjusted to represent a common year through application of inflation indices as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC.

(4) Initial relative weights are computed by calculation of the average MAD charge for each DRG category divided by the average charge for all DRGs.

(5) Where the New Mexico MAD-specific claims and charge data are insufficient to establish a stable relative weight, a relative weight is imported from other sources such as the CHAMPUS or medicare prospective payment systems. Weights obtained from external sources are normalized so that the overall case mix is 1.0.

(6) The relative weights computed as described above shall remain in effect until the next year. At that time, the relative weights will be recalculated using the DRG grouper version similar to the one in use by medicare.

C. Computation of hospital prospective payment rates:

(1) Rebasing of rates: Beginning October 1, 1997, the HCA discontinued the rebasing of

rates every three years. Hospital rates in effect October 1, 1996 were updated by the most current market basket index (MBI) as determined by the centers for medicare and medicaid services (CMS) for rates effective October 1, 1997 and succeeding years. Thereafter, pursuant to budget availability and at the HCA's discretion, the application of the MBI inflation factor will be reviewed based upon economic conditions and trends. A notice will be sent annually, informing the provider if an MBI increase or a percentage up to the MBI is planned for the year. Comments will be accepted by the HCA prior to making a final decision.

(2) Base year discharge and cost data:

(a) The state's fiscal agent will provide the HCA with MAD discharges for the provider's last fiscal year which falls in the calendar year prior to year one.

(b) The state's audit agent will provide MAD costs incurred, reported, audited, or desk audited for the same period.

(c) To calculate the total reimbursable inpatient operating costs from the cost and discharge data described above, the HCA will:

(i) exclude estimated outlier discharges and costs as described in Paragraph (4) of Subsection C of 8.311.3.12 NMAC;

(ii) exclude pass-through costs, as identified in the TEFRA provisions and further defined in Paragraph (3) of Subsection C of 8.311.3.12 NMAC below.

(3) Definition of excludable costs per discharge; reduction of excludable capital costs:

(a) The approach used by the HCA to define excludable costs parallels medicare's approach. Excludable costs are defined according to the PPS or TEFRA methodology and include such costs as those associated with capital, organ acquisition, and certified nurse anesthetists.

(b) The pass-through capital costs identified using TEFRA provisions will be reduced in a manner similar to that employed by the medicare PPS. For example, excludable capital costs for fiscal year 1989 will be reduced by fifteen percent as required by Section 4006 of the Omnibus Budget Reconciliation Act of 1987. However, any such reduction to pass-through capital costs will only apply to those costs incurred after October 1, 1989.

(4) Outlier adjustment factors: Hospital-specific outlier adjustment factors will be used to deduct outlier costs and cases from the total MAD inpatient operating costs and cases used in rate setting. These factors will be determined by using actual claim and cost data for outlier cases for the base year period. Only claims for cases to be paid by DRG will be included in the analysis used to determine this estimate. The definition of an outlier case can be found in Paragraph (1) of Subsection F of 8.311.3.12 NMAC.

(5) Calculation of base year operating cost per discharge: The total reimbursable inpatient operating cost (excluding pass-through costs and estimated outlier costs) is divided by the hospital's number of non-outlier MAD discharges to produce the base year operating cost per discharge. The base rate methodology is described below:

BYOR = OC/D

BYOR = base year operating cost per discharge

OC = total Title XIX inpatient operating cost for the base year, less excludable costs and estimated outlier costs

D = MAD discharges for the hospital's base year as provided by the HCA's fiscal agent, less estimated outlier cases

(6) Possible use of interim base year operating cost per discharge rate:

(a) If the fiscal agent and audit agent have not provided the HCA with a hospital's base year discharges and costs as of June 1 prior to year one, the HCA will develop an interim operating cost per discharge base rate. This rate will be developed according to the normal base rate methodology, but using costs and discharges for the fiscal year prior to the base year.

(b) When an interim rate is developed, the operating costs per discharge are first multiplied by an inflation index (as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC) to bring the costs to the midpoint of the base year. When the provider's actual base year costs and discharges become available, the HCA will calculate a final base year operating cost per discharge using the normal base rate methodology. The rate that is computed from the final base year operating costs per discharge will apply to all discharges in year one, retroactive to the effective date of the interim rate.

(7) Prohibition against substitution or rearrangement of base year cost reports:

(a) A hospital's base year cost reports cannot be substituted or rearranged once the HCA has determined that the actual cost submission is suitable. A submission shall be deemed suitable 180 calendar days from the date of the notice of proposed rate (NPR) issued by the state's intermediary in the absence of

an appeal by the hospital to the intermediary and the state.

(b) In the event of such an appeal, the state must make a written determination on the merits of the appeal within 180 calendar days of receipt, although the state may make a determination to extend such period to a specified date as necessary. Once such an appeal has been determined, the resulting base cost will be effective retroactively to year one and will not be changed until subsequent rebasing of all hospitals has been completed.

(8) Application of inflation factors:

(a) The inflation factors used to update operating costs per discharge will be identical to those established by congress and adopted for use by CMS to update medicare inpatient prospective payment rates. The medicare prospective payment update factor (MPPUF) is determined by CMS, usually on an annual basis, and may differ depending upon the hospital type (urban, large urban, or rural) as defined by CMS.

(b) Each hospital's base year operating cost per discharge will be indexed up to the common point of December 31 falling prior to year one, using the applicable medicare prospective payment update factors (MPPUF) for that hospital for that period. That is, the inflation factors used will be identical to those established by congress and adopted for use by CMS to update medicare inpatient prospective payment rates, including any established differential for urban and rural hospitals. Then this value will be indexed using the applicable MPPUF corresponding to the period beginning October 1 (prior to year one) and ending with the midpoint of operating year one. For years two and three, the inflation factors will be the applicable MPPUF as specified by CMS.

(c) For the period October 9, 1991, through September 30, 1992, an exception to (a) and (b) above was made. The inflation factor used to update rates for that period is half percent for urban hospitals and one and a half percent for rural hospitals.

(9) Case-mix adjustments for base year operating cost per discharge rate:

(a) The HCA will adjust the operating cost per discharge rate to account for case-mix changes, based on the classification of inpatient hospital discharges according to the DRG methodology established and used by the medicare program.

(b) For each DRG, the HCA determines a relative value (the DRG relative weight) which reflects the charges for hospital resources used for the DRG relative to the average charges of all hospital cases. The HCA's methodology for computing DRG relative weights was discussed earlier in Subsection B of 8.311.3.12 NMAC. Case-mix adjustments will be computed using the methodology described below.

(c) Case-mix computation: Each base year, a hospital's case-mix index will be computed by the HCA and its fiscal agent as follows:

(i) all MAD discharges are assigned to appropriate DRGs;

(ii) the case-mix index is computed for each hospital by summing the products of the case frequency and its DRG weight and dividing this sum by the total number of title XIX cases at the hospital.

(d) The case-mix adjustment is applied to the base year operating cost per discharge as described in Subparagraph (e) of Paragraph (10) of Subsection C of 8.311.3.12 NMAC below.

(10) Limitations on operating cost prospective per discharge rates:

(a) Limitations on operating cost prospective base rates will be imposed using a peer group methodology. Effective October 1, 1989, hospitals will be placed in one of six possible peer groups (teaching, referral, regional, low-volume regional, community and low-volume community) based on the following criteria: bed size, case-mix, services available, population served, location, trauma designation, teaching status, and low-volume (i.e. less than 150 MAD discharges per year.)

(b) At the time of the next rebasing year following October 1, 1989, the criteria regarding low-volume utilization was dropped along with the low-volume peer groups, thus leaving four possible peer groups for assignment (teaching, referral, regional and community).

(c) The HCA will determine the peer group assignment of each hospital, and appeal of such assignment will be allowed only as described in Paragraph (1) of Subsection D of 8.311.3.12 NMAC.

(d) A ceiling on allowable operating costs will be set at one hundred ten percent of the median of costs for all hospitals in the peer group, after application of each hospital's case mix and indexing of the cost from the hospital's fiscal year end to a common point of December 31. These adjustments are made to equalize the status of each hospital for ceiling establishment purposes. The median shall be the midpoint of rates (or the average of the rates of the two hospitals closest to the midpoint).

(e) The case-mix equalization for each hospital in a peer group will be calculated as follows:

PGR = BYOR/CMI
PGR = hospital rate equalized for peer group comparison
BYOR = base year operating cost per discharge
CMI = case-mix index in the base year

(f) The allowable operating cost per discharge rate (hospital-specific rate) will be the lower of:

(i) the ceiling for the hospital's peer group; or

(ii) the hospital rate resulting from the computation found in Subparagraph (e) of Paragraph (10) of Subsection C of 8.311.3.12 NMAC above.

(11) Computation of prospective operating cost per discharge rate: The following formulas are used to determine the prospective operating cost per discharge rate for years one, two and three:

Year one

PDO1 = HSR x (1 + MPPUF)
PDO1 = per discharge operating cost rate for year one
HSR = the hospital-specific rate, which is the lower of the peer group ceiling or the hospital's rate, equalized for peer group comparison
MPPUF = the applicable medicare prospective payment update factor as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC

Year two

PDO2 = PDO1 x (1 + MPPUF)
PDO2 = per discharge operating cost rate for year two
PDO1 = per discharge operating cost rate for year one
MPPUF = the applicable medicare prospective payment update factor as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC

Year three

PDO3 = PDO2 x (1 + MPPUF)
PDO3 = per discharge operating cost rate for year three
PDO2 = per discharge operating cost rate for year two
MPPUF = the applicable medicare prospective payment update factor as described in Paragraph (8) of Subsection C of 8.311.3.12 NMAC.

(12) Computation of excludable cost per discharge rate: Total MAD excludable cost, as identified in TEFRA, with excludable capital costs reduced as indicated in Paragraph (3) of Subsection C of 8.311.3.12 NMAC, will be paid in the following manner:

(a) An excludable cost per discharge rate is computed using the following methodology:

ER = ECP/DCY
ER = excludable cost per discharge rate
ECP = excludable costs on the hospital's most recently settled cost report prior to the rate year, as determined by the audit agent.
DCY = MAD discharges for the calendar year prior to the rate year, as determined by the HCA's fiscal agent.

(b) The retrospective settlement will be determined based on a percentage of the actual allowable amount of MAD excludable costs incurred by a hospital during the hospital's fiscal year as determined by the HCA.

(13) Computation of prospective per discharge rate: The excludable cost per discharge, as described in Paragraph (12) of Subsection C of 8.311.3.12 NMAC above, will be added to the appropriate operating per discharge rates to determine the prospective rates.

(14) Effective dates of prospective rates: Rates were implemented October 1, 1989 and continue to be effective as of October 1 of each year for each hospital.

(15) Effect on prospective payment rates of a change of hospital ownership: When a hospital is sold or leased, no change is made to the hospital's per discharge rate as a result of the sale or lease transaction.

(16) Rate setting for border-area hospitals: Border-area hospitals will be reimbursed at median rate (including excludable cost pass-throughs) for the regional peer group.

D. Changes to prospective rates:

(1) Appeals: Hospitals may appeal for a change in the operating component of the

prospective payment rate, including a change in peer group assignment, as applicable. For an appeal to be considered, the hospital must demonstrate in the appeal that:

(a) the following five requirements are satisfied:

(i) the hospital inpatient service mix for MAD admissions has changed due to a major change in scope of facilities and services provided by the hospital;

(ii) the change in scope of facilities and services has satisfied all regulatory and statutory requirements which may be applicable, such as facility licensure and certification requirements and any other facility or services requirements which might apply;

(iii) the expanded services were a) not available to eligible recipients in the area; or b) are now provided to eligible recipients by the hospital at a lower reimbursement rate than would be obtained in other hospitals providing the service;

(iv) the magnitude of the proposed (as appealed) prospective per discharge rate for the subsequent year will exceed one hundred five percent of the rate that would have otherwise been paid to the hospital;

(v) in addition to requirements Items (i) through (iv) above, appeals for rate adjustment will not be considered if cost changes are due to changes in hospital occupancy rate, collective bargaining actions, changes in hospital ownership or affiliation, or changes in levels of rates of increases of incurred cost items which were included in the base rate;

(b) the appeal must provide a specific recommendation(s) regarding the magnitude of alterations in the appellant's prospective rate per discharge and peer group reassignment, as applicable; in making its decision on any appeal, the HCA shall be limited to the following options:

(i) reject the appeal on the basis of a failure of the appellant to demonstrate necessary conditions and documentation for an appeal as specified in Subparagraph (a) of Paragraph (1) of Subsection D of 8.311.3.12 NMAC above; or

(ii) accept all of the specific recommendations, as stated in the appeal, in their entirety; or

(iii) adopt modified versions of the recommendations as stated in the appeal; or

(iv) reject all of the recommendations in the appeal;

(c) hospitals are limited to one appeal per year, which must be filed in writing with the MAD director by a duly authorized officer of the hospital no later than July 1 of each year; within 15 calendar days of the filing date, the HCA shall offer the appellant the opportunity for hearing of the appeal; if such a hearing is requested, it shall occur within 30 calendar days of the filing date; the HCA shall notify the appellant of the decision of the appeal in writing no later than September 15 of the year in which the appeal is filed.

E. Retroactive settlement:

(1) Retroactive settlement may occur in those cases in which no audited cost reports were available at the time of rate setting and an interim rate was used. Retroactive settlement will only occur in those cases where adjustments to interim rates are required. For year one, the HCA's audit agent will determine the difference between payments to the hospital under the interim operating cost per discharge rate and what these payments would have been under the final rate. The audit agent will report the amount of overpayment or underpayment for each facility within 90 calendar days of the effective date of the final rate. Retroactive settlements will be based on actual claims paid while the interim rate was in effect.

(2) Underpayments: In the event that the interim rate for year one is less than the final rate, the HCA will include the amount of underpayment in a subsequent payment to the facility within 30 calendar days of notification of underpayment.

(3) Overpayments: In the event that the interim rate exceeds the final rate, the following procedure will be implemented: the facility will have 30 calendar days from the date of notification of overpayment to submit the amount owed to the HCA in full. If the amount is not submitted on a timely basis, the HCA will begin withholding from future payments until the overpayment is satisfied in full.

(4) Retroactive settlements for excludable costs will be handled in the same manner as described above.

F. Special prospective payment provisions:

(1) Outlier cases:

(a) For other than the state teaching hospital, outlier cases are defined as those cases with medically necessary services exceeding $100,000 in billed charges, or those with medically necessary lengths of stay of 75 calendar days or more, when such services are provided to eligible children up to age six in

disproportionate share hospitals, and to eligible infants under age one in all hospitals. For the state teaching hospital only, the outlier provisions are applied without regard to age of the recipient in cases with medically necessary services exceeding $125,000 in billed charges or those medically necessary lengths of stay of 75 calendar days or more. All cases will be removed from the DRG payment system and paid at an amount equal to eighty-five percent of the hospital's standardized cost. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio as calculated from the hospital's most recent cost report.

(b) Utilization review will be performed on all outlier cases to determine the medical necessity of services rendered. Should this review determine non-medical necessity for all or part of the services, these services will be deducted from the billed amount prior to payment.

(2) Payment for transfer cases:

(a) All cases transferred from one acute care hospital to another will be monitored under a utilization review policy to ensure that the HCA does not pay for inappropriate transfers.

(b) The following methodology will be used to reimburse the transferring and discharging hospitals for appropriate transfers if both hospitals and any hospital units involved are included in the PPS.

(i) A hospital inpatient shall be considered "transferred" when an eligible recipient has been moved from one DRG acute inpatient facility to another DRG acute inpatient facility. Movement of an eligible recipient from one unit to another unit within the same hospital shall not constitute a transfer, unless the eligible recipient is being moved to a PPS exempt unit within the hospital.

(ii) The transferring hospital will be paid the lesser of standardized costs or the appropriate DRG payment amount. Should the stay in the transferring hospital qualify for an outlier payment, then the case will be paid as an outlier as described in Subsection F of 8.311.3.12 NMAC. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio.

(iii) The receiving hospital which ultimately discharges the eligible recipient will receive the full DRG payment amount, or, if applicable, any outlier payments associated with the case. All other hospitals which admitted and subsequently transferred the eligible recipient to another acute care hospital during a single spell of illness shall be considered transferring hospitals.

(c) If the transferring or discharge hospital or unit is exempt from the PPS, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or unit.

(3) Payment for readmissions:

(a) Readmissions that occur within 24 hours of the previous discharge of an eligible recipient with the same or related diagnosis related group (DRG) will be considered part of the prior admission and not paid separately when the admissions are to the same hospital. When the second admission is to a different hospital, the claims may be reviewed to determine if the initial claim should be considered as a transfer.

(b) Readmissions occurring within 15 calendar days of prior acute care admission for a related condition may be reviewed to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the HCA.

(4) Payment for inappropriate brief admissions: Hospital stays of up to two calendar days in length may be reviewed for medical necessity and appropriateness of care. (Discharges involving eligible recipient healthy mothers and healthy newborns are excluded from this review provision.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient discharge will be denied. If the inpatient claim is denied, the hospital is permitted to resubmit an outpatient claim for the services rendered. Such review may be further focused to exempt certain cases at the sole discretion of the HCA.

(5) Payment for non-medically warranted days:

(a) Reimbursement for eligible recipients admitted to a hospital receiving services at an inappropriate level of care will be made at rates reflecting the level of care actually received. The number of days covered by the MAD program is determined based only upon medical necessity for an acute level of hospital care.

(b) When it is determined that an eligible recipient no longer requires acute-level care but does require a lower level of institutional care, and when placement in such care cannot be located, a DRG hospital will be reimbursed for "awaiting placement" days. Reimbursement will be made at the weighted average rate paid by the HCA in the preceding calendar year for the level of care needed. There is no limit on the number of covered "awaiting placement" days as long as those days are medically necessary. However, the hospital is encouraged to make every effort to secure appropriate placement for the eligible recipient as soon as possible. During "awaiting placement" days, no ancillary services will be paid, but medically necessary physician visits will

be reimbursed.

(6) Indirect medical education (IME) adjustment: To help cover the cost of residency programs, each acute care hospital that qualifies as a teaching hospital will receive an IME payment adjustment, which covers the increased operating or patient care costs that are associated with approved intern and resident programs. The IME payment adjustment is subject to available state and federal funding, as determined by the HCA and shall not exceed any amounts specified in the *medicaid state plan*.

(a) In order to qualify as a teaching hospital and be deemed eligible for an IME adjustment, the hospital must:

(i) be licensed by the state of New Mexico; and

(ii) be reimbursed on a DRG basis under the plan; and

(iii) have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs or operate a nationally-accredited primary care residency program.

(b) Determination of a hospital's eligibility for an IME adjustment will be done annually by the HCA, as of the first day of the provider's fiscal year. If a hospital meets the qualification for an IME adjustment after the start of its fiscal year, it will be deemed eligible for the IME adjustment beginning on the first day of the quarter after the date the qualification were met. A determination that a hospital qualifies as a teaching hospital for IME payments is not to be construed as the state teaching hospital with regard to DRG outlier payments or for GME payments.

(c) The IME payment will be calculated separately for regular medicaid and group VIII (the other adult group who are newly eligible for medicaid under the affordable care act).

(d) The IME payment amount by population group is determined by multiplying DRG operating payments for each group, which are DRG payments and outlier payments, by the IME adjustment factor computed by the following formula:

$1.89*((1+R)^{.405}-1)$

where R equals the number of approved full-time equivalent (FTE) residents divided by the number of available beds (excluding nursery and neonatal bassinets). FTE residents are counted in accordance with 42 CFR 412.105(f), except that the limits on the total number of FTE residents in 42 CFR 412.10(f)(1)(iv) shall not apply, and at no time shall exceed 450 FTE residents. For purposes of this paragraph, DRG operating payments include the estimated average per discharge amount that would otherwise have been paid for MAD managed care enrollees if those persons had not been enrolled in managed care.

(e) Quarterly IME payments will be made to qualifying hospitals at the end of each quarter. Prior to the end of each quarter, the provider will submit to the HCA's audit agent the information necessary to make the calculation, i.e. number of beds, number of estimated residents for the quarter, and the MAD DRG amount. After review and adjustment, if necessary, the audit agent will notify the HCA of the amount due to/from the provider for the application quarter. Final settlement of the IME adjustment amount will be made through the cost report; that is, the number of beds, residents, and DRG amounts used in the quarterly calculation will be adjusted to the actual numbers shown on the provider's cost report for those quarters.

(7) Payment for direct graduate medical education (GME): For services provided on or after July 1, 1998, payment to hospitals for GME expense is made on a prospective basis as described in this section. Payments will be made quarterly to qualifying hospitals, at a rate determined by the number of resident full-time-equivalents (FTEs) in the various categories defined below, who worked at the hospital during the preceding year, and subject to an upper limit on total payments. The GME payment is subject to available state and federal funding, as determined by the HCA, and shall not exceed any amounts specified in the *medicaid state plan*.

(a) To be counted for MAD reimbursement, a resident must be participating in an approved medical residency program, as defined by medicare in 42 CFR 413.75. With regard to categorizing residents, as described in Subparagraph (b) of Paragraph (9) below, the manner of counting and weighting resident FTEs will be the same as is used by medicare in 42 CFR 413.79 except that the number of FTE residents shall not be subject to the FTE resident cap described in 42 CFR 413.79(b)(2). Resident FTEs whose costs will be reimbursed by the HCA as a medical expense to a federally qualified health center are not eligible for reimbursement under this section. To qualify for MAD GME payments, a hospital must be licensed by the state of New Mexico, be currently enrolled as a MAD provider, and must have achieved a MAD inpatient utilization rate of five percent or greater during its most recently concluded hospital fiscal year. For the purposes of this section, the MAD inpatient utilization rate will be calculated as the ratio of New Mexico MAD eligible days, including inpatient days paid under MAD managed care arrangements, to total inpatient hospital days.

(b) Approved resident FTEs are categorized as follows for MAD GME payment:

(i) Primary care/obstetrics resident: Primary care is defined per 42

CFR 413.75(b).

(ii) Rural health resident: A resident is defined as participating in a designated rural health residency program. Residents enrolled in a designated rural health residency program will be counted as a rural health resident FTE for the entire duration of their residency, including those portions of their residency which may be served in a non-rural hospital or clinic. Should any resident meet the criteria for both rural health and primary care in this section, this resident will be counted as a rural health resident.

(iii) Other approved resident: Any resident not meeting the criteria in Items (i) or (ii), above.

(c) MAD GME payment amount per resident FTE:

(i) The annual MAD payment amount per resident FTE with state fiscal year 2017 is as follows:

Primary care/obstetrics resident:	$41,000
Rural health resident:	$52,000
Other resident:	$50,000

(ii) The per resident amounts specified in Item (i) of Subparagraph (c) of Paragraph (9) of Subsection F of 8.311.3.11 NMAC will be inflated for state fiscal years beginning on or after July 1, 2017 using the annual inflation update factor described in Item (ii) of Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC.

(d) Annual inflation update factor:

(i) Effective for state fiscal years 2000 and beyond, the HCA has updated the per resident GME amounts and the upper limit on GME payments for inflation, using the market basket forecast published in the CMS Dallas regional medical services letter issued for the quarter ending in March 1999 to determine the GME rates for state fiscal year 2000 (July 1, 1999 - June 30, 2000).

(ii) The HCA will use the market basket forecast shown for PPS hospitals that is applicable to the period during which the rates will be in effect. MAD will determine the percentage of funds available for GME payments to eligible hospitals.

(e) Annual upper limits on GME payments:

(i) Total annual MAD GME payments will be limited to $18,500,000 for state fiscal year 2017. This amount will be updated for inflation, beginning with state fiscal year 2018, in accordance with Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC.

(ii) Total annual GME payments for residents in Category B.3, "Other," will be limited to the following percentages of the $18,500,000 total annual limit (as updated for inflation in accordance with Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC):

state fiscal year 1999	58.3 percent
state fiscal year 2000	56.8 percent
state fiscal year 2001	53.3 percent
state fiscal year 2002	50.7 percent
state fiscal year 2003	48.0 percent
state fiscal year 2004	45.5 percent
state fiscal year 2005	43.0 percent
state fiscal year 2006	40.4 percent
state fiscal year 2017 and thereafter	no limit

(f) Allocation Methodology: The result of the GME payment calculation will be allocated between regular medicaid and group VIII (the other adult group who are newly eligible for medicaid under the affordable care act) based on the medicaid enrollment ratio from the most recent available quarter.

(g) Reporting and payment schedule:

(i) Hospitals will count the number of residents working according to the specification in this part during each fiscal year (July 1 through June 30) and will report this information to the HCA by December 31. Counts will represent the weighted average number of residents who worked in the hospitals during the specified 12-month period. Hospitals may also add to this count any FTEs associated with newly approved residency programs that will be implemented on or before the start of the prospective GME payment year, to the extent that these FTEs are not already reflected in the weighted average counts of the preceding year. To illustrate, resident FTE amounts would be counted from 07/01/96 - 06/30/97 for the payment year 07/01/98 - 06/30/99. The HCA may require hospitals to provide documentation necessary to support the summary counts provided.

(ii) The HCA will establish the amount payable to each hospital for the

prospective payment period that will begin each July 1. Should total payments as initially calculated exceed either of the limitations in Subsection D of 8.311.3.11 NMAC, the amount payable to each will be proportionately reduced.

(iii) The annual amount payable to each hospital is divided into four equal payments. These payments will be made by the HCA on or about the start of each prospective payment quarter.

(iv) Should a facility not report timely with the accurate resident information as required in Item (i) of Subparagraph (f) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC above, it will still be entitled to receive payment for any quarter yet remaining in the prospective payment year, after acceptable information has been submitted. However, payments to untimely reporting facilities will be limited to the amount of funds that remain available under the upper limits described in Subsection D of 8.311.3.11 NMAC, after prospective payment amounts to timely filing facilities have been established.

[8.311.3.12 NMAC - Rp, 8.311.3.12 NMAC, 6/1/2016; A, 1/1/2018; A, 1/1/2019]

8.311.3.13 DISPROPORTIONATE SHARE HOSPITALS: To take into account the situation of hospitals serving a disproportionate number of low-income patients with special needs, a payment will be made to qualifying hospitals.

A. Criteria for deeming hospitals eligible for a disproportionate share payment:

(1) Determination of each hospital's eligibility for a disproportionate share payment for the MAD inpatient utilization rate as listed below, will be done annually by the HCA's audit agent, based on the hospital's most recently filed cost report. Hospitals which believe they qualify under the low income utilization rate must submit documentation justifying their qualification. This documentation should be submitted to the HCA by March 31 of each year.

(2) In the case of a DRG hospital with a PPS exempt specialty unit, data from the entire facility will be considered to determine DSH status.

(3) The following criteria must be met before a hospital is deemed to be eligible:

(a) Minimum criteria: The hospital must have:

(i) a MAD inpatient utilization rate greater than the mean MAD inpatient utilization rate for hospitals receiving MAD payments in the state; or

(ii) a low-income utilization rate exceeding twenty-five percent; (refer to Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC for definitions of these criteria).

(iii) The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to eligible recipients entitled to such services under MAD; in the case of a hospital located in a rural area (defined as an area outside of a metropolitan statistical area (MSA), as defined by the United States executive office of management and budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

(iv) Item (iii) of Subparagraph (a) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC does not apply to a hospital which meets the following criteria: the inpatients are predominantly individuals under 18 years of age; or the hospital did not offer non-emergency obstetric services as of December 22, 1987;

(v) the hospital must have, at a minimum, a MAD inpatient utilization rate (MUR) of one percent.

(b) Definitions of criteria:

(i) MAD inpatient utilization: For a hospital, the total number of its MAD inpatient days in a cost reporting period, divided by the total number of the hospital's inpatient days in the same period. These include both MAD managed care and non-managed care MAD inpatient days.

(ii) Low-income utilization rate: For a hospital, the sum (expressed as a percentage) of the following fractions: the sum of total MAD inpatient and outpatient net revenues (this includes MAD managed care and non-managed care revenues) paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of net revenues of the hospital for inpatient and outpatient services (including the amount of such cash subsidies) in the same cost reporting period; and the total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the amount of the cash subsidies received directly from the state and local governments in that period reasonably attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. If this number is zero or less than zero, then it is assumed to be zero. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts

(other than for indigent patients not eligible for medical assistance under an approved MAD state plan), that is, reductions in charges given to other third-party payers, such as HMOs, medicare, or Blue Cross.

(iii) The medicaid utilization rate (MUR) is computed as follows:

MUR % = 100 x M/T

M = hospital's number of inpatient days attributable to eligible recipients under the MAD state plan; these include MAD managed care and non-managed care days

T = hospital's total inpatient days.

(iv) Newborn days, days in specialized wards, and administratively necessary days are included in this calculation. Additionally, days attributable to individuals eligible for medicaid in another state are included. MAD inpatient days includes both MAD managed care and non-managed care patient days.

(v) The numerator (M) does not include days attributable to recipients 21 or older in institutions for mental disease (IMD) as these patients are not eligible for MAD coverage in IMDs under the New Mexico state plan and cannot be considered a MAD day.

B. Inpatient disproportionate share pools: Section 1923 of the Social Security Act allows qualifying hospitals to receive a disproportionate share payment, in addition to their allowable regular claims payments and any other payments to which they are entitled. This determination is performed annually as described in Subsection A of 8.311.3.13 NMAC. Qualifying hospitals will be classified into one of three disproportionate share hospital pools: Teaching PPS hospitals, non-teaching PPS hospitals, and PPS-exempt (TEFRA) hospitals. Hospitals may also qualify for a payment from a fourth pool: reserve pool, as explained in this Subsection C of 8.311.3.13 NMAC below.

(1) To qualify as a teaching hospital and be eligible for the teaching hospital DSH payment, the hospital must:

(a) be licensed by the state of New Mexico; and

(b) reimbursed, or be eligible to be reimbursed, under the DRG basis under the plan; and

(c) have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

(2) A non-teaching PPS (DRG) hospital qualifies if it is an in-state acute care hospital reimbursed by or eligible to be reimbursed by prospective payment methodology.

(3) A PPS-exempt hospital (TEFRA) such as rehabilitation hospitals, children's hospitals, or free-standing psychiatric hospitals, qualify if it is reimbursed by or eligible to be reimbursed by TEFRA methodology as described in 8.311.3.11 NMAC.

(4) The reserve pool is to compensate DSH qualifying hospitals which have had a disproportionate shift in the delivery of services between low-income and MAD-covered inpatient days in any given quarter. A hospital will qualify for payment from the reserve pool if its charity ratio, as described in Item (ii) of Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC, exceeds twenty percent. A qualifying hospital may receive a payment from the reserve pool in addition to its payment from one of the three other pools.

C. Disproportionate share hospital payments:

(1) DSH payments are subject to available state and federal funding, as determined by the HCA.

(2) If DSH funds are available, they shall be allocated to each pool and paid to qualifying hospitals based on the number of MAD discharges. These include both MAD managed care and non-managed care discharges. A discharge occurs when a patient dies in the hospital, is formally released from the hospital, or is transferred to another hospital or nursing home.

(3) Payments are made quarterly, with the annual amount for the pool divided into four parts, and each part distributed after the end of each quarter based on MAD discharges during that quarter. The quarterly payment to each hospital qualifying for DSH pools one, two, or three will be computed by dividing the number of MAD discharges for that hospital by the total number of MAD discharges from all hospitals qualifying for that DSH pool and then multiplying this pro-rata share by the quarterly allocation for the respective pool. This amount cannot exceed the OBRA 93 DSH limit, which is described in Subsections E and F of 8.311.3.13 NMAC.

(4) MAD will review the allocation of DSH funds prior to the start of each state fiscal year and may re-allocate funds between pools at that time in consideration of shifts in the hospital utilization of MAD and low-income/indigent care patients.

(5) The percentages allocated to each pool for state fiscal year 1998 are as listed below. The total allocations shall be adjusted in subsequent state fiscal years based on the medicare prospective payment update

factor (MPPUF) or the DSH budget as defined by the HCA. The base year DSH budget for state fiscal year 1998 is $22,000,000.

(a) The teaching PPS hospital DSH pool is fifty-six percent of the overall DSH budget, as defined by HCA.

(b) The non-teaching PPS (DRG) hospital DSH pool is twenty two and a half percent of the overall DSH budget, as defined by HCA.

(c) The PPS-exempt hospital (TEFRA) DSH pool is one and a half percent of the overall DSH budget, as defined by HCA.

(d) The reserve DSH pool is twenty percent of the overall DSH budget, as defined by HCA. Quarterly payments may be made directly from the reserve pool to hospitals qualifying for any of the other three DSH pools at the rate of N dollars per MAD discharge, where N is equal to the fraction described in Item (ii) of Subparagraph (b) of Paragraph (3) of Subsection A of 8.311.3.13 NMAC minus twenty percent, multiplied by $1,750.

D. Request for DSH payment procedures: Hospitals must submit to the HCA the number of MAD discharges (both managed care and fee for service discharges), which they have incurred 30 calendar days after the end of each quarter. The HCA will review the hospital's documentation supporting their discharge information. Any requests received later than 60 calendar days from the end of the quarter will be denied as untimely.

E. DSH limits:

(1) Pursuant to section 1923 (g) of the Social Security Act, a limit is placed on the payment adjustment for any hospital. A hospital's payment adjustment determined in Subsections B through D of 8.311.3.13 NMAC shall not exceed that hospital's hospital-specific DSH limit, as determined under Subsection E of 8.311.3.13 NMAC. This limit is calculated as follows:

DSH limit = M + U

M = Cost of services to eligible recipients, less the amount paid by the MAD program under the non-DSH payment provisions of this plan

U = Cost of services to uninsured patients, less any cash payments made by them.

(2) The cost of services will include both inpatient and outpatient costs for purposes of calculating the limit. The "costs of services" are defined as those costs determined allowable under this plan. "Uninsured patients" are defined as those patients who do not possess health insurance or do not have a source of third-party payment for services provided, including individuals who do not possess health insurance which would apply to the service for which the individual sought treatment. Payments made to a hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third-party payment.

(3) Recovery of Overpayments: The HCA has one year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the federal share must be refunded to CMS in accordance with 42 CFR 433.312. Upon DSH reconciliation, the audit agent or the HCA will notify the provider in writing of an overpayment and will specify the dollar amount that is subject to recovery. The provider has 90 calendar days from the date of notification to submit the payment in full unless otherwise directed by the HCA.

F. Limitations in New Mexico DSH allotment: If the DSH payment amounts as described in Subsections C through E of 8.311.3.13 NMAC above, exceed in any given year, the federal determined DSH allotment for New Mexico, the DSH allocations by pool will be reduced proportionately to a level in compliance with the New Mexico DSH allotment.

[8.311.3.13 NMAC - Rp, 8.311.3.13 NMAC, 6/1/2016; A, 1/1/2019]

8.311.3.14 DETERMINATION OF ACTUAL, ALLOWABLE, AND REASONABLE COSTS:

A. Adequate cost data:

(1) All hospitals must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The hospital will submit a cost report each year. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

(2) The cost finding method to be used by hospitals will be the step-down method. This method recognizes that services rendered by certain non-revenue-producing HCAs or centers are utilized by certain other non-revenue-producing centers. All costs of non-revenue-producing centers are allocated to all centers which

they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue-producing center serving the greatest number of other centers while receiving benefits from the least number of centers is apportioned first. Following the apportionment of the cost of the non-revenue-producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greatest amount of expense will be allocated first.

B. **Reporting year:** For the purpose of determining payment rates, the reporting year is the hospital's fiscal year.

C. **Cost reporting:** At the end of each of its fiscal years, the hospital will provide to the HCA or its audit agent an itemized list of allowable costs (financial and statistical report) on the New Mexico MAD cost reporting form. The cost report must be submitted within five months after the close of the hospital's fiscal year. Failure to file a report within the five month limit, unless an extension is granted, will result in any or all of the following: suspensions of MAD payments, suspension of the provider's medicaid number, or a penalty of $100 per day until such time as the report and other substantiating data is received. Extensions may be granted based on 42 CFR Part 413.

D. **Retention of records:**

(1) Each hospital will maintain financial and statistical records of the period covered by such cost report for a period of 10 years following the date of submittal of the New Mexico MAD cost report to the HCA. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider will make such records available upon demand to representatives of the HCA, the state of New Mexico audit agent, or the United States department of health and human services.

(2) The HCA or its audit agent will retain all cost reports submitted by providers for a period of 10 years following the date of final settlement of such reports.

E. **Audits:**

(1) **Desk audit:** Each cost report submitted will be subjected to a comprehensive desk audit by the state's audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the HCA.

(2) **Field audit:** Field audits will be performed on all facilities and per the auditing schedule established by medicare. The purpose of the field audit of the facility's financial and statistical records is to verify that the data submitted on the cost report is accurate, complete, and reasonable. The field audits are conducted in accordance with generally accepted auditing standards. Field audits are of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost and to determine whether the expense attributable to such proper items of cost was accurately determined and reasonable. After each field audit is performed, the audit agent will submit a complete report of the audit to the HCA. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate, and reasonable. These audit reports will be retained by the HCA for a period of not less than three years from the date of final settlement of such reports. Audits will be performed in accordance with applicable federal regulations.

F. **Overpayments:** All overpayments found in audits will be accounted for on the CMS-64 report in accordance with 42 CFR 433.300 through 42 CFR 433.322.

G. **Allowable and non-allowable costs:** Allowable costs, non-allowable costs, and reasonableness of costs will be determined as on the basis of the medicare health insurance manual (HIM-15).

[8.311.3.14 NMAC - Rp, 8.311.3.14 NMAC, 6/1/2016; A, 1/1/2019; A, 9/1/2021]

8.311.3.15 PUBLIC DISCLOSURE OF COST REPORTS:

A. As required by law, cost reports submitted by participating providers as a basis for reimbursement are available to the public upon receipt of a written request to the medical assistance program audit agent. Disclosure information is limited to cost report documents required by social security administration regulations and, in the case of a settled cost report, the notice of program settlement.

B. The request must identify the provider and the specific report(s) requested.

C. The provider whose report has been requested will be notified by the MAD audit agent that its cost report has been requested, by whom the request was made, and that the provider shall have 10 calendar days in which to comment to the requestor before the cost report is released.

D. The cost for copying will be charged to the requestor.

[8.311.3.15 NMAC - Rp, 8.311.3.15 NMAC, 6/1/2016]

8.311.3.16 SEVERABILITY: If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.
[8.311.3.16 NMAC - Rp, 8.311.3.16 NMAC, 6/1/2016]

HISTORY OF 8.311.3 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
SP-Rule 004.1901, General Program Administration Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care, 1/17/1985.
SP-Rule 004.1901, Section 4, General Program Administration Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care, 7/2/1985.
SP-Rule 004.1901, Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services, 8/25/1986.
ISD 306.4000, Providers Protesting Certified Cost Reimbursement Rates, 1/7/1980.
SP-004.1901, Section 4, General Program Administration Methods and Standards For Establishing Payment Rates - Inpatient Hospital Care, 6/10/1981.
8 NMAC 4.MAD.721.D, Provider Policies, Reimbursement Methodology, Methods and Standards For Establishing Payment Rates-Inpatient Hospital Services, 1/18/1995.
8 NMAC 4.MAD.721.D, Amendment to 8 NMAC 4.MAD.721.D [Section IV], 1/17/1996.
8 NMAC 4.MAD.721.D, Amendment to 8 NMAC 4.MAD.721.D [Section IV], 7/17/1997.
8 NMAC 4.MAD.721.D, Amendment to 8 NMAC 4.MAD.721.D [Section III], 10/17/1997.
8 NMAC 4.MAD.721.D, Amendment to 8 NMAC 4.MAD.721.D [Section III], 6/15/1998.
8 NMAC 4.MAD.721.D, Amendment to 8 NMAC 4.MAD.721.D [Section III], 7/31/1998.
8 NMAC 4.MAD.721.D, Amendment to 8 NMAC 4.MAD.721.D [Section III], 12/14/1998.

History of Repealed Material:
8.311.3 NMAC, Methods and Standards for Establishing Payment-Inpatient Hospital Services, filed 12/13/2000 - Repealed effective 6/1/2016.

TITLE 8 SOCIAL SERVICES
CHAPTER 311 HOSPITAL SERVICES
PART 5 SWING BED HOSPITAL SERVICES

8.311.5.1 ISSUING AGENCY: New Mexico Health Care Authority.
[2/1/1995; 8.311.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.311.5.2 SCOPE: The rule applies to the general public.
[2/1/1995; 8.311.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/2012]

8.311.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.311.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.311.5.4 DURATION: Permanent
[2/1/1995; 8.311.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/2012]

8.311.5.5 EFFECTIVE DATE: February 1, 1995
[2/1/1995; 8.311.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/2012]

8.311.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/1995; 8.311.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/2012]

8.311.5.7 DEFINITIONS: [**RESERVED**]

8.311.5.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/1995; 8.311.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012]

8.311.5.9 SWING BED HOSPITAL SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for services furnished in general hospital settings which can also be used interchangeably as high or low nursing facility beds. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.
[2/1/1995; 8.311.5.9 NMAC - Rn, 8 NMAC 4.MAD.723, 3/1/2012]

8.311.5.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, small rural hospitals that meet the following requirements are eligible to be reimbursed for providing services as swing bed providers:

(1) hospital is licensed and certified by the licensing and certification bureau of the HCA to participate in the medicare and/or the medicaid programs and has received additional certification to act as a swing bed provider;

(2) hospital must have fewer than 100 inpatient hospital beds, counting all inpatient hospital beds maintained by the hospital, exclusive of beds for newborns and intensive care beds; and

(3) hospital must be located in a rural area; any geographic area not designated as “urban” in the most recent census is considered “rural” for the purpose of this regulation.

B. Since a swing bed hospital already has an approved provider agreement for the provision of acute care services, a separate agreement for swing bed services is not required. An addendum to the current provider agreement grants approval for swing bed participation.

C. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2/1/1995; 8.311.5.10 NMAC - Rn, 8 NMAC 4.MAD.723.1, 3/1/2012]

8.311.5.11 CONDITIONS OF PARTICIPATION: To participate as a swing bed hospital, the facility must comply with the following conditions:

A. be licensed and certified as meeting all the requirements for participation as a hospital;

B. meet the requirements for hospital providers of long term care services. See 42 CFR 405.1041;

C. conform to MAD policy regarding recipient's personal funds; and

D. have an addendum to the medicaid provider agreement which conveys approval for swing bed participation; hospitals which have a waiver of the 24 hour coverage requirement of Section 1861(e)(s) of the Social Security Act are not eligible to participate as swing bed hospitals.

[2/1/1995; 8.311.5.11 NMAC - Rn, 8 NMAC 4.MAD.723.2, 3/1/2012]

8.311.5.12 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC *General Provider Policies*.

[2/1/1995; 8.311.5.12 NMAC - Rn, 8 NMAC 4.MAD.723.3, 3/1/2012]

8.311.5.13 COVERED SERVICES: Medicaid covers hospital and nursing facility (low or high level) services which are medically necessary for the diagnosis and/or treatment of an illness or injury as indicated by the condition of the recipient.

[2/1/1995; 8.311.5.13 NMAC - Rn, 8 NMAC 4.MAD.723.4, 3/1/2012]

8.311.5.14 NONCOVERED SERVICES: Swing bed services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*.

[2/1/1995; 8.311.5.14 NMAC - Rn, 8 NMAC 4.MAD.723.5, 3/1/2012]

8.311.5.15 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: All utilization review activities, including level of care determinations and length of stay assignments for recipients at a nursing facility are carried out according to established MAD policy. All physical therapy, occupational therapy, and speech therapy furnished to inpatients in swing bed facilities at a high or low level require prior approval. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials and other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/1995; 8.311.5.15 NMAC - Rn, 8 NMAC 4.MAD.723.6, 3/1/2012]

8.311.5.16 RECIPIENT PERSONAL FUNDS ACCOUNTS:

A. As a condition for participation in medicaid, each swing bed provider must establish and maintain an acceptable system of accounting for a resident's personal funds when a Title XIX (medicaid) recipient requests that their personal funds be cared for by the facility. See 42 CFR 483.10(c).

(1) Requests for swing bed providers to care or not care for a recipient's funds must be made in writing and secured by the request to handle recipient's fund form or a letter signed by the recipient or their representative. The form or letter is kept in the recipient's file at the facility.

(2) A recipient's personal fund consists of a monthly maintenance allowable, established by MAD. If the recipient receives any income in excess of this allowance, the excess is applied to the cost of the recipient's medical care at the facility. This excess is reported as a medical care credit to the swing bed provider by the local county income support division (ISD) office, when applicable.

(3) All swing bed facilities must have procedures for handling of medicaid recipients' funds. These procedures must not allow the facility to commingle medicaid recipients' funds with facility funds.

(4) Swing bed facilities should use medicaid guidelines to develop procedures for handling recipient funds.

(5) Recipients have the right to manage their financial affairs and no facility can require recipients to deposit their personal funds with the facility.

(6) Facilities must purchase a surety bond or provide self-insurance to ensure the security of all personal funds deposited with the facility.

B. **Fund custodians:** Swing bed facilities must designate a full-time employee and an alternate to serve as fund custodians for handling all medicaid residents' money on a daily basis.

(1) Another individual, other than those employees who have daily responsibility for the fund, must do the following:

(a) reconcile balances of the individual medicaid recipients' accounts with the collective bank account;

(b) periodically audit and reconcile the petty cash fund; and

(c) authorize checks for the withdrawal of funds from the bank account.

(2) Facilities must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each recipient's personal funds entrusted to the facilities on the recipient's behalf.

C. **Bank account:** Swing bed facilities must establish a bank account for the deposit of all money for medicaid recipients who request the facility to handle their funds. Recipients' personal funds are held separately and not commingled with facility funds.

(1) Facilities must deposit any recipient's personal funds more than $50 dollars in an interest bearing account that is separate from any of the facility operating accounts and which credits all interest earned on the recipient's account to that account.

(2) Facilities must maintain recipients' personal funds up to $50 in a non-interest bearing account or a petty cash fund. Recipients must have convenient access to these funds.

(3) Individual financial records must be available on the request of recipients or their legal representatives.

(4) Within 30 days of the death of a recipient whose personal funds are deposited with the facility, a swing bed provider must convey the recipient's funds and a final accounting of these funds promptly to the individual or probate jurisdiction administering the recipient's estate.

D. **Establishment of individual accounts:** Swing bed facilities must establish an account for each medicaid recipient in which all transactions can be recorded. Accounts can be maintained in a general ledger book, a card file or looseleaf binder.

(1) For money received, the source, amount and date is recorded. Recipients or their authorized representatives must be given receipts for the money. The swing bed facility retains a copy of the deposit in the recipient's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of recipients must be recorded. Any money spent either on behalf of recipients or withdrawn by recipients or their representatives must be validated by receipts or signatures on individual ledger sheets.

(3) Facilities must notify each medicaid recipient when the account balance is $200 less than the supplemental security income (SSI) resource limit for one person specified in section 1611(a)(3)(B) of the Social Security Act. If the amount of the account and the value of the recipient's other nonexempt resources reach the SSI resource limit for one person, the recipient can lose eligibility for medicaid or SSI.

E. Personal fund reconciliation: The swing bed facility must balance individual accounts, collective bank accounts and the petty cash fund at least once a month. The swing bed facility must provide medicaid recipients or their authorized representatives with an accounting of the recipients' funds at least once a quarter. Copies of individual account records can be used to provide this information.

F. Petty cash fund: A swing bed facility must maintain a cash fund in the facility to accommodate the small cash requirements of medicaid recipients. Five dollars ($5.00) or less per individual recipient may be adequate. The amount of money kept in the petty cash fund is determined by the number of recipients using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all action regarding money in this fund.

(1) To establish the fund, the swing bed facility must withdraw money from the collective bank account and keep it in a locked cash box.

(2) To use the petty cash fund, the following procedures should be established:

(a) recipients or their authorized representatives request small amounts of spending money;

(b) the amount disbursed is entered on the individual ledger record; and

(c) the recipient or representative signs an account record and receives a receipt.

(3) To replenish the petty cash fund, the following procedures should be used:

(a) the money left in the cash box is counted and added to the total of all disbursements made since the last replenishment; and the total of the disbursements plus cash on hand equals the beginning amount;

(b) money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedure should be used once each month:

(a) count money on hand; and

(b) total cash disbursed either from receipts or individual account records. The cash on hand plus total disbursements equals petty cash total.

(5) To close the recipient account, the swing bed facility should to the following:

(a) enter date of and reason for closing the account;

(b) write a check against the collective bank account for the balance shown on the individual account record;

(c) get signature of the recipient or their authorized representative on the individual recipient account record as receipt of payment; and

(d) notify the local ISD office if closure is caused by death of a recipient so that prompt action can be taken to terminate assistance.

(6) Within 30 days of the death of a recipient who has no relatives, the swing bed facility conveys the recipient's funds and a final accounting of the funds to the individual or probate jurisdiction administering the recipient's estate. See 42 CFR 483.10(c)(6).

G. Retention of records: All account records are retained for a minimum of three years or, in case of an audit, until the audit is completed.

H. Non-acceptable uses of recipients' personal funds:

(1) Non-acceptable uses of recipients' personal funds include the following:

(a) payment or charges for services or supplies covered by medicaid or medicare-specified as allowable costs; see Subsection G of 8.312.3.11 NMAC, *Costs Related Reimbursement of Nursing Facilities*;

(b) difference between the swing bed facility's billed charge and the medicaid payment; and

(c) payment for services or supplies routinely furnished by the facility, such as linens and nightgowns.

(2) A swing bed facility cannot impose charges against recipients' personal funds for any item or service for which payment is made by medicaid or for any item recipients or their representatives did not request. Facilities must not require recipients or representatives to request any item or service as a condition of admission or continued stay. Swing bed facilities must inform recipients or representatives who request a noncovered item or service that there is a charge for the item and the amount of the charge.

I. State monitoring of recipients' personal funds: Swing bed facilities must make all files and records involving recipients' personal funds available for inspection by authorized state personnel or federal auditors.

(1) The licensing and certification bureau of the DOH verifies that facilities have established systems to account for recipients' personal funds, including the components described above. Failure to provide an acceptable accounting system constitutes a deficiency that must be corrected.

(2) The HCA or its designee can complete a thorough audit of recipients' personal funds at HCA's discretion.

[2/1/1995; 8.311.5.16 NMAC - Rn, 8 NMAC 4.MAD.723.7, 3/1/2012]

8.311.5.17 PATIENT SELF DETERMINATION ACT: All adult recipients must be informed of their right to make health decisions, including their right to accept or refuse medical treatment, as specific in the Patient Self-Determination Act. See 8.302.1.18 NMAC, *General Provider Policies*.

[2/1/1995; 8.311.5.17 NMAC - Rn, 8 NMAC 4.MAD.723.8, 3/1/2012]

8.311.5.18 RESERVE BED DAYS: To allow recipients to visit family or friends for short periods of approved therapeutic leave or to allow trial placement to adjust to a new environment as part of a discharge plan, MAD pays the routine rate to hold or reserve the bed for the recipient's return.

A. Coverage of reserve bed days: Medicaid covers six reserve bed days per calendar year for every swing bed recipient at a high or low nursing facility level without prior approval of the reserve days for any reason other than acute hospitalization, including home visits and acclimation to a new environment. Medicaid covers an additional six days per calendar year with prior approval for visits which help the recipient adjust to a new environment, as part of a discharge plan.

(1) In these cases, the recipient's discharge plan must clearly state objectives including how the home visit or visit to alternative placement relates to discharge implementation.

(2) The prior approval request must include the recipient's name, medicaid number, requested approval dates, and a copy of the discharge plan.

B. Reserve bed days and services not covered: Medicaid does not cover reserve bed days used for transfer to a nursing facility. Medicaid does not pay for ancillary services associated with reserve bed days.

C. Level of care determinations needed: A new level of care determination must be performed if a recipient is gone from the facility for more than three midnights. An abstract must be completed which includes the reason the recipient was absent, outcome of the leave and any other pertinent information.

D. Reimbursement and billing: Reimbursement to a hospital is limited to the rate applicable for the level of care medically necessary for the eligible recipient as determined and certified by MAD. Billing for reserve beds days is based on the nursing census, which runs from midnight to midnight. Under normal circumstances, medicaid pays for the admission day but does not pay for the discharge day. The same principle applies in calculating and billing reserve bed days.

[2/1/1995; 8.311.5.18 NMAC - Rn, 8 NMAC 4.MAD.723.9, 3/1/2012]

8.311.5.19 REIMBURSEMENT: Swing bed providers must submit claims for reimbursement on the long term care turn around document (TAD) or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Swing bed hospitals are paid for high and low nursing facility routine services at the statewide average rates paid under the state plan during the previous calendar year to nursing facilities, as appropriate.

A. The following services or items are considered routine and are reimbursed as part of the routine rate:

(1) regular room;

(2) dietary and nursing services;

(3) medical and surgical supplies, including syringes, catheters, ileostomy, and colostomy supplies;

(4) use of equipment and facilities;

(5) general services, including administration of oxygen and related medications, hand feeding, incontinence care, tray service and enemas;

(6) standard items furnished routinely to all patients, such as patient gowns, water pitchers, basins and bed pans;

(7) items stocked at nursing stations in gross supply and distributed or used individually in small quantities such as cotton balls, band aids, laxatives, stool softeners, aspirin, antacids, OTC ointments and tongue depressors;

(8) reusable items expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen administration equipment and other durable medical equipment;

(9) laundry services, including basic personal laundry;

(10) special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician; and

(11) oxygen.

B. Ancillary services: Ancillary services are reimbursed at the same rate as outpatient services. Swing bed providers must submit claims using its hospital provider number for ancillary services on the UB-92 claim form or its successor. The reasonable costs of ancillary services for swing bed facility levels of care are determined in the same manner as for outpatient hospital services. Ancillary services are those services not considered routine, such as lab, radiology, pharmacy, and therapies.

C. Cost allocation: To allocate costs between hospital and long term care services, the total reimbursement due for all classes of long-term care recipients is subtracted from the hospital's total routine costs, before determining reimbursement for routine hospital services.

D. Medical care credits: If a recipient has income above the maintenance allowance, MAD reimburses the provider facility the difference between the allowed rate and the medical care credit. The facility is responsible for collecting the amount reported as a medical care credit.

[2/1/1995; 8.311.5.19 NMAC - Rn, 8 NMAC 4.MAD.723.10, 3/1/2012]

HISTORY OF 8.311.5 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 312 LONG TERM CARE SERVICES - NURSING SERVICES
PART 2 NURSING FACILITIES

8.312.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.312.2.1 NMAC - Rp, 8.312.2.1 NMAC, 8/1/2014; A, 7/1/2024]

8.312.2.2 SCOPE: The rule applies to the general public.
[8.312.2.2 NMAC - Rp, 8.312.2.2 NMAC, 8/1/2014]

8.312.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.312.2.3 NMAC - Rp, 8.312.2.3 NMAC, 8/1/2014; A, 7/1/2024]

8.312.2.4 DURATION: Permanent.
[8.312.2.4 NMAC - Rp, 8.312.2.4 NMAC, 8/1/2014]

8.312.2.5 EFFECTIVE DATE: August 1, 2014, unless a later date is cited at the end of a section.
[8.312.2.5 NMAC - Rp, 8.312.2.5 NMAC, 8/1/2014]

8.312.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.312.2.6 NMAC - Rp, 8.312.2.6 NMAC, 8/1/2014]

8.312.2.7 DEFINITIONS:

A. "**Authorized representative**" means the individual designated to represent and act on the claimant's behalf. The eligible recipient or managed care organization (MCO) member's authorized representative must provide formal 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 ad litem, or any other individual or individuals designated in writing by the eligible recipient or MCO member.

B. "**Designee**" means a state agency or an institution MAD has designated to be responsible for:

(1) conducting a preadmission screening and annual resident review (PASRR) level 1 screening to identify if a medical assistance program (MAP) eligible recipient or a MCO member has a mental illness or an intellectual disability; or

(2) conducting a PASRR level 2 evaluation.

C. "**DDSD**" means the developmental disabilities support division of the HCA, which conducts the PASRR level II evaluation for a MAP eligible recipient or a MCO member that has been identified through a PASRR level 1 screen.

D. "**HCA administrative hearing**" or "fair hearing" means an informal evidentiary hearing that is conducted by the HCA fair hearings bureau (FHB) so that evidence may be presented as it relates to an adverse action taken, or intended to be taken, by MAD, the MCO or their designees.

E. "**MAD**" means the medical assistance division, which administers medicaid and other medical assistance programs (MAP) under HCA.

F. "**MAP**" means the medical assistance programs administered by MAD.

G. "**MCO**" means a member's HCA contracted managed care organization.

H. "**Member**" means a MAP eligible recipient enrolled in a HCA contracted MCO. Once a member requests a HCA administrative hearing, the member is referred to as a claimant.

I. "**Notice of action**" means the notice issued by MAD, the MCO or their designees of their intent to take an adverse action against an eligible recipient or a member in the form an adverse determination is made with regard to the preadmission or annual resident review requirements.

J. "**Nursing facility (NF)**" means a MAD enrolled, and as appropriate, a MCO contracted, nursing facility which meets the requirements as described in 8.312.2 NMAC. The NF completes a PASRR level one screen for a MAP eligible recipient or a MCO member.
[8.312.2.7 NMAC - Rp, 8.312.2.7 NMAC, 8/1/2014]

8.312.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.312.2.8 NMAC - Rp, 8.312.2.8 NMAC, 8/1/2014]

8.312.2.9 NURSING FACILITIES: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients and members. To help New Mexico eligible recipients and members receive necessary services, MAD pays for services furnished in nursing facilities.
[8.312.2.9 NMAC - Rp, 8.312.2.9 NMAC, 8/1/2014]

8.312.2.10 ELIGIBLE PROVIDERS: Health care to eligible recipients or members is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (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 must be enrolled before submitting a claim for payment to the MAD claims processing contractors or the MCO. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review (UR) instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD, its selected claims processing contractor or the MCO issues payments to a provider using electronic funds transfer (EFT) only. Eligible providers include:

A. nursing facilities (NF) which:

(1) are currently licensed and certified to meet MAD nursing facility conditions of participation; see 42 CFR Part 483, as amended;

(2) comply with the eligible recipient or MCO member resident's personal funds rules;

(3) comply with MAD, its UR or the MCO UR processes and agree to operate in accordance with all MAD NMAC rules, including the performance of discharge planning;

(4) comply with the NMAC MAD rules for the pre-admission screening and resident review (PASRR) of mentally ill and intellectually disabled program;

(5) ensure the required nurse aide training is implemented; and

(6) ensure that facilities with 60 or more MAD beds certify a minimum of four distinct beds in the medicare program;

B. the above requirements can be waived if the NF meets one of the following conditions:

(1) the NF is located in a rural area and is unable to attract therapists as required by the medicare program. For a waiver to be granted under this condition, the provider must prove that good faith efforts to hire or contract with the required therapists have been made;

(2) the NF has obtained a waiver of the registered nurse (RN) staffing requirement from DOH, in accordance with applicable federal regulations; or

(3) the NF is one of two or more NFs in the same town owned or operated by the same owner/manager and one of the other facilities is medicare-certified; in addition, the NF must demonstrate on a yearly basis that the waiver does not hinder access to medicare part A services for eligible recipients or members and that the facility is using, to the best of its ability, corridor billings to medicare for part B services(s); if medicare removes the ability to do corridor billing, the waiver automatically ceases.

(a) Any requests for a waiver must contain sufficient documentation to support the request and must be submitted in writing to MAD;

(b) medicare is the primary payer for NF services covered under the medicare program; NF services must be provided within the scope of the practice and licensure for each provider; and must

be in compliance with the statutes, rules and regulations of the applicable practice and with the New Mexico administrative code (NMAC) MAD rules.
[8.312.2.10 NMAC - Rp, 8.312.2.10 NMAC, 8/1/2014]

8.312.2.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient or member must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD PPA. A provider also must conform to MAD program rules and instructions as specified in the MAD NMAC rule manual and its appendices, and program directions and billing instructions, as updated. A provider 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 must verify that an individual is eligible for a specific health care program administered by HCA and its authorized agents and must verify the recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient or member has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient or member.

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HCA, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services; see 8.302.1 NMAC.
[8.312.2.11 NMAC - Rp, 8.312.2.11 NMAC, 8/1/2014]

8.312.2.12 REQUIRED NURSING FACILITY SERVICES: A NF is required to provide the following to a MAP eligible recipient or member resident.

A. Room and board.

B. Professional nursing services 24 hours a day, seven days a week. Professional nursing services are those services which are performed directly by a RN or a licensed practical nurse (LPN), under the direction of a MAD enrolled, and, as appropriate, MCO contracted medical practitioner.

C. Services of a RN are on an eight hours a day, seven days a week basis, and at least the services of a LPN at all other times.

D. Personal assistance services on a 24 hours a day, seven days a week basis. Personal assistance services are those services, other than professional nursing services, that are provided to an eligible recipient who, because of age, infirmity, physical or behavioral health limitations, requires assistance to accomplish activities of daily living.
[8.312.2.12 NMAC - Rp, 8.312.2.12 NMAC, 8/1/2014]

8.312.2.13 COVERED SERVICES:

A. MAD covers NF services identified as allowable costs; see 8.312.3 NMAC.

B. MAD covers physical, occupational and speech therapy services furnished to an eligible recipient or member residing in a NF in the following manner:

(1) if the eligible recipient or member is also eligible for medicare and the NF does part B billing, the co-payment or deductible is processed by MAD or the MCO for services is paid by MAD or the MCO;

(2) if the eligible recipient or member receives high NF level services, services are included in the MAD facility rate; or

(3) if eligible, the recipient or member receives low NF level services, services are billed separately by participating therapy providers.
[8.312.2.13 NMAC - Rp, 8.312.2.13 NMAC, 8/1/2014]

8.312.2.14 NONCOVERED SERVICES: NF services are subject to the limitations and coverage restrictions which exist for other MAD services. See also 8.310.2, 8.310.3, 8.312.3, 8.324.4 NMAC.
[8.312.2.14 NMAC - Rp, 8.312.2.14 NMAC, 8/1/2014]

8.312.2.15 ELIGIBLE RECIPIENT AND MEMBER PERSONAL FUND ACCOUNTS:

A. As a condition for MAD provider participation, each NF must establish and maintain an acceptable system of accounting for an eligible recipient or member resident's personal funds when an eligible

recipient or member requests that their personal funds be cared for by the facility. See 42 CFR Section 483.10(c) and see 7.9.2.22 NMAC.

(1) Requests for a NF to care or not care for an eligible recipient or member resident's funds must be made in writing and secured by a request to handle recipient or member funds form or letter signed by the eligible recipient or member or their authorized representative. The form or letter is kept in the eligible recipient or member's file at the facility.

(2) An eligible recipient or member's personal fund consists of a monthly maintenance allowable, established by MAD. If the eligible recipient or member resident receives any income in excess of this allowance, the excess is applied to the cost of the eligible recipient or member resident's medical care at the NF. This excess is reported as a medical care credit to the facility by the local county income support division (ISD) office, when applicable.

(3) A NF must have procedures on the handling of eligible recipient or member residents' funds. These procedures must not allow the facility to commingle eligible recipient or member residents' funds with facility funds.

(4) A NF should use these applicable federal statutes, regulations and state rules to develop procedures for handling eligible recipient or member resident's funds.

(5) An eligible recipient or member resident has the right to manage their financial affairs and no NF can require an eligible recipient or member resident to deposit their personal funds with the NF.

(6) A NF must purchase a surety bond or furnish self-insurance to ensure the security of all personal funds deposited with the NF.

(7) Failure of a NF to furnish an acceptable accounting system constitutes a deficiency that must be corrected by the provider and verified by DOH survey teams.

B. Fund custodians: A NF must designate a full-time employee and an alternate to serve as fund custodians for handling an eligible recipient or member resident's money on a daily basis; see 7.9.2.22 NMAC.

(1) Another individual, other than those employees who have daily responsibility for the fund, must do the following:

(a) reconcile balances of each eligible recipient or member accounts with the collective bank account;

(b) periodically audit and reconcile the petty cash fund; and

(c) authorize checks for the withdrawal of funds from the bank account.

(2) A NF must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each eligible recipient or member resident's personal funds entrusted to their NF on the eligible recipient or member resident's behalf.

C. Bank account: A NF must establish a bank account for the deposit of all money for each eligible recipient or member resident who requests the NF to handle their funds. An eligible recipient or member resident's personal funds are to be held separately and not commingled with the NF funds; see 7.9.2.22 NMAC.

(1) A NF must deposit an eligible recipient or member's personal funds of more than $50 in an interest bearing account that is separate from any of the NF operating accounts and which credits all interest earned on the eligible recipient or member resident's account to that account. An eligible recipient or member resident must have convenient access to these funds.

(2) A NF must maintain an eligible recipient or member resident's personal funds up to $50 in an interest bearing account or a petty cash fund that is separate from any of the NF operating accounts. An eligible recipient or member resident must have convenient access to these funds.

(3) Individual financial records must be available on the request of an eligible recipient or member resident or their authorized representative.

(4) Within 30 calendar days of the death of an eligible recipient or member resident whose personal funds are deposited with the facility, a NF must convey the deceased eligible recipient or member resident's funds and a final accounting of these funds to the individual or probate jurisdiction administering the deceased eligible recipient or member resident's estate.

D. Establishment of individual accounts: A NF must establish accounts for each eligible recipient or member resident in which all transactions can be recorded. Accounts can be maintained in a general ledger book, card file or loose leaf binder; see 7.9.2.22 NMAC.

(1) For money received, the source, amount and date must be recorded. The NF must provide the eligible recipient or member resident or their authorized representative receipts for the money. The NF stills retains a copy of the deposit in the eligible recipient or member resident's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of an eligible recipient or member resident must be recorded. All money spent either on behalf of the eligible recipient or member resident or withdrawn by the eligible recipient or member resident or their authorized representative must be validated by receipts or signatures on each eligible recipient or member resident's individual ledger sheet.

(3) The NF must notify each eligible recipient or member resident when the account balance is $200 less than the supplemental security income (SSI) resource limit for one person specified in Subparagraph (a) of Paragraph (3) of Subsection B of Section 1611 of the Social Security Act. If the amount of the account and the value of the eligible recipient or member resident's other nonexempt resources reach the SSI resource limit for one person, the eligible recipient or member resident can lose eligibility for a medical assistance program (MAP) or SSI.

E. Personal fund reconciliation: The NF must balance each eligible recipient or member resident's individual accounts, the collective bank accounts and the petty cash fund at least once each month. The NF must furnish each eligible recipient or member resident or their authorized representative with an accounting of the eligible recipient or member residents' funds at least quarterly. Copies of each eligible recipient or member resident's individual account records can be used to furnish this information; see 8.370.16 NMAC.

F. Petty cash fund: The NF must maintain a cash fund in the facility to accommodate the small cash requirements of an eligible recipient or member resident. Five dollars ($5.00) or less per each eligible recipient or member resident may be adequate. The amount of money kept in the petty cash fund is determined by the number of NF residents using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all actions regarding money in this fund; see 8.370.16 NMAC.

(1) To establish the fund, the NF must withdraw money from the collective bank account and keep it in a locked cash box.

(2) To use the petty cash fund, the following procedures should be established:

(a) an eligible recipient or member resident or their authorized representative request small amounts of spending money;

(b) the amount disbursed is entered on each eligible recipient resident's individual ledger record; and

(c) the eligible recipient or member resident or their authorized representative signs an account record and receives a receipt.

(3) To replenish the petty cash fund, the following procedures should be used.

(a) The money left in the cash box is counted and added to the total of all disbursements made since the last replenishment; and the total of the disbursements plus cash on hand equals the beginning amount.

(b) Money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedures should be used once each month:

(a) count money at hand; and

(b) total cash disbursed either from receipts or each eligible recipient or member resident's individual account records; the cash on hand plus total disbursements equals petty cash total.

(5) To close each eligible recipient or member resident account, the NF should do the following:

(a) enter date of and reason for closing the account;

(b) write a check against the collective bank account for the balance shown on each eligible recipient or member resident's individual account record;

(c) get signature of the eligible recipient resident or their authorized representative on the eligible recipient or member resident's individual account record, as receipt of payment; and

(d) notify the local ISD office if closure is caused by death of an eligible recipient or member resident so that prompt action can be taken to terminate assistance; within 30 calendar days of the death of an eligible recipient or member resident who has no relatives; the NF conveys the eligible recipient or member resident's funds and a final accounting of the funds to the individual or probate jurisdiction administering the eligible recipient or member resident's estate; see 42 CFR Section 483.10(c)(6).

G. Retention of records: All account records are retained for at least six years or, in case of an audit, until the audit is completed.

H. Non-acceptable uses of residents' personal funds: Non-acceptable uses of an eligible recipient or member resident's personal funds include the following:

(1) payment or charges for services or items covered by MAD or medicare specified as allowable costs; see 8.312.3 NMAC;

(2) difference between the NF's billed charge and the MAD payment; and

(3) payment for services or supplies routinely furnished by the NF, such as linens or nightgowns;

(4) a NF cannot impose charges against eligible recipient resident's personal funds for any item or service for which payment is made by MAD or for any item the eligible recipient or member resident or their authorized representative did not request;

(5) a NF must not require eligible recipient or member resident or their authorized representative to request any item or service as a condition of admission or continued stay;

(6) a NF must inform an eligible recipient or member resident or their authorized representative who requests non-covered items or services that there is a charge for the item and the amount of the charge.

I. Monitoring of residents' personal funds: NFs must make all files and records involving an eligible recipient or member resident's personal funds available for inspection by authorized state or federal auditors. DOH survey teams verify that a NF has established systems to account for an eligible recipient or member resident's personal funds, including the components described above. Failure to furnish an acceptable accounting system constitutes a deficiency that must be corrected; see 8.370.16 NMAC.

[8.312.2.15 NMAC - Rp, 8.312.2.15 NMAC, 8/1/2014]

8.312.2.16 RESERVE BED DAYS: MAD pays to hold or reserve a bed for an eligible recipient or member resident in a NF to allow for the eligible recipient or member resident to make a brief home visit, for acclimation to a new environment, or for hospitalization according to the limits and conditions outlined below.

A. Coverage of reserve bed days: MAD covers six reserve bed days per calendar year for every long term care eligible recipient or member resident for hospitalization without prior approval. MAD covers three reserve bed days per calendar year for a brief home visit without prior approval. MAD covers an additional six reserve bed days per calendar year with prior approval to support an eligible recipient or member resident to adjust to a new environment as part of the discharge plan.

(1) An eligible recipient or member resident's discharge plan must clearly state the objectives, including how the home visits or visits to alternative placement relate to discharge implementation.

(2) The prior approval request must include the eligible recipient or member resident's name, MAP identification number, requested approval dates, copy of the discharge plan, name and address for individuals who will care for the eligible recipient or member resident during the visit or placement and a written medical order for trial placement.

B. Documentation of reserve bed days: When an eligible recipient or member resident is discharged from a NF for any reason, appropriate documentation must be placed in the eligible recipient or member resident's chart. A medical order must be obtained if the eligible recipient or member resident is hospitalized, requests a home visit or a trial placement.

C. Re-admission review: A new level of care (LOC) determination must be performed by MAD, its UR contractor or the MCO if an eligible recipient or member resident is gone from their NF for more than three midnights. A NF notification form must be completed, including information on the reason for the eligible recipient or member resident's absence, outcome of the leave and any other pertinent information concerning the leave; see the MAD managed care policy manual.

D. Reimbursement and billing for reserve bed days: Reimbursement for reserve bed days to the NF is limited to the rate applicable for LOC medically necessary for the eligible recipient or member resident, as determined and approved by MAD, its UR contractor or the MCO. The reserve bed day reimbursement is equal to 50% of the regular payment rate for MAD fee-for-service or as otherwise negotiated between the NF provider and the MCO. Billing for reserve bed days is based on the nursing census, which runs from midnight to midnight. MAD or the MCO pays for the admission day but not for the discharge day.

[8.312.2.16 NMAC - Rp, 8.312.2.16 NMAC, 8/1/2014]

8.312.2.17 LEVEL OF CARE DETERMINATION: Medical necessity, LOC, and length of stay determinations are carried out in accordance with MAD UR instructions or the MAD MCO policy manual, as authorized under Title XIX of the Social Security Act; see 8.310.2 and 8.350.4 NMAC.

[8.312.2.17 NMAC - Rp, 8.312.2.17 NMAC, 8/1/2014]

8.312.2.18 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) OF MENTALLY ILL AND INTELLECTUALLY DISABLED INDIVIDUALS: As part of the initial NF communication form for

a new admission or as part of a subsequent specified review as determined by PASRR, or a significant change review as indicated by the minimum data set (MDS) for an eligible recipient or member resident with identified mental illness or is intellectually disabled, the NF must complete a level I PASRR screening. See Omnibus Reconciliation Acts of 1987 and 1990 as codified at 42 CFR Section 483.100 Subpart C. See also P.L. 104-315 which amends title XIX of the Social Security Act effective October 19, 1996. This requirement applies to all applicants or residents, regardless of payment source.

A. Pre-admission screens not required: Pre-admission screens do not need to be performed on the following eligible recipient or member resident:

(1) when admitted from the hospital whose attending physicians certify before admission to the NF that the eligible recipient or member resident is likely to require NF care for less than 30 days (as determined by PASRR review of their level I screen data which was done prior to NF admission);

(2) when readmitted to NFs from a hospital to which they were transferred for the purpose of receiving care; and

(3) when transferred from one NF to another without an intervening hospital stay.

B. Purpose of the screens: The purpose of the PASRR screen is to determine whether residents have a mental illness or an intellectual disability, need the level of services furnished in a NF and need specialized services based on the mental illness or intellectual disability. A NF performs the level I screen which identifies an eligible recipient or member resident who has a mental illness or an intellectual disability. When an eligible recipient or member resident is identified, the NF refers them to the DDSD for a PASRR level II evaluation.

C. Level II screen determination: The PASRR level II screen determines the following:

(1) the eligible recipient or member resident's total needs are such that their needs can be met in an appropriate community setting;

(2) the eligible recipient or member resident's total needs are such that they can be met only on an inpatient basis, which can include the option of placement in a home and community-based service waiver program, but for which inpatient care is necessary;

(3) if inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs; or

(4) if inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the eligible recipient or member resident's needs, another setting, such as an intermediate care facility for individuals with intellectual disabilities (ICF-IID) can be indicated.

D. Right to an administrative hearing: An individual who has been adversely affected by the preadmission screening or resident review screening is entitled to a HCA administrative hearing. See 8.354.2 NMAC for a detailed description of this specific type of HCA administrative hearings.

(1) An eligible recipient or member or their authorized representative may request a HCA administrative hearing.

(2) MAD, the MCO or their designees do not pay fees or costs, including attorney's fees, incurred by the individual or their authorized representative as a result of a HCA pre-hearing conference or a HCA administrative hearing, or if they file an appeal of the HCA administrative hearing final decision.

E. Restriction on reimbursement for medicaid residents: A NF is not reimbursed for any service furnished to an eligible recipient or member resident when pre-admission screens, subsequent specified reviews or significant change reviews are not performed in a timely manner. MAD or the MCO pays only for services furnished after the screens or reviews are performed and will recoup amounts paid to a NF during periods of noncompliance. MAD or the MCO payment for services does not begin until a level II screening has been performed, if applicable.

[8.312.2.18 NMAC - Rp, 8.312.2.18 NMAC, 8/1/2014]

8.312.2.19 MINIMUM DATA SET:

A. A long term care facility participating in the medicare and is an enrolled MAD provider is required to conduct a comprehensive, accurate, standardized, reproducible assessment of each eligible recipient or member resident's functional capacity. See Sections 4201 (a)(3) and 4211 (a)(3) of the Omnibus Reconciliation Act (OBRA) of 1987.

B. The capacity assessment describes the resident's ability to perform daily life functions and any significant impairment in functional capacity. The assessment is based on a uniform MDS of core elements and common definitions specified by the secretary of the federal health and human services department. A NF is required to use the most current iteration of the MDS. A section of the MDS requires a NF to identify eligible recipient or member residents who may be interested in transitioning back to their community.

(1) The resident assessment instrument (RAI) is specified by the state. State RAIs include at least the health care financing administration MDS, triggers, resident assessment protocols (RAPs) and utilization guidelines.

(2) On a date to be specified by the federal government, NFs will be required to encode the MDS in machine-readable form. After that date, all MDS reporting will be done electronically.
[8.312.2.19 NMAC - Rp, 8.312.2.19 NMAC, 8/1/2014]

8.312.2.20 MEDICAL CARE CREDITS: If an eligible recipient or member resident is required to pay a medical care credit, MAD or the MCO reimburses the NF for the difference between the NF's reimbursable rate and the medical care credit. The NF is responsible for collecting the amount reported as the medical care credit. These medical care credit requirements also apply to co-payments and deductibles for medicare crossover payments.
[8.312.2.20 NMAC - Rp, 8.312.2.20 NMAC, 8/1/2014]

8.312.2.21 NURSE AIDE TRAINING: A NF must comply with nurse aide training requirements as a condition of MAD and MCO enrollment and participation; see 42 CFR Section 483 Subpart D. The NF will not be approved as a MAD or MCO provider if the NF has been out of compliance with federal requirement within the previous two calendar years.

A. Requirements for nurse aide training: A NF cannot employ individuals as nurse aides for more than four months unless they have completed a nurse aide training and competency evaluation program (NATCEP). The NATCEP program must have a minimum duration of 75 hours.

(1) A nurse aide who has not performed nursing or nursing-related services for monetary compensation for a period of 24 consecutive months since completion of a NATCEP must take either a new NATCEP or a new competency evaluation program (CEP).

(2) A NF must not use temporary nurse aides who have not completed a NATCEP or a CEP.

(3) A NF must ensure that students in the NATCEP programs do not perform any services for which they have not been trained and found proficient by instructors. A NF must ensure that all students in NATCEP programs are under the general supervision of licensed or registered nurses when they perform services for eligible recipient or member residents.

(4) A NF must furnish regular performance reviews and in-service education to ensure that individuals who serve as nurse aides are competent to perform nurse aide services.

B. Other nurse aide requirements: A NF must not employ individuals who have been convicted by the court of abuse or neglect of any NF residents or misappropriation of any NF residents' property.

C. Nurse aide registry: DOH maintains a registry of all nursing aides who have successfully completed, who have been considered to have completed a NATCEP or CEP program or who have had the NATCEP or CEP requirement waived by New Mexico.
[8.312.2.21 NMAC - Rp, 8.312.2.21 NMAC, 8/1/2014]

8.312.2.22 PATIENT SELF DETERMINATION ACT: All adult eligible recipient or member residents of nursing facilities must be informed of their right to make their own health decisions, including the right to accept or refuse medical treatment as specified in the Patient Self-Determination Act; see 8.302.1 NMAC.
[8.312.2.22 NMAC - Rp, 8.312.2.22 NMAC, 8/1/2014]

8.312.2.23 RESIDENT RIGHTS TO REQUEST AN ADMINISTRATIVE HEARING: An eligible recipient or member resident who believes that the NF has erroneously determined that they should be transferred or discharged may request a HCA administrative hearing. A NF must provide an eligible recipient or member resident notice of the proposed transfer or discharge. The notice must inform the eligible recipient or member resident of their right to request a hearing, the method by which a hearing can be requested and their right to present evidence in person or through their authorized representative; see 8.354.2 NMAC and the MAD MCO policy manual.
[8.312.2.23 NMAC - Rp, 8.312.2.23 NMAC, 8/1/2014]

8.312.2.24 PRIOR APPROVAL AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made, or after payment is made; see 8.310.2 NMAC. The provider must contact HCA or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the

information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials.

A. Prior approval: Certain procedures or services can require prior approval from MAD, the MCO or their designee. Services for which prior approval was obtained remain subject to UR at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that an individual is eligible for MAD services or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient or member has other health insurance.

C. Reconsideration: A provider who disagrees with a prior approval request denial or other review decisions can request a reconsideration of utilization review; see 8.350.2 NMAC.

[8.312.2.24 NMAC - Rp, 8.312.2.24 NMAC, 8/1/2014]

8.312.2.25 REIMBURSEMENT: A NF provider must submit claims for reimbursement on the long term care turn around document (TAD) or its successor; see 8.302.2 NMAC.

A. MAD reimburses a NF at the lesser of the following:

(1) the NF's billed charges;

(2) the prospective reimbursement rates constrained by the ceilings established by MAD; see 8.312.3 NMAC; and

(3) the NF's billed charge must be its usual and customary charge for services; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

B. Reimbursement limitations: Payments are made only to a MAD enrolled, and as appropriate a HCA MCO contracted NF. Payments to a NF are limited to those service costs which are included as allowable costs under approved provisions of the medicaid state plan or the MAD alternative benefit; see 8.312.3 NMAC. All claims for payment from MAD or the MCO are subject to utilization review and control.

C. Reimbursement methodology: See 8.312.3 NMAC for a detailed description of this methodology.

[8.312.2.25 NMAC - Rp, 8.312.2.25 NMAC, 8/1/2014]

HISTORY OF 8.312.2 NMAC:

Pre- NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.0300, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 2/27/1980.
MAD Rule 310.03, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 12/1/1987.
MAD Rule 310.03, Care in Skilled Nursing Facility and Intermediate Care Facility, filed 1/6/1988.
MAD Rule 310.03, Care in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded, filed 3/27/1992.
SP-004.1903, Section 4, General Program Administration Reserve Beds, filed 6/10/1981.
SP-004.1101, Section 4, General Program Administration Standards for Institutions, filed 6/26/1981.

History of Repealed Material:

MAD Rule 310.03, Care in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded, filed 3/27/1992 - Repealed effective 2/1/1995.
8.312.2 NMAC, Nursing Facilities, filed 5/27/2010 - Repealed effective 10/15/2012.
8.312.2 NMAC, Nursing Facilities, filed 10/2/2012 - Repealed effective 8/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 312 LONG TERM CARE SERVICES - NURSING SERVICES
PART 3 COST RELATED REIMBURSEMENT OF NURSING FACILITIES

8.312.3.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.312.3.1 NMAC - Rp, 8.312.3.1 NMAC, 9/1/2021; A, 7/1/2024]

8.312.3.2 SCOPE: The rule applies to the general public.
[8.312.3.2 NMAC - Rp, 8.312.3.2 NMAC, 9/1/2021]

8.312.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.312.3.3 NMAC - Rp, 8.312.3.3 NMAC, 9/1/2021; A, 7/1/2024]

8.312.3.4 DURATION: Permanent.
[8.312.3.4 NMAC - Rp, 8.312.3.4 NMAC, 9/1/2021]

8.312.3.5 EFFECTIVE DATE: September 1, 2021, unless a later date is cited at the end of a section.
[8.312.3.5 NMAC - Rp, 8.312.3.5 NMAC, 9/1/2021]

8.312.3.6 OBJECTIVE: The objective of this rule is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.312.3.6 NMAC - Rp, 8.312.3.6 NMAC, 9/1/2021]

8.312.3.7 DEFINITIONS:

A. Accrual basis of accounting: Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected. The expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

B. Allocable costs: An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

C. Applicable credits: Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the federal government to finance hospital activities or service operations should be treated as applicable credits.

D. Cash basis of accounting: Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

E. Charges: The regular rates established by the provider for services rendered to both beneficiaries and to other paying patients whether inpatient or outpatient. The rate billed to the HCA shall be the usual and customary rate charged to all patients.

F. Closed facility: A facility which has been either voluntarily or involuntarily terminated from participation in the medicaid program not to include termination for construction of a replacement facility.

G. Cost center: A division, department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

H. Cost finding: A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.

I. Facility: The actual physical structure in which services are provided.

J. **General service cost centers:** Those cost centers which are operated for the benefit of other general service areas as well as special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.

K. **Governmental institution:** A provider of services owned and operated by a federal, state or local governmental agency.

L. **Imputed occupancy:** The level of occupancy attributed for the purpose of calculating the reimbursement rate.

M. **Inpatient cost centers:** Cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

N. **Owner:** The entity holding legal title to the facility.

O. **Provider:** The entity responsible for the provision of services. The provider must have entered into a valid agreement with the medicaid program for the provision of such services.

P. **RCC:** This is the ratio of charges to charges. The bases or charges used in the RCC formula vary as to the costs to be allocated. The ratios may be expressed as follows:

(1) ratio of beneficiary charges to total charges on a departmental basis.

(2) ratio of beneficiary charges for ancillary services to total charges for ancillary services.

(3) ratio of total patient charges by patient care center to the total charges of all patient care centers.

Q. **Related organization:** Organizations related to the provider by common ownership or control as defined by the provisions of the medicare provider reimbursement manual (HIM-15).

R. **Replaced facility:** The facility replaced by a replacement facility as defined above.

S. **Replacement facility:** A facility which replaces a facility that was participating in medicaid on July 1, 1984, or whose construction received Section 1122 approval by July 1, 1984, and where the basic structure of the facility to be replaced is at least 25 years old and has been in continuous use as a skilled nursing or intermediate care facility for at least 25 years or which facility has been destroyed by catastrophic occurrence and rendered unusable and irreparable, or condemned by eminent domain.

T. **Special service cost centers:** Commonly referred to as ancillary cost centers. Such centers usually provide direct identifiable services to individual patients, and include departments such as the physical therapy and supply departments.

[8.312.3.7 NMAC - Rp, 8.312.3.7 NMAC, 9/1/2021]

8.312.3.8 **MISSION STATEMENT:** To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.312.3.8 NMAC - Rp, 8.312.3.8 NMAC, 9/1/2021]

8.312.3.9 **COST RELATED REIMBURSEMENT OF NURSING FACILITIES:** The New Mexico Title XIX program makes reimbursement for appropriately licensed and certified nursing facility (NF) services as outlined in this material.

[8.312.3.9 NMAC - Rp, 8.312.3.9 NMAC, 9/1/2021]

8.312.3.10 **GENERAL REIMBURSEMENT POLICY:** The HCA will reimburse nursing facilities (effective October 1, 1990, the skilled nursing facility/intermediate care facility SNF/ICF distinction is eliminated; see 8.312.3.16 NMAC) the lower of the following, effective July 1, 1984:

A. billed charges; and

B. the prospective rate as constrained by the ceilings (8.312.3.16 NMAC) established by the HCA as described in this plan.

[8.312.3.10 NMAC - Rp, 8.312.3.10 NMAC, 9/1/2021]

8.312.3.11 **DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS AND SETTING OF PROSPECTIVE RATES:**

A. **Adequate cost data:**

(1) Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where

governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

(2) Cost finding: The cost finding method to be used by NF providers will be the step-down method. This method recognizes that services rendered by certain non-revenue-producing departments or centers are utilized by certain other non-revenue-producing centers. All costs of non-revenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the non-revenue-producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greater amount of expense will be allocated first.

B. Reporting year: For the purpose of determining a prospective per diem rate related to cost for NF services, the reporting year is the provider's fiscal year. The provider will submit a cost report each year.

C. Cost reporting: At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable cost (financial and statistical report) on the N.M. Title XIX cost reporting form. This itemized list must be submitted within 150 days after the close of the provider's cost reporting year. Failure to file a report within the 150-day limit will result in termination of Title XIX payments. In the case of a change of ownership the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The HCA will withhold the last month's payment to the previous provider as security against any outstanding obligations to the HCA. The provider must notify the HCA 60 days prior to any change in ownership.

D. Retention of records:

(1) Each NF provider shall maintain financial and statistical records of the period covered by such cost report for a period of 10 years following the date of submittal of the New Mexico Title XIX cost report to the state agency. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider shall make such records available upon demand to representatives of the state agency, the state audit agent, or the department of health and human services.

(2) The state agency or its audit agent will retain all cost reports submitted by providers for a period of 10 years following the date of final settlement of such reports.

E. Audits: Audits will be performed in accordance with 42 CFR 447.202.

(1) Desk audit: Each cost report submitted will be subjected to a comprehensive desk audit by the state audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the state agency.

(2) Field audit: Field audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost and to determine whether the expenses attributable to such proper items of cost were accurately determined and reasonable. After each field audit is performed, the audit agent will submit a complete report of the audit to the state agency. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate and reasonable in accordance with the state plan. These audit reports will be retained by the state agency for a period of not less than three years from the date of final settlement of such reports.

F. Overpayments: All overpayments found in audits will be accounted for on the HCFA-64 report to health and human services (HHS) no later than the second quarter following the quarter in which found.

G. Allowable costs: The following identifies costs that are allowable in the determination of a provider's actual, allowable and reasonable costs. All costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.

(1) Cost of meeting certification standards: These will include all items of expense that the provider must incur under:

(a) 42 CFR 442;

(b) Sections 1861(j) and 1902(a)(28) of the Social Security Act;

(c) standards included in 42 CFR 431.610; and

(d) cost incurred to meet requirements for licensing under state law which are necessary for providing NF service.

(2) **Costs of routine services:** Allowable costs shall include all items of expense that providers incur to provide routine services, known as operating costs. Operating costs include such things as:

(a) regular room;

(b) dietary and nursing services;

(c) medical and surgical supplies (including syringes, catheters; ileostomy, and colostomy supplies);

(d) use of equipment and facilities;

(e) general services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas;

(f) items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans;

(g) items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, bandaids, laxatives and fecal softeners, aspirin, antacids, over-the-counter (OTC) ointments, and tongue depressors;

(h) items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable equipment;

(i) special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician;

(j) laundry services including basic personal laundry;

(k) the HCA will make payment directly to the medical equipment provider in accordance with procedures outlined in 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*, and subject to the limitations on rental payments contained in that section; and

(l) managerial, administrative, professional, and other services related to the providers operation and rendered in connection with patient care.

(3) **Facility costs**, for purpose of specific limitations included in this plan, include only depreciation, lease costs, and long-term interest.

(a) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated useful life of the assets.

(i) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.

(ii) Historical cost is the actual cost incurred in acquiring and preparing an asset for use.

(iii) Fair market value is the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American institute of real estate appraisers (MAI) and who is acceptable to the HCA.

(iv) In determining the historical cost of assets where an on-going facility is purchased, the provisions of medicare provider reimbursement manual (HIM-15), Section 104.14 will apply.

(v) Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American hospital association chart of accounts for hospitals.

(b) Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.

(c) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

(4) **Gains and losses on disposition:** Gains or losses on the disposition of depreciable assets used in the program are calculated in accordance with Section 130 and 132 of HIM-15. Disposition of a provider's depreciable assets which effectively terminates its participation in the program shall include the sale, lease or other disposition of a facility to another entity whether or not that entity becomes a participant in the program. The amount of gain on the disposition of depreciable assets will be subject to recapture as allowed by HIM-15.

(5) Depreciation, interest, lease costs, or other costs are subject to the limitations stated in Section 2422 of HIM-15 regarding approval of capital expenditures in accordance with Section 1122 of the Social Security Act.

(6) Facility costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.

H. Non-allowable costs:

(1) bad debts, charity, and courtesy allowances: bad debts on non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs;

(2) purchases from related organizations: cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere; providers shall identify such related organizations and costs in the state's cost reports;

(3) return on equity capital;

(4) other cost and expense items identified as unallowable in HIM-15;

(5) interest paid on overpayments as per 8.302.2 NMAC, *Billing for Medicaid Services*; and

(6) any civil monetary penalties levied in connection to intermediate sanctions, licensure, certification, or fraud regulations.

[8.312.3.11 NMAC - Rp, 8.312.3.11 NMAC, 9/1/2021]

8.312.3.12 ESTABLISHMENT OF PROSPECTIVE PER-DIEM RATES: Prospective per diem rates will be established as follows and will be the lower of the amount calculated using the following formulas, or the ceiling:

A. Base year: Rebasing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as year one, year two and year three. Because rebasing is done every three years, operating year four will again become year one, etc. Cost incurred, reported, audited or desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year one will be used to rebase the prospective per-diem rate. Rebasing of costs in excess of one hundred and ten percent of the previous year's audited cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs. For implementation year one (effective July 1, 1984) the base year is the provider's last available audited cost report prior to January 1, 1984. Rebasing will occur out of cycle for rates effective January 1, 1996, using the provider's FYE 1994 audited cost reports. The rate period January 1, 1996, through June 30, 1996, will be considered year one. The rate period July 1, 1996, through June 30, 1997, will be considered year two, and the rate period July 1, 1997, through June 30, 1998, will be considered year three. The rebasing cycle will resume for rates effective July 1, 1998, and continue as described in the first paragraph of this section. Pursuant to budget availability, any changes to reimbursement, including the decision to rebase rates will be at the HCA's discretion.

B. Inflation factor to recognize economic conditions and trends during the time period covered by the provider's prospective per diem rate:

(1) Pursuant to budget availability and at the HCA's discretion, an inflation factor may be used to recognize economic conditions and trends. A notice will be sent out every July informing each provider that a:

(a) MBI will or will not be authorized; and

(b) the percentage increase if the MBI is authorized.

(2) If utilized, the index used to determine the inflation factor will be the center for medicare and medicaid services (CMS) market basket index (MBI) or a percentage up to the MBI.

(3) Each provider's operating costs will be indexed up to a common point of 12/31 for the base year, and then indexed to a mid-year point of 12/31 for operating year one, if applicable. For out-of-cycle rebasing occurring for rates effective January 1, 1996, through June 30, 1996, the mid-year point for indexing in operating year one will be 3/31.

(4) The inflation factor for the period July 1, 1996, through June 30, 1997, will be the percentage change in the (MBI) for the previous year plus two percentage points.

C. Incentives to reduce increases in costs: As an incentive to reduce the increases in the costs of operation, the HCA will share with the provider in accordance with the following formula, the savings below the operating cost ceiling in effect during the state's fiscal year.

$I = [1/2(M - N)] \leq \$2.00$

where

M = current operating cost ceiling per diem
N - allowable operating per diem rate based on the base year's cost report
I = allowable incentive per diem

D. Calculation of the prospective per-diem rate: The following formulas are used to determine the prospective per diem rate:

YEAR ONE

PR = BYOC x (1 + Δ MBI) + I + FC

where

PR = prospective per diem rate

BYOC = allowable base year operating costs as described in A above, and indexed as described in B above.

NHI = the change in the MBI as described in B above

I = allowable incentive per diem

FC = allowable facility costs per diem

YEARS TWO and THREE

PR = (OP+ I) x (1 + Δ MBI) + FC

where

PR = prospective per-diem rate

OP= allowable operating costs per diem

I = allowable incentive per diem

NHI = the change in the MBI as described in B above

FC = allowable facility costs per diem

E. Effective dates of prospective rates: Rates are effective July 1 of each year for each facility.

F. Calculation of rates for existing providers that do not have 1983 actuals, and for newly constructed facilities entering the program after July 1, 1984.

(1) For existing and for newly constructed facilities entering the program that do not have 1983 actuals, the provider's interim prospective per-diem rate will become the sum of:

(a) the applicable facility cost ceiling; and

(b) the operating cost ceiling.

(2) After six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report. This will be audited to determine the actual operating and facility cost, and retroactive settlement will take place. The provider's prospective per-diem rate will then become the sum of:

(a) the lower of allowable facility costs or the applicable facility cost ceiling; and

(b) the lower of allowable operating costs or the operating cost ceiling.

(3) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

G. Changes of provider by sale of an existing facility:

(1) When a change of ownership occurs, the provider's prospective per-diem rate will become the sum of:

(a) the lower of allowable facility costs determined by using the medicare principles of reimbursement, or the facility cost ceiling; and

(b) the operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

(2) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

H. Changes of provider by lease of an existing facility:

(1) When a change of ownership occurs, the provider's prospective per-diem rate will become the sum of:

(a) the lower of allowable facility costs or the facility cost ceiling, as defined by this plan; and

(b) the operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

(2) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

I. Sale/leaseback of an existing facility: When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

J. Replacement of an existing facility: When an existing facility is replaced, the provider's prospective rate will become the sum of:

(1) the lower of allowable facility costs or the facility cost ceiling as defined by this plan; and

(2) the operating cost plus incentive payment paid to the provider prior to the construction of the replacement facility.

K. Replaced facility re-entering the medicaid program:

(1) When a facility is replaced by a replacement facility and the replaced facility re-enters the medicaid program either under the same ownership or under different ownership, the provider's prospective rate will become the sum of:

(a) the median operating cost for its category; and

(b) the lower of allowable facility costs or the applicable facility cost ceiling.

(2) Such providers will not be eligible for incentive payments until the next operating year one, after rebasing.

L. Closed facility re-entering the medicaid program:

(1) When a facility has been closed and re-enters the medicaid program under new ownership, it shall be considered a change of ownership and either Subsection G or Subsection H, whichever is applicable, will apply.

(2) When a facility has been closed and re-enters the medicaid program under the same ownership within 12 months of closure, the provider's prospective rate will be the same as prior to the closing.

(3) When a facility has been closed and re-enters the medicaid program under the same ownership more than 12 months after closure, the provider's prospective rate will be the sum of:

(a) the median operating cost for its category; and

(b) the lower of allowable facility costs or the applicable facility cost ceiling.

(4) Providers of such facilities will not be eligible for incentive payments until the next operating year one, after rebasing.

[8.312.3.12 NMAC - Rp, 8.312.3.12 NMAC, 9/1/2021]

8.312.3.13 ESTABLISHMENT OF CEILINGS: The following categories are used to establish ceilings for calculating prospective per diem rates: 1) state-owned and operated NF, 2) non-state-owned and operated NF. The HCA determines the status of each provider for exclusion from or inclusion in any one category. Ceilings will be separately established for each category as described above, and separately established for the two areas of allowable costs, i.e. operating costs and facility costs. The operating cost ceiling will be calculated using the base year costs for year one. For years two and three, the operating cost ceiling will not be recalculated. It will be indexed forward using the appropriate inflation factor. The facility cost ceiling of $11.50 will be trended forward in year two beginning July 1, 1985, by MBI minus one percentage point and then annually by the MBI.

A. Operating costs: The ceiling for operating costs will be established at one hundred and ten percent of the median of allowable costs for the base year, indexed to 12/31 of base year.

B. Facility costs: For existing, replacement, and newly constructed facilities, including remodeling of a facility to become a long term care facility, facility costs will be limited as follows:

(1) Any facility that is participating in medicaid by July 1, 1984, or has been granted Section 1122 approval by July 1, 1984, for construction (including bed additions to such facilities) will be paid the lower of actual allowable facility costs or the applicable facility cost ceiling for implementation year one. The facility cost ceiling will be eleven dollars and fifty cents ($11.50).

(2) Any new facility not approved July 1, 1984, under Section 1122 for construction (including bed additions to such facilities) will be paid the lower of actual allowable facility costs or the median of facility costs for all other existing facilities in the same category.

(3) Effective for leases executed and binding on both parties on or after January 1, 1988, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor an annual rate of return on the fair market value of the facility equal to one time the average of the rates of interest on special issues of public debt obligations issued to the federal hospital insurance trust fund for the twelve months prior to the date the facility became a provider in the New Mexico medicaid program. The rates of interest for this fund are published in both the federal register and the commerce clearing house (CCH). The basis of the total investment will be subject to the limitations described in Paragraphs 1 and 2 of Subsection B of 8.312.3.13 NMAC. The rate of return described above will be exclusive of

any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective and the reasonableness of such clauses will be determined by the inflation factor described in Subsection B of 8.312.3.12 NMAC. Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider and is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with the geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the HCA the name of the appraiser, a copy of their certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the HCA.

(4) For newly constructed facilities, reconstruction of a facility to become a long term care facility, and replacement facilities entering the medicaid program on or after January 1, 1988, the total basis of depreciable assets shall not exceed the median cost of construction of a nursing home as listed in the Robert S. Means construction index, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to enter the New Mexico medicaid program. The costs of construction referred to herein is expected to include only the cost of the building and fixed equipment. A reasonable value of land and major moveable equipment will need to be added to obtain the value of the entire facility.

(5) When an existing facility is sold, facility costs per day will be limited to the lower of:

(a) allowable facility costs determined by using the medicare principles of reimbursement; or

(b) the facility cost ceiling.

(6) When an existing facility is leased, the facility costs per day will be limited to the lower of:

(a) actual allowable facility costs; or

(b) for facilities owned or operated by the lessor for 10 years or longer, the applicable facility cost ceiling; or

(c) for facilities owned or operated by the lessor less than 10 years, one hundred and ten percent of the median of facility costs for all providers in the same category.

(7) When a replaced facility re-enters the medicaid program either under the same ownership as existed prior to the replacement or under different ownership, facility costs per day will be limited to the lower of:

(a) actual allowable facility costs; or

(b) the median of facility costs for all other existing facilities in the same category.

[8.312.3.13 NMAC - Rp, 8.312.3.13 NMAC, 9/1/2021]

8.312.3.14 IMPUTED OCCUPANCY: In order to insure that the medicaid program does not pay for costs associated with unnecessary beds as evidenced by under-utilization, allowable facility costs will be calculated by imputing a ninety percent occupancy rate. This provision will apply to:

A. any new facility certified for participation in the medicaid program on or after January 1, 1988;

B. existing facilities, if the number of licensed or certified beds increases on or after January 1, 1988. In such cases, occupancy will be imputed for all beds;

C. replacement facilities, certified for participation in the medicaid program on or after January 1, 1988, if the replacement facility contains a higher number of licensed or certified beds than the facility being replaced;

D. any replaced facility which re-enters the medicaid program on or after January 1, 1988, either under the same ownership or different ownership;

E. any closed facility which re-enters the medicaid program on or after January 1, 1988;

F. facility costs will be adjusted and the resulting rate change will become effective when any of the above occurs; providers operating such facilities shall submit appropriate information regarding facility costs so that the rate adjustment can be computed.

[8.312.3.14 NMAC - Rp, 8.312.3.14 NMAC, 9/1/2021]

8.312.3.15 ADJUSTMENTS TO BASE YEAR COSTS:

A. Since rebasing of the prospective per diem rate will take place every three years, the HCA recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:

(1) additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, social security taxation of 501 (c)(3) corporations, minimum wage change, property tax increases, etc.);

(2) additional costs incurred as a result of uninsurable losses from catastrophic occurrences; and

(3) additional costs of approved expansion, remodeling or purchase of equipment;

B. Such additional costs must reach a minimum of $10,000 incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The provider is encouraged to submit such rebasing requests before the cost is actually incurred if possible. The HCA will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect:

(1) beginning with the month the cost was actually incurred if prior approval was obtained; or

(2) no later than 30 days from the date of the approval if retroactive approval was obtained.

C. At no time will rebasing in excess of the applicable operating or facility cost ceilings be allowed, unless the HCA determines that a change in law or regulation has equal impact on all providers regardless of the ceiling limitation. An example of this would be the minimum wage law.

D. Pursuant to budget availability, the decision to approve any adjustments to base year costs will be at the HCA's discretion.

[8.312.3.15 NMAC - Rp, 8.312.3.15 NMAC, 9/1/2021]

8.312.3.16 IMPLEMENTATION OF NURSING HOME REFORM REQUIREMENTS EFFECTIVE OCTOBER 1, 1990: As mandated by Section 1919 of the Social Security Act, the following changes are made effective October 1, 1990:

A. Elimination of SNF/ICF Distinction: Effective October 1, 1990, the SNF and ICF distinctions will be eliminated and all participating providers will become NFs. In order to account for the change the following will be implemented:

(1) Two levels of NF services will exist, representing the care needs of the respective recipients: High NF; Low NF.

(2) A high NF rate and a low NF rate will be established for each provider.

(3) For existing SNFs, the High NF rate will be the provider's SNF rate in effect on September 30, 1990.

(4) For existing SNFs with no existing ICF rate, the low NF rate will be the provider's SNF rate in effect on September 30, 1990, minus an amount equal to the statewide mean differential of the operating component of current SNF/ICF rates.

(5) For existing ICFs, the low NF rate will be the provider's ICF rate in effect on September 30, 1990.

(6) For existing ICFs with no existing SNF rate, the high NF rate will be the provider's ICF rate in effect on September 30, 1990, plus an amount equal to the statewide mean differential of the operating component of current SNF/ICF rates.

B. Cost increases related to nursing home reform: To account for cost increases necessary to comply with the nursing home reform provisions, the following amounts will be added to NF rates (see above), effective October 1, 1990: high NF $3.69; low NF $4.96.

[8.312.3.16 NMAC - Rp, 8.312.3.16 NMAC, 9/1/2021]

8.312.3.17 PAYMENT OF RESERVE BED DAYS: When medicaid payment is made to reserve a bed while the recipient is absent from the facility, the reserve bed day payment shall be in an amount equal to fifty percent of the regular payment rate.

[8.312.3.17 NMAC - Rp, 8.312.3.17 NMAC, 9/1/2021]

8.312.3.18 RECONSIDERATION PROCEDURES FOR LONG TERM CARE DETERMINATIONS:

A. A provider who is dissatisfied with the base year rate determination or the final settlement (in the case of a change in ownership) may request a reconsideration of the determination by addressing a request for reconsideration to: director, medical assistance division, health care authority, P.O. Box 2348, Santa Fe, New Mexico 87504-2348.

B. The filing of a request for reconsideration will not effect the imposition of the determination.

C. A request for reconsideration, to be timely, must be filed with or received by the medical assistance division director no later than 30 days after the date of the determination notice to the provider.

D. The written request for reconsideration must identify each point on which it takes issue with the audit agent and must include all documentation, citation of authority, and argument on which the request is based. Any point not raised in the original filed request may not be raised later.

E. The medical assistance division will submit copies of the request and supporting material to the audit agent. A copy of the transmittal letter to the audit agent will be sent to the provider. A written response from the audit agent must be filed with or received by the medical assistance division no later than 30 days after the date of the transmittal letter.

F. The medical assistance division will submit copies of the audit agent's response and supporting material to the provider. A copy of the transmittal letter to the provider will be sent to the audit agent. Both parties may then come up with additional submittals on the point(s) at issue. Such follow-up submittals must be filed with or received by the medical assistance division no later than 15 days after the date of the transmittal letter to the provider.

G. The request for reconsideration and supporting materials, the response and supporting materials, and any additional submittal will be delivered by the medical assistance division director to the secretary, or their designee, within 5 days after the closing date for final submittals.

H. The secretary, or their designee, may secure all information and call on all expertise they believe necessary to decide the issues.

I. The secretary, or their designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to the secretary. The secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The secretary's decision will be final and any changes to the original determination will be implemented pursuant to that decision.

[8.312.3.18 NMAC - Rp, 8.312.3.18 NMAC, 9/1/2021]

8.312.3.19 PUBLIC DISCLOSURE OF COST REPORTS:

A. Providers' cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the medical assistance division. Information thus disclosed is limited to cost report documents required by social security administration regulations and, in the case of a settled cost report, the notice of program settlement.

B. The request must identify the provider and the specific report(s) requested.

C. The provider whose report has been requested will be notified by the medical assistance division that its cost report has been requested, and by whom. The provider shall have 10 days in which to comment to the requester before the cost report is released.

D. The cost for copying will be charged to the requester.

[8.312.3.19 NMAC - Rp, 8.312.3.19 NMAC, 9/1/2021]

8.312.3.20 SEVERABILITY: If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.

[8.312.3.20 NMAC - Rp, 8.312.3.20 NMAC, 9/1/2021]

HISTORY OF 8.312.3 NMAC:

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

ISD 306.4000, Provider Protesting Certified Costs Reimbursement Rates, 1/7/1980.

SP-004.2400, Section 4, General Program Administration Standards For Payments For Skilled Nursing And Intermediate Care Facility Services, 3/5/1981.

History of Repealed Material: 8.312.3 NMAC, Nursing Services, Cost Related Reimbursement of Nursing Facilities filed 6/14/2002, repealed effective 9/1/2021.

Other History: 8.312.3 NMAC, Nursing Services, Cost Related Reimbursement of Nursing Facilities filed 6/14/2002 was replaced by 8.312.3 NMAC, Nursing Services, Cost Related Reimbursement of Nursing Facilities, effective 9/1/2021.

TITLE 8 SOCIAL SERVICES
CHAPTER 314 LONG TERM CARE SERVICES - WAIVERS
PART 3 MEDICALLY FRAGILE HOME AND COMMUNITY-BASED SERVICES WAIVER SERVICES

8.314.3.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.314.3.1 NMAC - Rp, 8 .314.3.1 NMAC, 3/1/2018; A, 7/1/2024]

8.314.3.2 SCOPE: The rule applies to the general public.
[8.314.3.2 NMAC - Rp, 8 .314.3.2 NMAC, 3/1/2018]

8.314.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12, et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.314.3.3 NMAC - Rp, 8 .314.3.3 NMAC, 3/1/2018; A, 7/1/2024]

8.314.3.4 DURATION: Permanent.
[8.314.3.4 NMAC - Rp, 8 .314.3.4 NMAC, 3/1/2018]

8.314.3.5 EFFECTIVE DATE: March 1, 2018 unless a later date is cited at the end of a section.
[8.314.3.5 NMAC - Rp, 8 .314.3.5 NMAC, 3/1/2018]

8.314.3.6 OBJECTIVE: The objective of this rule is to provide policies for the service portion of the New Mexico medical assistance program (MAP). These policies describe eligible providers, covered services, non-covered services, utilization review, and provider reimbursement.
[8.314.3.6 NMAC - Rp, 8 .314.3.6 NMAC, 3/1/2018]

8.314.3.7 DEFINITIONS:

A. Activities of daily living (ADLs): Those activities associated with an individual's daily functioning. The basic skills of everyday living such as toileting, bathing, dressing, grooming, and eating and the skills necessary to maintain the normal routines of the day, such as housekeeping, shopping and preparing meals. The term also includes exercising, personal, social and community skills.

B. Adult: An individual who is 18 years of age or older.

C. Authorized representative: An individual designated by the eligible recipient or their guardian, if applicable, to represent the eligible recipient and act on their behalf. The authorized representative must provide formal documentation authorizing them to access the identified case information for this specific purpose. An authorized representative may be, but need not be, the eligible recipient's guardian or attorney.

D. Category of eligibility (COE): To qualify for medical assistance program (MAP) services, an applicant must meet financial criteria and belong to one of the groups that the New Mexico medical assistance division (MAD) has defined as eligible.

E. Centers for medicare and medicaid services (CMS): Federal agency within the United States department of health and human services that works in partnership with New Mexico to administer medicaid and MAP services under HCA.

F. Child: An individual under the age of 18. For purpose of early periodic screening, diagnosis and treatment (EPSDT) services eligibility, "child" is defined as an individual under the age of 21.

G. Eligible recipient: An applicant meeting the financial and medical level of care (LOC) criteria to receive MAD services through the medically fragile program.

H. Home and community-based services (HCBS) waiver: A set of MAD services that provides alternatives to long-term care services in institutional settings, such as the medically fragile waiver program. CMS waives certain statutory requirements of the Social Security Act to allow HCA to provide an array of home and community-based options through these waiver programs.

I. Intermediate care facilities for individuals with intellectual disabilities (ICF/IID): Facilities that are licensed and certified by the New Mexico department of health (DOH) to provide room and board,

continuous active treatment and other services for eligible recipients with a primary diagnosis of intellectual disabilities.

J. Level of care (LOC): The level of care an eligible recipient must meet to be eligible for the medically fragile program.

K. Medically Fragile: a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following: a life threatening condition characterized by reasonable frequent periods of acute exacerbation which require frequent medical supervision, or physician consultation and which in the absence of such supervision or consultation would require hospitalization; a condition requiring frequent, time consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include but are not limited to ventilators, dialysis machines, enteral or parenteral nutrition support and supplemental oxygen.

L. Medically Fragile Waiver (MFW): New Mexico's 1915 (c) HCBS program serving individuals diagnosed with a medically fragile condition prior to the age of 22 and a developmental disability or who are developmentally delayed or at risk for developmental delay and meet an ICF/IID level of care.

M. Person centered planning: A service planning process that is directed and led by the recipient, with assistance as needed or desired from a representative or other persons of the recipient's choosing. Person-centered planning is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the recipient. The person-centered process is an ongoing process that enables and assists the recipient to identify and access a personalized mix of paid and non-paid services and supports that assists them to achieve personally defined outcomes in the community.

N. **Recipient**: Individual receiving waiver services.

O. Waiver: A program in which the CMS has waived certain statutory requirements of the Social Security Act to allow states to provide an array of HCBS options as an alternative to providing long-term care services in an institutional setting.

[8.314.3.7 NMAC - Rp, 8 .314.3.7 NMAC, 3/1/2018]

8.314.3.8 MISSION STATEMENT: [RESERVED]

8.314.3.9 MEDICALLY FRAGILE HOME AND COMMUNITY-BASED SERVICES WAIVER: The New Mexico MAP pays for medically necessary services furnished to eligible recipients. To help New Mexico recipients receive services in a cost-effective manner, the New Mexico medical assistance division (MAD) has obtained a waiver of certain federal regulations to provide home and community-based services (HCBS) waiver programs to recipients as an alternative to institutionalization. See 42 CFR 441.300. Section 8.314.3.9 NMAC describes the HCBS waiver program for the medically fragile population, including eligible providers, covered waiver services, service limitations, and general reimbursement methodology.

[8.314.3.9 NMAC - Rp, 8 .314.3.9 NMAC, 3/1/2018]

8.314.3.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico MAP provider participation agreements by MAD, providers who meet the following requirements are eligible to be reimbursed for furnishing waiver services to recipients:

(1) standards established by the HCBS waiver program; and

(2) provide services to recipients in the same scope, quality and manner as provided to the general public; see Section 8.302.1.14 NMAC.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD and the New Mexico DOH. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

C. Qualifications of case management agency providers: Agencies must meet the standards developed for this HCBS waiver program by the applicable division of the DOH. Case management agencies are required to have national accreditation. These accrediting organizations are the commission on accreditation of rehabilitation facilities (CARF), the joint commission or another nationally recognized accrediting authority. Case management assessment activities necessary to establish eligibility are considered administrative costs.

D. Qualifications of case managers: Case managers employed by case management agencies must have the skills and abilities necessary to perform case management services for recipients who are medically fragile, as defined by the DOH medically fragile waiver standards. Case managers must be registered nurses, as defined by

the New Mexico state board of nursing and have a minimum of two years of supervised experience with the target population in one or more areas of pediatrics, critical care or public health.

E. Qualifications of home health aide service providers:

(1) Home health aide services must be provided by a licensed home health agency, a licensed rural health clinic or a licensed or certified federally qualified health center using only home health aides who have successfully completed a home health aide training program as described in 42 CFR 484.36(a) (1) and (2); or who have successfully completed a home health aide training program described in the New Mexico regulations governing home health agencies, Section 8.370.22 NMAC. Additionally, home health aides providing services must be deemed competent through a written examination and meet competency evaluation requirements specified in the 42 CFR 484.36(b) (1), (2) and (3); or meet the requirement for documentation of training or competency evaluation specified in the New Mexico regulations governing home health agencies, Section 8.370.22 NMAC.

(2) Supervision: Supervision must be performed by a registered nurse and shall be in accordance with the New Mexico Nursing Practice Act, Section 61-3-1, NMSA 1978. Supervision must occur at least once every 60 days in the recipient's home and be specific to the individual service plan (ISP). All supervisory visits must be documented in the recipient's file.

(3) The supervision of home health aides is an administrative expense to the provider and is not billable as a direct service.

F. Qualifications of private duty nursing providers:

(1) Private duty nursing services must be provided by a licensed home health agency, a licensed rural health clinic, or a licensed or certified federally qualified health center, using only registered nurses or licensed practical nurses holding a current New Mexico board of nursing license and having a minimum of one year of supervised nursing experience; nursing experience preferably with individuals with developmental disabilities or who are medically fragile.

(2) Supervision: Supervision must be performed by a registered nurse and shall be in accordance with the New Mexico Nursing Practice Act. Supervision must be specific to the ISP.

(3) The supervision of nurses is an administrative expense to the provider and not billable as a direct service.

G. Qualifications of skilled therapy providers: Skilled therapy services may be provided by a licensed group practice/home health agency that employs licensed occupational therapists, physical therapists, or speech therapists and certified occupational therapy assistants and certified physical therapy assistants in accordance with the New Mexico regulation and licensing department. Physical therapy services must be provided by a physical therapist currently licensed by the state of New Mexico. Occupational therapy services must be provided by an occupational therapist currently licensed by the state of New Mexico, and registered with the American occupational therapy association or be a graduate of a program in occupational therapy approved by the council on medical education of the American occupational therapist association. Speech therapy services must be provided by a speech therapist currently licensed by the state of New Mexico and certified by the national association for speech and hearing. A physical therapy assistant working only under the direction and supervision of a licensed physical therapist, Section 16.20.6 NMAC, may provide physical therapy services. An occupational therapy assistant working only under the direction and supervision of a licensed occupational therapist, Section 16.15.3 NMAC, may provide occupational therapy services.

H. Qualifications of behavior support consultation providers:

(1) Behavior support consultation providers must possess one of the following licenses approved by a New Mexico licensing board: psychiatrist; clinical psychologist; independent social worker (LISW); professional clinical mental health counselor (LPCC); professional art therapist (LPAT); marriage and family therapist (LMFT); mental health counselor (LMHC); master social worker (LMSW); psychiatric nurse, or psychologist associate (PA).

(2) Behavior support consultation may be provided through a corporation, partnership or sole proprietor.

(3) Providers of behavior support consultation must have a minimum of one year of experience working with individuals with developmental disabilities or who are medically fragile. All behavior support consultants must maintain current New Mexico licensure with their professional field licensing body.

I. Qualifications of respite care service providers:

(1) Respite may be provided in the following locations: participant's home or private place of residence, the private residence of a respite care provider, or specialized foster care home. The participant and or the participant's authorized representative has the option and gives final approval of location of the respite services

being provided. A specialized foster care home must be certified by the New Mexico children, youth and families department.

(2) Respite services are provided by a licensed home health care agency, a licensed or certified federally qualified health center, or a licensed rural health clinic. The registered nurses (RNs) and licensed practical nurses (LPNs) who work for the home health agency and provide respite services must be licensed by the New Mexico state board of nursing as an RN or LPN. See the New Mexico Nursing Practice Act, Section 61-3-1, NMSA 1978, and Section 16.12.2 NMAC. The home health aides who work for the home health agency and provide respite services, must have successfully completed a home health aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a home health aide training program described in the New Mexico regulations governing home health agencies.

J. Qualifications of nutritional counseling providers: Nutritional counseling must be furnished by a licensed dietitian registered by the commission on dietetic registration of the American dietetic association, Nutrition and Dietetics Practice Act, Section 61-7A-1, NMSA 1978.

K. Qualifications of specialized medical equipment and supplies providers: Specialized medical equipment and supplies providers must have a business license for the locale they are in, a tax identification (ID) number for state and federal government, proof of fiscal solvency, proof of use of approved accounting principles, meet bonding required by the department of health (DOH), and comply with timeliness standards for this service.

L. Qualifications of an environmental modification provider agency: An environmental modification contractor and their subcontractors and employees must be bonded, licensed by the New Mexico regulation and licensing department (RLD), and authorized by DOH to complete the specified project. All services shall be provided in accordance with applicable federal, state and local building codes.

[8.314.3.10 NMAC - Rp, 8 .314.3.10 NMAC, 3/1/2018; A, 7/1/2019]

8.314.3.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations, rules, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement and the DOH provider agreement. A provider also must meet and adhere to all applicable NMAC rules and instructions as specified in the MAD provider rules manual and its appendices, MFW service standards, MFW service definitions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and the centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services. Provider must maintain current knowledge and adherence to MFW requirements.

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section 8.302.1 NMAC.

[8.314.3.11 NMAC - Rp, 8 .314.3.11 NMAC, 3/1/2018]

8.314.3.12 ELIGIBLE RECIPIENTS:

A. Enrollment in the MFW program is contingent upon the applicant meeting the eligibility requirements as described in this rule, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated eligible recipients. Once an allocation has been offered to the applicant, they must meet certain medical and financial criteria in order to qualify. This criteria is contained in Section 8.290.400 NMAC. The eligible recipient must meet the LOC required for admittance to an ICF/IID. After initial eligibility has been established for a recipient, on-going eligibility must be determined on an annual basis.

B. Eligibility is limited to individuals who in addition to a developmental disability, developmental delay, or are at risk of developmental delay, have a medically fragile condition, diagnosed before the age of 22, defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following:

(1) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which require frequent medical supervision, or physician consultation and which in the absence of such supervision or consultation, would require hospitalization;

(2) a condition requiring frequent, time consuming administration of specialized treatments which are medically necessary; or

(3) dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include but are not limited to ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen.
[8.314.3.12 NMAC - Rp, 8 .314.3.12 NMAC, 3/1/2018]

8.314.3.13 COVERED WAIVER SERVICES: The services covered by the MFW program are intended to provide a home and community-based alternative to institutional care for an eligible recipient. In all services covered under the MFW the recipient has the right to privacy, dignity, and respect. The recipient further has the right to freedom from coercion and restraint. The MFW program covers the following services for a specified number of medically fragile recipients. The program is limited by the number of federally authorized unduplicated recipient (UDR) positions and program funding.

A. Case management services: Case management services assist recipients in gaining access to needed waiver and other state plan services, as well as medical, social, educational, and other services regardless of the funding source for the services. Case management services are offered in a manner that allows direct communication between the case manager, the recipient, and the family and appropriate service personnel. Case managers provide a link between recipients and care providers and coordinate the use of community resources needed for that care. At least every other month, the case manager conducts a face-to-face contact with the recipient, and on a monthly basis conducts a telephonic or electronic contact with the recipient. The scope of the case manager's duties includes the following:

(1) identifying medical, social, educational, family and community support resources;

(2) scheduling and coordinating timely interdisciplinary team (IDT) meetings to develop and modify the ISP annually and as needed by any team member;

(3) documenting contacts with the recipient and providers responsible for delivery of services to the recipient;

(4) verifying eligibility on an annual basis;

(5) ensuring the medically fragile long-term care assessment abstract (LTCAA) is completed and signed by the physician, physician assistant or clinical nurse practitioner (CNP);

(6) submitting the LOC packet including the LTCAA to the third-party assessor (TPA) contractor for prior authorization on a timely basis;

(7) ensuring the waiver review form (MAD 046) is submitted timely, both annually and as needed;

(8) initiating an ongoing monitoring process that provides for evaluation of delivery, effectiveness, appropriateness of services and support provided to the recipient as identified in the ISP;

(9) performing an annual recipient satisfaction survey; and

(10) coordinating services provided though the MFW program and other sources (state plan, family infant toddler (FIT), commercial insurance, educational and community).

B. Home health aide: Home health aide services are covered under the state plan as expanded early and periodic screening, diagnosis and treatment EPSDT benefits for waiver participants under the age of 21. Home health aide services are provided in the eligible recipient's own home or in the community. Home health aide services provide total care or assist a recipient in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampooing (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake. The home health aide services assist the recipient in a manner that promotes an improved quality of life and a safe environment for the recipient. Home health aide services can be provided outside the recipient's home. Home health aides perform simple procedures such as an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are normally self-administered, reporting changes in patient conditions and needs, and completing appropriate records. Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice.

C. Private duty nursing: Private duty nursing services are covered under the state plan as expanded EPSDT benefits for waiver recipients under the age of 21. Private duty nursing services are provided in the eligible recipient's own home and in the community and include activities, procedures and treatment for a physical condition, physical illness, or chronic disability. Services may include medication management; administration and teaching; aspiration precautions; feeding management such as gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure

management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance. DOH requires certain standards to be maintained by the private duty nursing care provider with which it contracts. In carrying out their role for DOH, private duty nursing care agencies must:

(1) employ only RNs and LPNs licensed in the state of New Mexico;

(2) assure that all nurses delivering services are culturally sensitive to the needs and preferences of the recipients and their families. Based upon the recipient's individual language needs or preferences, nurses may be requested to communicate in a language other than English;

(3) inform the case manager immediately of the agency's inability to staff according to the ISP;

(4) develop and implement an individual nursing plan in conjunction with the recipient's physician and case manager in a manner that identifies and fulfills the recipient's specific needs;

(5) document all assessments, observations, treatments and nursing interventions;

(6) document and report to the case manager any non-compliance with the ISP; and

(7) document any incidence of recipient harm, medication error, or other adverse event in accordance with the New Mexico Nursing Practice Act.

D. Skilled therapy services for adults: Skilled therapy services are covered under the state plan as expanded EPSDT benefits for waiver recipients under the age of 21. Adults access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Waiver services are provided when the limits of the state plan skilled therapy services are exhausted. The amount, duration, and goals of skilled therapy services must be included in an ISP. A therapy treatment plan must be developed with the initiation of therapy services and updated at least every six months. The therapy treatment plan includes the following: developmental status of the recipient in areas relevant to the service provided; treatment provided, including the frequency and duration; and recommendation for continuing services and documentation of results. Skilled maintenance therapy services specifically include the following:

(1) Physical therapy: Physical therapy services promote gross/fine motor skills, facilitate independent functioning or prevent progressive disabilities. Specific services may include: professional assessment(s), evaluation(s) and monitoring for therapeutic purposes; physical therapy treatments and interventions; training regarding physical therapy activities, use of equipment and technologies or any other aspect of the individual's physical therapy services; designing, modifying or monitoring use of related environmental modifications; designing, modifying, and monitoring use of related activities supportive to the ISP goals and objectives; and consulting or collaborating with other service providers or family members, as directed by the recipient.

(2) Occupational therapy: Occupational therapy services promote fine motor skills, coordination, sensory integration, or facilitate the use of adaptive equipment or other assistive technology. Specific services may include: teaching of daily living skills; development of perceptual motor skills and sensory integrative functioning; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment; use of specifically designed crafts and exercise to enhance function; training regarding occupational therapy activities; and consulting or collaborating with other service providers or family members, as directed by the recipient.

(3) Speech language therapy: Speech language therapy services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology, or prevent progressive disabilities. Specific services may include: identification of communicative or oropharyngeal disorders and delays in the development of communication skills; prevention of communicative or oropharyngeal disorders and delays in the development of communication skills; development of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the recipient's environment to meet his/her needs; training regarding speech language therapy activities; and consulting or collaborating with other service providers or family members, as directed by the recipient.

E. Behavior support consultation services: This medicaid waiver provides services to assist the medically fragile recipient, their parents, family members or primary care givers. Behavior support consultation includes assessment, treatment, evaluation and follow-up services to assist the recipient, parents, family members or primary care givers with the development of coping skills which promote or maintain the recipient in a home environment. Behavior support consultation:

(1) informs and guides the recipient's providers with the services and supports as they relate to the recipient's behavior and his/her medically fragile condition;

(2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s);

(3) supports effective implementation based on a functional assessment;

(4) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and

(5) monitors and adapts support strategies based on the response of the recipient and his/her service and support providers. Based on the recipient's ISP, services are delivered in an integrated/natural setting or in a clinical setting.

F. Respite care services: The IDT is responsible for determining the need for respite care. Respite services are provided to recipients unable to care for themselves that are furnished on a short-term basis to allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite care is provided in the eligible recipient's own home, in a private residence of a respite care provider, or in a specialized foster care home. The recipient or the recipient's authorized representative has the option and gives final approval of where the respite services will be provided. Respite services include: medical and non-medical health care; personal care bathing; showering; skin care; grooming; oral hygiene; bowel and bladder care; catheter and supra-pubic catheter care; preparing or assisting in preparation of meals and eating; as appropriate, administering enteral feedings; providing home management skills; changing linens; making beds; washing dishes; shopping; errands; calls for maintenance; assisting with enhancing self-help skills; promoting use of appropriate interpersonal communication skills and language; working independently without constant supervision/observation; providing body positioning, ambulation and transfer skills; arranging for transportation to medical or therapy services; assisting in arranging health care needs and follow-up as directed by the primary care giver, physician, and case manager; ensuring the health and safety of the recipient at all times. Respite services are limited to 14 days or 336 hours per budget year.

G. Nutritional counseling: Nutritional counseling is designed to meet the unique food and nutrition requirements of recipients with medical fragility and developmental disabilities. Examples of recipients who may require nutritional counseling are children or adults with specific illnesses such as failure to thrive, gastroesophageal reflux, dysmotility of the esophagus and stomach etc., or who require specialized formulas, or receive tube feedings or parenteral nutrition. This does not include oral-motor skill development such as that provided by a speech language pathologist. Nutritional counseling services include assessment of the recipient's nutritional needs, regimen development, or revisions of the recipient's nutritional plan, counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan. These services advise and help recipients obtain appropriate nutritional intake by integrating information from the nutritional assessment with information on food, other sources of nutrients, and meal preparation consistent with cultural backgrounds and socioeconomic status. These services can be delivered in the home.

H. Specialized medical equipment and supplies: This medicaid waiver provides specialized medical equipment and supplies which include:

(1) devices, controls or appliances specified in the plan of care that enable recipients to increase their ability to perform activities of daily living;

(2) devices, controls, or appliances that enable the recipient to perceive, control, or communicate with the environment in which they live;

(3) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

(4) such other durable and non-durable medical equipment not available under the state plan that is necessary to address recipient functional limitations; and

(5) necessary medical supplies not available under the state plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the recipient. The costs of maintenance and upkeep of equipment are included in the cost of equipment and supplies. All items must meet applicable standards of manufacture, design, and installation. Medical equipment and supplies that are furnished by the state plan are not covered under this service. This service does not include nutritional or dietary supplements, disposable diapers, bed pads, or disposable wipes.

I. Environmental modifications: Environmental modifications include the purchasing and installing of equipment or making physical adaptions to an eligible recipient's residence that are necessary to ensure

the health, welfare and safety of the eligible recipient or enhance their access to the home environment and increase their ability to act independently.

(1) Adaptations, installations and modifications include:

(a) heating and cooling adaptations;

(b) fire safety adaptations;

(c) turnaround space adaptations;

(d) specialized accessibility, safety adaptations or additions;

(e) installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;

(f) installation of trapeze and mobility tracks for home ceilings;

(g) installation of ramps;

(h) widening of doorways or hallways;

(i) modification of bathroom facilities (roll-in showers, sink, bathtub and toilet modification, water faucet controls, floor urinals and bidet adaptations and plumbing);

(j) purchase or installation of air filtering devices;

(k) purchase or installation of lifts or elevators;

(l) purchase and installation of glass substitute for windows and doors;

(m) purchase and installation of modified switches, outlets or environmental controls for home devices; and

(n) purchase and installation of alarm and alert systems or signaling devices.

(2) Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the eligible recipient. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to an eligible recipient's residence or to configure a bathroom to accommodate a wheelchair).

(3) Environmental modification services must be provided in accordance with applicable federal, state and local building codes.

(4) Environmental modification services are limited to $5,000 every five years. An eligible recipient transferring into the medically fragile program, from another HCBS waiver, will carry their history for the previous five years of HCBS reimbursed environmental modifications.

[8.314.3.13 NMAC - Rp, 8.314.3.13 NMAC, 3/1/2018 A, 7/1/2019]

8.314.3.14 NON-COVERED SERVICES: Only services listed as covered waiver services are covered under the waiver program. Ancillary services can be available to waiver recipients through the MAP state plan services. These ancillary services are subject to the limitations and coverage restrictions which exist for other MAP services. See Section 8.301.3 NMAC for an overview of non-covered services.

[8.314.3.14 NMAC - Rp, 8 .314.3.14 NMAC, 3/1/2018]

8.314.3.15 INDIVIDUALIZED SERVICE PLAN: The CMS requires a person-centered individualized service plan (ISP) for each individual receiving services through a HCBS waiver program. The ISP is developed annually through an ongoing person-centered planning process.

A. The case manager assists the recipient in identifying his/her dreams, goals, preferences and outcomes for service. The case manager obtains information about the recipient's strengths, capacities, needs, preferences, desired outcomes, health status, and risk factors. This information is gained through a review of the LOC assessment; interviews between the case manager and recipient; and the person-centered planning process that takes place between the case manager and recipient to develop the ISP.

B. The ISP addresses: activities of daily living assistance needs, health care needs, equipment needs, relationships in the home and community, personal safety and provider responsibilities.

C. During the pre-planning process, the case manager provides the recipient with information about the MFW program. The case manager provides information about the range and scope of service choices and options, as well as the rights, risks, and responsibilities associated with the MFW program. The case manager is responsible for completing the CIA and obtaining other medical assessments needed for the ISP; completing the annual LOC redetermination process; and referring the recipient to the New Mexico health care authority (HCA) income support division (ISD) for financial eligibility determination annually and as needed.

D. The case manager works with the recipient to identify service providers to participate in the IDT meeting. State approved providers are selected from a list provided by the case manager. The recipient sets the date

and time of the IDT meeting. The case manager works with the recipient to plan the IDT meeting and encourages him/her to lead the IDT meeting to the extent possible.

E. The case manager assists the recipient in ensuring that the ISP addresses the recipient's goals, health, safety and risks along with addressing the information or concerns identified through the assessment process. The case manager writes up the ISP as identified in the IDT meeting. Each provider develops care activities and strategies for each outcome, goal, and objective identified at the IDT meeting. The case manager assures the ISP budget is within the capped dollar amount (CDA). To ensure continuity of care, additional funding is available for an eligible recipient's ISP budget that exceeds the CDA due to the impact of provider rate increases. Requests for additional funding are submitted by the case manager to the TPA contractor for review. Implementation of the ISP begins when provider service plans have been received by the case manager and recipient, and the plan and budget have been approved by the TPA contractor.

F. The case manager ensures for each recipient that:

(1) the plan addresses the recipient's needs and personal goals in medical supports needed at home for health and wellness;

(2) services selected address the recipient's needs as identified during the assessment process; needs not addressed in the ISP are addressed through resources outside the MF waiver program;

(3) the outcomes of the assessment process for assuring health and safety are considered in the plan;

(4) services do not duplicate or supplant those available to the recipient through the medicaid state plan or other public programs;

(5) services are not duplicated in more than one service code;

(6) the parties responsible for implementing the plan are identified and listed within the document;

(7) the back-up plans are complete; and

(8) the ISP is submitted to and reviewed by the TPA contractor in compliance with the MF waiver service standards.

G. The ISP is updated if personal goals, needs or life circumstances change that may or may not result in a change of the LOC. Revisions may be requested by the recipient. Each member of the IDT may request an IDT meeting to address changes or challenges. The case manager contacts the recipient to initiate revisions to the budget. The case manager initiates the scheduling of IDT meetings and assures the IDT meeting is in compliance with the MF waiver service standards.

H. The case manager is responsible for monitoring the ISP pre-planning and development process. The case management agency conducts internal quality improvement monitoring of service plans. The ISP is monitored monthly via phone, electronically, and face-to-face by the case manager.

I. After the initial ISP, the IDT reviews the ISP at least annually or more often as needed, in order to assess progress toward goal achievement and determine any needed revisions in care.

[8.314.3.15 NMAC - Rp, 8 .314.3.15 NMAC, 3/1/2018; A, 7/1/2019]

8.314.3.16 UTILIZATION REVIEW: All medicaid services, including services covered under the MFW, are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See Section 8.310.2.14 NMAC. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: To be eligible for MFW program services, recipients must require an ICF/IID LOC and meet the eligibility requirements defined in Subsection B of Section 8.314.3.12 NMAC. LOC determinations are made by MAD or its designee. The ISP must specify the type, amount and duration of services. Certain procedures or services specified in the ISP can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for MAP. Providers must verify that individuals are eligible for MAP at the time services are furnished and determine if recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and reconsideration. See Section 8.350.2 NMAC.

[8.314.3.16 NMAC - Rp, 8 .314.3.16 NMAC, 3/1/2018]

8.314.3.17 REIMBURSEMENT: Waiver service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. Claims must be filed per the billing instructions in the medicaid policy manual. Providers must follow all medicaid billing instructions. See Section 8.302.2 NMAC. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of medicaid waiver services is made at a predetermined reimbursement rate.
[8.314.3.17 NMAC - Rp, 8 .314.3.17 NMAC, 3/1/2018]

8.314.3.18 RIGHT TO A HCA ADMINISTRATIVE HEARING:

A. Pursuant to 42 CFR Section 431.220(a)(1) and (2), Section 27-3-3 NMSA 1978 an eligible recipient may request a HCA administrative hearing to appeal an adverse action or adverse decision. See Section 8.352.2 NMAC for a description of the HCA administrative hearing process. In addition to adverse actions defined in Section 8.352.2 the recipient may request an administrative hearing in the following circumstances:

(1) when an applicant has been determined not to meet the LOC requirement for medically fragile waiver program services; and

(2) when an applicant has not been given the choice of HCBS as an alternative to institutional care.

B. DOH and its counsel, if necessary, shall participate in any relevant HCA administrative hearing involving an eligible recipient. HCA's office of general counsel may elect to participate in the administrative hearing. See Section 8.352.2 NMAC for a complete description, instructions, and hearing process of a HCA administrative hearing for an eligible recipient.
[8.314.3.18 NMAC - N, 3/1/2018]

8.314.3.19 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to an eligible recipient who requests a HCA administrative hearing within the timeframe defined in Section 8.352.2 NMAC.

B. The continuation of a benefit is only available to an eligible recipient that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the eligible recipient's current allocation, budget or LOC. See Section 8.352.2 NMAC for a complete description, instructions and process of a HCA administrative hearing and continuation of benefits process of a MAP eligible recipient.
[8.314.3.19 NMAC - N, 3/1/2018]

8.314.3.20 GRIEVANCE SYSTEM: An eligible recipient has the opportunity to register a grievance or complaint concerning the MFW program. An eligible recipient may register complaints via e-mail, mail or phone. Complaints will be referred to the appropriate division or as appropriate referred to MAD for resolution. The filing of a complaint or grievance does not preclude an eligible recipient from pursuing a HCA administrative hearing. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for requesting a HCA administrative hearing.
[8.314.3.20 NMAC - N, 3/1/2018]

HISTORY OF 8.314.3 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives.
ISD-Rule 310.2300, Medically Fragile Individuals In-Home Care Program, (Services), 1/13/1986.

History of Repealed Material:
8.314.3 NMAC, Medically Fragile Home and Community-Based Services Waiver Services (filed 4/16/2002) - Repealed effective 3/1/2018.

TITLE 8 SOCIAL SERVICES
CHAPTER 314 LONG TERM CARE SERVICES - WAIVERS
PART 5 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER

8.314.5.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.314.5.1 NMAC - Rp, 8.314.5.1 NMAC, 12/1/2018; A, 7/1/2024]

8.314.5.2 SCOPE: The rule applies to the general public.
[8.314.5.2 NMAC - Rp, 8.314.5.2 NMAC, 12/1/2018]

8.314.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.314.5.3 NMAC - Rp, 8.314.5.3 NMAC, 12/1/2018; A, 7/1/2024]

8.314.5.4 DURATION: Permanent.
[8.314.5.4 NMAC - Rp, 8.314.5.4 NMAC, 12/1/2018]

8.314.5.5 EFFECTIVE DATE: December 1, 2018, unless a later date is cited at the end of a section.
[8.314.5.5 NMAC - Rp, 8.314.5.5 NMAC, 12/1/2018]

8.314.5.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.314.5.6 NMAC - Rp, 8.314.5.6 NMAC, 12/1/2018]

8.314.5.7 DEFINITIONS:

A. Activities of daily living (ADLs): Basic personal everyday activities that include bathing, dressing, transferring (e.g., from bed to chair), toileting, oral care, mobility and eating.

B. Adult: An individual who is 18 years of age or older.

C. Authorized representative: An individual designated by the eligible recipient or their guardian, if applicable, to represent the eligible recipient and act on their behalf. The authorized representative must provide formal documentation authorizing them to access the identified case information for this specific purpose. An authorized representative may be, but need not be, the eligible recipient's guardian or attorney.

D. Child: An individual under the age of 18. For purpose of early periodic screening, diagnosis and treatment (EPSDT) services eligibility, "child" is defined as an individual under the age of 21.

E. Clinical Documentation: Sufficient information and documentation that demonstrates the request for initial and ongoing developmental disabilities waiver (DDW) services is necessary and appropriate based on the service specific DDW clinical criteria established by the developmental disabilities support division (DDSD) for adult recipients excluding class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990). Examples of clinical documentation include but are not limited to: the DDW therapy documentation form (TDF), intensive medical living supports (IMLS) and adult nursing services parameter tools, electronic comprehensive health assessment tool (e-Chat), all other assessments, clinical notes, progress notes, interdisciplinary team (IDT) meeting minutes, letters or reports from physicians or ancillary service providers that provide sufficient clinical information that demonstrates the need for requested services, etc. Any relevant supporting information and documentation is acceptable and will be considered by the outside reviewer.

F. Clinical justification: Information and documentation that justifies the need for services based on the eligible recipient's assessed need and the DDW clinical criteria. Based on assessed need, the justification must:

(1) meet the eligible recipient's clinical, functional, physical, behavioral or habilitative needs;

(2) promote and afford support to the eligible recipient for their greater independence and to maintain current level of function or minimize risk of further decline; or

(3) contribute to and support the eligible recipient's efforts to remain in the community; to contribute and be engaged in their community, and to reduce their risk of institutionalization; and

(4) address the eligible recipient's physical health, behavioral, and social support needs (not including financial support) that arise as a result of their functional limitations or conditions, such as: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

(5) relate to an outcome in the eligible recipient's individual service plan (ISP).

G. DDW clinical criteria: A set of criteria established by the DDSD that is applied by an outside reviewer to each DDW service when a DDW service is requested for recipients excluding class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990).

H. Electronic visit verification (EVV): A telephone and computer-based system that electronically verifies the occurrence of selected services, as required by the 21st Century CURES Act. The EVV system verifies the occurrence of authorized service visits electronically by documenting the precise time and location where service delivery visit begins and ends. EVV is implemented according to federal requirements and timelines. The 21st Century CURES Act requires EVV for personal care services (PCS), defined as services that provide assistance with activities of daily living (ADLs) or instrumental activities for daily living (IADLs) effective January 1, 2020 and for home health services effective January 1, 2023.

I. Individual service plan (ISP): A person-centered plan for an eligible recipient that includes their needs, functional levels, intermediate and long-range outcomes for achieving their goals and specifies responsibilities for the eligible recipient's support needs. The ISP enables and assists the recipient to identify and access a personalized mix of paid waiver and non-paid services and supports that assists them to achieve personally defined outcomes in the community.

J. Outside reviewer: An independent third-party assessor who has a contract with the DOH to conduct clinical reviews of all requested DDW services. The outside reviewer will make a written determination on whether the requested supports are clinically justified and will recommend whether the eligible recipient's requested ISP and budget should be approved or denied. The decision of the outside reviewer to approve any requested service is binding on the state. However, the state may agree to overturn a decision to deny requested services.

K. Person centered planning (PCP): Person centered planning is a process that places a person at the center of planning their life and supports. It is an ongoing process that is the foundation for all aspects of the DDW program and DDW service provider's work with individuals with I/DD. The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the recipient. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. It involves person centered thinking, person centered service planning and person- centered practice.

L. Waiver: Permission from the centers for medicaid and medicare services (CMS) to cover supports for a particular population or service not ordinarily allowed.

M. Young Adult: An individual between the ages of 18 through 20 years of age who is allocated to the DDW and is receiving specific services as identified in the DDSD standards. An individual under age 21 is eligible for medical services funded by their medicaid providers under EPSDT. Upon the individual's 21st birthday, they are considered to be an adult recipient of DDW services.

[8.314.5.7 NMAC - Rp. 8.314.5.7 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.8 SAFEGUARDS CONCERNING RESTRAINTS, RESTRICTIONS AND SECLUSION:

A. Seclusion and isolation is prohibited during waiver services.

B. Use of restraints or restrictions is only permitted during the course of delivery of waiver services under strict limitations and oversight.

(1) Certain specific interventions are considered ethically unacceptable for application and, as such, are unequivocally prohibited. Interventions that are prohibited include but are not limited to:

(a) contingent electrical aversion procedures;

(b) seclusion and isolation;

(c) use of time out (for an adult);

(d) use of mechanical or chemical restraints;

(e) use of manual application of any physical restraint, except in emergent situations involving imminent risk of harm to self or others (personal restraints);

(f) overcorrection;

(g) forced physical guidance;

(h) forced exercise;

(i) withholding food, water, or sleep;
(j) public or private humiliation;
(k) privacy violations;
(l) restricting exit from home with locks on windows or doors;
(m) application of water mist; and
(n) application of noxious taste, smell, or skin agents; etc.

(2) Use of restrictive interventions must be documented in the individual's positive behavior support plan or behavioral crisis intervention plan or risk management plan and must be reviewed by the human rights committee prior to implementation.

(3) Chemical restraint is defined as the administration of medication at a dose or frequency to intentionally and exclusively preclude behavior without identifying an underlying anxiety, fear or severe emotional distress or other symptoms of psychiatric/emotional disturbance to be eased, managed or treated. The administration may be regularly scheduled or on a pro re nata (PRN), or "as needed" basis. The use of chemical restraints is prohibited.

(4) The administration of PRN psychotropic medication is allowed when prescribed in advance by the prescribing professional. A PRN psychotropic medication plan is a collaborative document that outlines the behavioral indications for using the medication. A human rights committee must approve use of PRN psychotropic medication prior to its implementation and the procedures that DSP must use to gain approval for its implementation.

(5) Mechanical restraints are defined as the use of a physical device to restrict the individual's capacity for desired or intended movement including movement or normal function of a portion of their body. The use of mechanical restraints is prohibited.

(6) Use of any emergency physical restraints must be written into a behavioral crisis intervention plan only and approved by a human rights committee prior to its use. Personal restraints (i.e. emergency physical restraints) are used as a last resort, only when other less intrusive alternatives have failed and under limited circumstances that include protecting an individual or others from imminent, serious physical harm, or to prevent or minimize any physical or emotional harm to the individual. Staff must be trained in both nonphysical and physical interventions.

(7) Any individual for whom the use of emergency physical restraints or PRN psychotropic medications is allowed is required to have a positive behavioral supports assessment, positive behavior support plan, and a behavioral crisis intervention plan or PRN psychotropic medication plan completed by a behavior support consultant in conjunction with the individual's agency nurse and interdisciplinary team.

(8) Ethical, medical or behavioral concerns, use of live or recorded video monitoring/observational systems, and resolution of plans contested on the individual team or provider agency level in local human rights committees are heard and resolved in a statewide and state coordinated super human rights committee.

[8.314.5.8 NMAC - N, 4/1/2022]

8.314.5.9 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER: The New Mexico medical assistance division (MAD) has obtained a waiver from certain medicaid payment and benefit statutes (42 CFR 441.300) to provide home and community-based services (HCBS) to eligible recipients as an alternative to institutionalization. DDW services are intended to enhance, not replace, existing natural supports and other available community resources. Services will emphasize and promote the use of natural and generic supports to address the eligible recipient's assessed needs in addition to paid supports. Provider agencies are required to ensure the settings in which they provide services meet the below requirements. All providers have a responsibility to monitor settings for compliance; monitor that waiver recipients are given choices; and, ensure rights are respected. DDW services must be provided in a setting that:

A. is integrated in and facilitates full access to the greater community;

B. ensures the individual receives services in the community to the same degree of access as individuals not receiving medicaid HCBS;

C. maximizes independence in making life choices;

D. is chosen by the individual (in consultation with the guardian if applicable) from among residential and day options, including non-disability specific settings;

E. ensures the right to privacy, dignity, respect and freedom from coercion and restraint;

F. supports health and safety based upon the individual's needs, decisions or desires;

G. optimizes individual initiative, autonomy and independence in making life choices;

H. provides an opportunity to seek competitive employment;

I. provides individuals an option to choose a private unit in a residential setting; and

J. facilitates choice of services and who provides them.

[8.314.5.9 NMAC - Rp, 8.314.5.9 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.10 ELIGIBLE PROVIDERS:

A. Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (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 must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including New Mexico administrative code (NMAC) rules, billing instructions, utilization review instructions, EVV requirements and instructions, service definitions and service standards and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

B. All DDW eligible providers must be approved by DOH or its designee and have an approved MAD PPA and a DOH provider agreement.

C. MAD through its designee, through DDSD, follows a subcontractor model for certain DDW services. The agency, following the DDSD model, must ensure that its subcontractors or employees meet all required qualifications. The agency must provide oversight of subcontractors and supervision of employees to ensure that all required MAD and DDSD qualifications and service standards are met. In addition, the agency must provide oversight and supervision of subcontractors and employees to ensure that services are delivered in accordance with all requirements set forth by the DDSD DDW service definition, all requirements outlined in the DDW services standards, applicable NMAC rules, MAD supplements, and as applicable, their New Mexico licensing board's scope of practice and licensure. Pursuant to federal regulations, an agency may not employ or subcontract with the spouse of an eligible recipient or the parent of an eligible recipient under 18 years of age to provide direct care services to the eligible recipient.

D. Qualifications of case management provider agency: A case management provider agency, its case managers, whether subcontractors or employees must comply with 8.314.5.10 NMAC. In addition, case management provider agency must ensure that a case manager meets the following qualifications:

(1) one year of clinical experience, related to the target population; and

(2) one or more of the following:

(a) hold a current social worker license as defined by the New Mexico regulation and licensing department (RLD); or

(b) hold a current registered nurse (RN) license as defined by the New Mexico board of nursing; or

(c) hold a bachelor's or master's degree in social work, psychology, sociology, counseling, nursing, special education, or a closely related field or have a minimum of six years of direct experience related to the delivery of social services to people with disabilities; and

(3) comply with all training requirements as specified by DDSD; and

(4) have received written notification from DOH that they do not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS);

(5) does not provide any direct waiver services through the same 1915 (c) HCBS waiver program; and

(6) any exception to the above must be approved by DDSD.

E. Qualifications of respite provider agency: A respite provider agency must comply and ensure that all direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. In addition, respite provider agencies and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(2) have and maintain documentation of current cardiopulmonary resuscitation (CPR) and first aid certification;

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS; and

(4) comply with all EVV requirements as defined by the 21st Century CURES Act and implemented by MAD including but not limited to documenting service provision using the approved EVV system.

F. Qualifications of adult nursing provider agencies: Adult nursing provider agencies must ensure all subcontractors or employees, including nurses, comply with DOH DDW service definitions, DDW service standards, applicable NMAC rules, MAD billing instructions, utilization review instructions, and supplements, and applicable federal and state laws, rules and statutes. Direct nursing services shall be provided by a New Mexico licensed RN or licensed practical nurse (LPN), have a minimum of one year experience as a licensed nurse, and must comply with all aspects of the New Mexico Nursing Practice Act, including supervision and delegation requirements of specific nursing function and 8.314.5.10 NMAC.

G. Qualifications of therapy provider agency: A therapy provider agency must comply and ensure that each of its therapists including physical therapists (PT), occupational therapists (OT), and speech therapists (SLP), physical therapy assistants (PTA), and certified occupational therapy assistants (COTA), whether a subcontractor or employee complies with 8.314.5.10 NMAC.

H. Qualifications for living supports provider agency: Living supports consist of family living, supported living, and intensive medical living supports. A living supports provider agency must comply with the accreditation policy and all requirements set forth by the DOH, DDW service definitions, all requirements outlined in the DDW service standards and the applicable NMAC rules. A living supports provider agency must ensure that all direct support personnel meet all qualifications set forth by DOH, DDW service standards, and applicable NMAC rules.

(1) A living supports provider agency and direct support personnel must:

(a) comply with all training requirements as specified by DOH;

(b) have and maintain documentation of current CPR and first aid certification; and

(c) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

(2) A family living provider agency must ensure that all direct support personnel, whether a subcontractor or employee, meet all qualifications set forth by DOH and the DDW service standards and the applicable NMAC rules. Legal guardians who are also natural or adoptive family members who meet the DDSD requirements and are approved to provide family living services may be paid for providing services.
A family living provider agency must employ or subcontract with at least one registered or licensed dietician or licensed nutritionist. A family living provider agency must also be an adult nursing services provider and must employ or subcontract with at least one licensed RN; employ or subcontract with at least one additional nurse for on call services and comply with the New Mexico Nurse Practice Act, including supervision and delegation requirements of specific nursing functions. The number of nurses (RNs and LPNs) must be sufficient to meet the routine and on call health care needs of the individuals. Both the direct support personnel employed by or subcontracting with the provider agency and the physical home setting must be approved through a home study completed prior to the initiation of services, revised with any change in family composition, move to a new home, or other significant event and periodically thereafter as required of the provider agency.

(3) A supported living provider agency must ensure that all direct support personnel meet all qualifications set forth by DOH and the applicable NMAC rules and the DDW service standards. A supported living provider agency must employ or subcontract with at least one registered or licensed dietician or licensed nutritionist. The number of RD/LDs employed or under contract must be sufficient to meet the routine nutritional needs of the individuals. They must employ or subcontract with at least one licensed RN, employ or subcontract with at least one additional nurse for on call and services, and comply with the New Mexico Nurse Practice Act, including supervision and delegation requirements of specific nursing functions. The number of nurses (RNs and LPNs) must be sufficient to meet the routine and on call health care needs of the individuals.

(4) An intensive medical living supports provider agency must employ or subcontract with at least one registered or licensed dietician or licensed nutritionist. The number of RD/LDs employed or under contract must be sufficient to meet the routine nutritional needs of the individuals. They must employ or subcontract with at least one New Mexico licensed RN who must have a minimum of one year of nursing experience employ or subcontract with at least one additional nurse for on call services and comply with the New Mexico Nursing Practice Act including supervision and delegation requirements of specific nursing functions. The number of nurses (RNs and LPNs) must be sufficient to meet the routine and on call health care needs of the individuals.

I. Qualifications of a customized community supports provider agency: A customized community supports provider agency must comply with and ensure that all direct support personnel comply with 8.314.5.10 NMAC. A customized community supports provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

J. Qualifications of a community integrated employment provider agency: A community integrated employment provider agency must comply with and ensure that all direct support personnel comply with 8.314.5.10 NMAC. A community integrated employment provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

K. Qualifications of a behavioral support consultation provider agency: A behavioral support consultation provider agency must comply with and ensure that all behavioral support consultants, whether subcontractors or employees, comply with 8.314.5.10 NMAC.

(1) A provider of behavioral support consultation services must be currently licensed in one of the following professions and maintain that licensure with the appropriate RLD board or licensing authority:

(a) a licensed clinical mental health counselor (LMHC), or

(b) a licensed psychologist; or

(c) a licensed psychologist associate, (masters or Ph.D. level); or

(d) a licensed independent social worker (LISW) or a licensed clinical social worker (LCSW); or

(e) a licensed master social worker (LMSW); or

(f) a licensed professional clinical mental health counselor (LPCC); or

(g) a licensed marriage and family therapist (LMFT); or

(h) a licensed professional art therapist (LPAT); or

(i) Other related licenses and qualifications may be considered with DOH's prior written approval.

(2) Providers of behavioral support consultation services must have a minimum of one year of experience working with individuals with intellectual or developmental disabilities.

(3) Behavioral support consultation providers must participate in training in accordance with the DOH/DDSD training policy.

L. Qualifications of a nutritional counseling provider agency: A nutritional counseling provider agency must comply with and ensure that all nutritional counseling providers, whether subcontractors or employees comply with 8.314.5.10 NMAC. In addition, a nutritional counseling provider must be registered as a dietitian or a licensed nutritionist by the commission on dietetic registration of the American dietetic association and be licensed by RLD as a nutrition counselor.

M. Qualifications of an environmental modification provider agency: An environmental modification contractor and their subcontractors and employees must be bonded, licensed by RLD, and authorized by DOH to complete the specified project. An environmental modification provider agency must comply with 8.314.5.10 NMAC. All services shall be provided in accordance with applicable federal, state and local building codes.

N. Qualifications of a crisis supports provider agency: A crisis supports provider agency must comply with and must ensure that direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. In addition, a crisis supports provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

O. Qualifications for a non-medical transportation provider agency: A non-medical transportation provider agency must comply with 8.314.5.10 NMAC. In addition, a non-medical transportation provider must have a business license and drivers must have a valid driver's license and not have a disqualifying conviction after submitting to the CCHS. Must have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

P. Qualifications of an assistive technology provider agency: An assistive technology purchasing agent provider and agency must comply with 8.314.5.10 NMAC, demonstrate fiscal solvency when functioning as a payee for this service. Assistive technology providers may also be the direct vendors of approved technology.

Q. Qualifications of an independent living transition service provider agency: An independent living transition service provider agency must comply with 8.314.5.10 NMAC, demonstrate fiscal solvency and function as a payee for this service.

R. Qualifications of a remote personal support technology provider agency: Remote personal support technology provider agencies must comply with 8.314.5.10 NMAC. This includes having a current business license and must demonstrate fiscal solvency and function as a payee of services. In addition, remote personal support technology provider agencies must comply with all laws, rules, and regulations of the federal communications commission (FCC) for telecommunications.

S. Qualifications of a preliminary risk screening and consultation (PRSC) related to inappropriate sexual behavior provider agency: A PRSC provider agency must comply with 8.314.5.10 NMAC and all training requirements as specified by DOH. Additionally, the PRSC provider agency must subcontract with or employ the evaluator, who at a minimum must be:

(1) an RLD independently licensed behavioral health practitioner, such as an LPCC, LCSW, LMFT, LISW, or a psychologist; or

(2) a practitioner who holds a master's or doctoral degree in a behavior health related field from an accredited college or university.

T. Qualifications of a socialization and sexuality education provider agency: A socialization and sexuality education provider agency must comply with 8.314.5.10 NMAC. A provider agency must be approved by the DOH, bureau of behavioral support (BBS) as a socialization and sexuality education provider and must meet training requirements as specified by DOH. In addition, a socialization and sexuality education provider agency must employ or contract with a provider who has one of the following qualifications for rendering the service:

(1) a master's degree or higher in psychology;

(2) a master's degree or higher in counseling;

(3) a master's degree or higher in special education;

(4) a master's degree or higher in social work;

(5) a master's degree or higher in a related field;

(6) a RN or LPN;

(7) a bachelor's degree in special education or a related field such as psychology or social work;

(8) a certification in special education;

(9) a New Mexico level three recreational therapy instructional support provider license; or

(10) a certified therapeutic recreation therapist (CTRS) obtained through the national council for therapeutic recreation.

U. Qualifications of a customized in-home supports provider agency: A customized in-home supports provider agency must comply with and ensure that direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. Legal guardians who are also natural or adoptive family members, relatives, or natural family members that meet the DOH/DDSD requirements and are approved to provide customized in-home supports may be paid for providing services. A customized in-home supports provider agency and direct support personnel must:

(1) comply with all training requirements as specified by DOH;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

(4) comply with all EVV requirements as defined by the 21st Century CURES Act and implemented by MAD including but not limited to documenting service provision using the approved EVV system.

V. Qualifications of a supplemental dental care provider agency: A supplemental dental care provider agency must comply with 8.314.5.10 NMAC. A supplemental dental care provider must contract with a New Mexico licensed dentist and dental hygienist who are licensed by RLD. The supplemental dental care provider will ensure that a RLD licensed dentist provides the oral examination; ensure that a RLD licensed dental hygienist provides all routine dental cleaning services; demonstrate fiscal solvency; and function as a payee for the service.
[8.314.5.10 NMAC - Rp, 8.314.5.10 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations, rules, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement and the DOH provider agreement. A provider also must meet and adhere to all applicable NMAC rules and instructions as specified in the MAD provider rules manual and its appendices, DDW service standards, DDW service definitions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and the centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HCA and its authorized agents and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. Provider agencies must mitigate any conflict of interest issues by adhering to at least the following:

(1) Any individual who operates or is an employee of a DDW provider shall not serve as guardian for a person served by that agency, except when related by affinity or consanguinity Paragraph (1) of Subsection A of Section 45-5-31 NMSA 1978. Affinity which stems solely from the caregiver relationship is not sufficient to satisfy this requirement.

(2) DDW provider agencies may not employ or sub-contract with a direct support person who is an immediate family member to support the person in services, except when the person is in family living, respite, or customized in home supports (CIHS).

(3) DDW provider agencies may not employ or subcontract with the spouse of the participant to support the person in any DDW funded services.

D. Case management agencies are required to mitigate real or perceived conflict of interest issues by adhering to, at minimum the following requirements. Case managers who are contracted under the DDW are identified as agents who are responsible for the development of the ISP.

(1) Case management agency owners and individually employed or contracted case managers may not:

(a) be related by blood or affinity to the person supported, or to any paid caregiver of the individual supported. Following formal authorization from DDSD, a case manager may provide family living services or respite to their own family member;

(b) have material financial interest in any entity that is paid to provide DDW or mi via services. A material financial interest is defined as anyone who has, directly or indirectly, any actual or potential ownership, investment, or compensation arrangement;

(c) be empowered to make financial or health related decisions for individuals on their caseload;

(d) be related by blood or affinity to any DDW service provider for individuals on their caseload. Providers are identified as providers of living care arrangements, community inclusion services, mi via consultants, mi via vendors, BSC's and therapist**.**

(2) A case management provider agency may not:

(a) be a provider agency for any other DDW service;

(b) provide guardianship services to an individual receiving case management services from that same agency;

(3) A case manager or director of a case management provider agency may not:

(a) serve on the board of directors of any DDW provider agency;

(b) provide training to staff of DDW provider agencies unless meeting criteria as outlined in the DDW service standards.

(4) Case management provider agencies must disclose to both DDSD and the people supported by their agency any familial relationships between employees or subcontract case managers and providers of other DDW services.

(5) Case management provider agency staff and subcontractors must maintain independence and avoid all activity which could be perceived as a potential conflict of interest.

[8.314.5.11 NMAC - Rp, 8.314.5.11 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.12 ELIGIBLE RECIPIENTS: The MAP category of eligibility criteria for DDW services is found in 8.290.400 NMAC.

[8.314.5.12 NMAC - Rp, 8.314.5.12 NMAC, 12/1/2018]

8.314.5.13 [RESERVED]
[8.314.5.13 NMAC - Rp, 8.314.5.13 NMAC, 12/1/2018]

8.314.5.14 DDW COVERED WAIVER SERVICES FOR IDENTIFIED POPULATION UNDER 18 YEARS OF AGE: The DDW program is limited to the number of federally authorized unduplicated eligible recipient (UDR) positions and program funding. All DDW covered services in an ISP must be authorized. DDW services must be provided in accordance with all requirements set forth by DDW service definitions, all requirements outlined in the DDW service standards, and the applicable NMAC rules, supplements and guidance. The DDW covers the following services for a specified and limited number of waiver eligible recipients as a cost effective alternative to institutionalization in an intermediate care facilities for individuals with intellectual disabilities (ICF-IID).

A. Eligible recipients age birth to 18: Services funded within this age category must be coordinated with and shall not duplicate other services such as the medicaid school-based services program, the MAD early periodic screening diagnosis and treatment (EPSDT) program, services offered through the New Mexico public education department (PED), or the early childhood education and care department (ECECD) family infant toddler (FIT) program.

B. Service options available include:

(1) environmental modifications;
(2) assistive technology;
(3) remote personal support technology;
(4) preliminary risk screening and consultation;
(5) socialization and sexuality education;
(6) behavioral support consultation;
(7) customized community support;
(8) respite;
(9) non-medical transportation;
(10) case management; and
(11) nutritional counseling.

[8.314.5.14 NMAC - Rp, 8.314.5.14 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.15 DDW COVERED WAIVER SERVICES: The DDW program is limited to the number of federally authorized unduplicated eligible recipient (UDR) positions and program funding. All DDW covered services in an ISP must be authorized by DOH. DDW services must be provided in accordance with all requirements set forth by DOH DDW service definition, all requirements outlined in the DDW service standards, and the applicable NMAC rules, supplements and guidance. Services for individuals under the age of 21 must be coordinated with and shall not duplicate other services such as the medicaid school-based services program, the MAD early periodic screening diagnosis and treatment (EPSDT) program, or the early childhood education and care department (ECECD) family infant toddler (FIT) program. Services offered through the New Mexico public education department (PED), the Individuals with Disabilities Education Act (IDEA), the New Mexico division of vocational rehabilitation (DVR), the Rehabilitation Act, the Workforce Innovation and Opportunities Act (WIOA), the New Mexico department of workforce solutions (DWS) must be utilized prior to accessing funding from the DDW. DDW covers the following services for a specified and limited number of waiver eligible recipients as a cost effective alternative to institutionalization in an ICF-IID.

A. There are seven proposed budget levels (PBL) which the IDT use for person centered planning. They encompass descriptions and characteristics of seven levels of typical support needs designed to meet the needs of most individuals. Each PBL has a corresponding suggested budget dollar amount based on the type of living care arrangement, typical service options, intensity of staffing needs, and support needs in each level. The case manager guides the IDT in the person-centered planning process. The IDT makes a determination of which proposed budget level the person falls based on history, current assessments, and support needs, using both the PBL and suggested dollar amount as a tool or guide in the person-centered planning process and in budget development. The OR approves services based on clinical justification. Approvals may be over or under the suggested amount. The OR does not verify or approve the IDT's determination of a PBL, nor does a PBL limit the request for services or require that the budget be developed within a set amount.

B. Exception authorization process, formerly known as the H authorization process is the process that allows individuals on the DDW, who have extenuating circumstances, including extremely complex clinical needs to receive services beyond what is authorized in their current ISP/budget level or to allow individual exceptions to DDW service standards. Exception authorization process includes:

(1) an eligible recipient who is included in the class established in the matter of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990) is to receive a permanent NM DDW exception authorization approval. A Jackson class member may receive service types and amounts consistent with those approved in their ISP**.**

(2) Exception authorization packet includes: the completed individual supports needs review form with all attachments indicated on the form as relevant to the nature/type of exception authorization process request submitted.

C. When determining what services the eligible recipient needs, the IDT should consider the individual's proposed budget level and service options with the understanding that the focus must always be on the individual's DDW support needs that can be clinically justified. Services available:

(1) **Case management services:** Case management services assist an eligible recipient to access MAD covered services. A case manager also links the eligible recipient to needed medical, social, educational and other services, regardless of funding source. DDW services are intended to enhance, not replace existing natural supports and other available community resources. Services will emphasize and promote the use of natural and community supports to address the eligible recipient's assessed needs in addition to paid supports. Case managers facilitate and assist in assessment activities, as appropriate. Case management services are person-centered and intended to advocate for and support an eligible recipient in pursuing their desired life outcomes while gaining independence, and access to services and supports. Case management is a set of interrelated activities that are implemented in a collaborative manner involving the active participation of the eligible recipient, their authorized representative, and the entire IDT. The case manager is an advocate for the eligible recipient they serve, is responsible for developing the ISP and for ongoing monitoring of the provision of services included in the ISP. Case management services include but are not limited to activities such as:

(a) assessing needs;

(b) assisting in the submission process of the application for assistance and yearly recertification to the local income support division (ISD) office;

(c) directing the person-centered planning process;

(d) advocating on behalf of the eligible recipient;

(e) coordinating waiver and state plan service delivery and collaborating with managed care organization care coordinators;

(f) assuring services are delivered as described in the ISP;

(g) maintaining a complete current central eligible recipient record (e.g. ISP, ISP budget, level of care documentation, assessments);

(h) health care coordination;

(i) assuring cost containment by preventing the expense of DDW services from exceeding a maximum cost established by DOH and by exploring other options to address expressed needs.

(j) Case managers must:

(i) evaluate and monitor direct service through face-to-face visits with the eligible recipient to ensure the health and welfare of the eligible recipient, and to monitor the implementation of the ISP;

(ii) support informed choice;

(iii) support participant self-advocacy;

(iv) allow participants to lead their own meetings, program and plan development;

(v) increase an individual's experiences with other paid, unpaid, publicly-funded and community support options;

(vi) increase self-determination;

(vii) demonstrate that the approved budget is not replacing other natural or non- disability specific resources available; and

(viii) document efforts demonstrating choice of non-waiver and non-disability specific options in the ISP, IDT meeting minutes or companion documents when an individual has only DDW funded supports.

(2) Respite services: Respite services are a flexible family support service for an eligible recipient. The primary purpose of respite services is to provide support to the eligible recipient and give the primary, unpaid caregiver relief and time away from their duties. Respite services include assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills and providing opportunities for play and other recreational activities; community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the eligible recipient to make their own choices with regard to daily activities. Respite services will be scheduled as determined by the primary caregiver. An eligible recipient receiving living supports or customized in-home supports (when an eligible recipient is not living with a family member), may not access respite services. Respite services may be provided in the eligible recipient's own home, in a provider's home, or in a community setting of the eligible recipient family's choice. Respite services must be provided in accordance with 8.314.5.10 NMAC.

(3) Adult nursing services: Adult nursing services (ANS) are provided by a licensed RN or LPN under the direct supervision of the RN to an eligible adult recipient. Adult nursing services are intended to support the highest practicable level of health, functioning and independence for an eligible recipient. This includes the direct nursing services and activities related to the assessment, planning, training and nursing oversight of unrelated direct support staff when assisting with a variety of health related needs in specific settings. Nursing services may be delivered in person and via remote or telehealth services. Nursing services include an array of supports including efforts to support aspiration risk management (ARM). Nursing services may be delivered in person and via remote or telehealth services. Individuals and their health care decision makers will be informed of telehealth service and technology as part of the ISP process.

(a) ANS is available to individuals ages 21 and over who reside in family living; those who receive customized in home supports and those who do not receive any living supports. It is available to any eligible recipient who has health related needs that require at least one of the following: nursing training, delegation or oversight of direct support staff during participation in customized community supports (individual or small group) or community integrated employment even if living supports or CCS-group are also provided.

(b) ANS is available to individuals ages 18-20 who reside in family living and who are at aspiration risk and desire to have aspiration risk management services. It is also available to individuals who have health related needs that require nursing training, delegation or the oversight of non-related direct support staff during substitute care; customized community supports (individual or small group); community integrated employment or customized in home supports.

(c) There are two categories of adult nursing services:

(i) assessment and consultation services which includes a comprehensive health assessment (including assessment for medication delivery needs and aspiration risk) and consultation regarding available or mandatory services which requires only budgeting; and

(ii) ongoing services, which requires clinical justification and are tied to the eligible recipient's specific health needs revealed in the comprehensive health assessment and prior authorization process.

(4) Therapy services: Therapy services are to be delivered consistent with the participatory approach philosophy and two models of therapy services (collaborative-consultative and direct treatment). These models support and emphasize increased participation, independence and community inclusion in combination with health and safety. DDW therapy services are intended to improve, maintain or minimize the decline in functional ability and skills. Therapy services are designed to support achievement of ISP outcomes and prioritized areas of need identified through therapeutic assessment. PT, OT and SLP are skilled therapies that are recommended by an eligible recipient's IDT members and a clinical assessment that demonstrates the need for therapy services. Therapy services may be delivered in an integrated setting, clinical setting, or through telehealth as appropriate and will support the use of assistive or remote personal support technology as needed. Upon recommendation for therapy assessment by the IDT members all three therapy disciplines: PT, OT, and SLP will be available to all DDW recipients if the therapy assessment indicates that services are needed. Individuals and their health care decision makers will be informed of telehealth service and technology as part of the ISP process. Therapy services for an eligible adult recipient require a prior authorization except for their initial assessment. A RLD licensed practitioner, as specified by applicable state laws and standards, provides the skilled therapy services. Therapy services for eligible adult recipients must comply with 8.314.5.10 NMAC. All medically necessary therapy services for children under 21 years of age, are covered under the state plan through the early periodic screening, diagnostic and treatment (EPSDT) and must comply with 8.320.2 NMAC. To the extent that any listed services are covered under the state plan, the services under the waiver are additional services not otherwise covered under the state plan, and

consistent with DDW objectives to support the recipient to remain in the community and prevent institutionalization. The exception is aspiration risk management supports for persons between age 18 and 21.

(a) Physical therapy (PT): PT is a skilled, RLD licensed therapy service involving the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance, and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy prevents the onset, symptoms and progression of impairments, functional limitations, and disability that may result from diseases, disorders, conditions or injuries. PT supports access, mobility and independence in all environments. A RLD licensed physical therapy assistant (PTA) may perform physical therapy procedures and related tasks pursuant to a plan of care/therapy intervention plan written by the supervising physical therapist. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC.

(b) Occupational therapy (OT): OT is a skilled, RLD licensed therapy service involving the use of everyday life activities (occupations) for the purpose of evaluation, treatment, and management of functional limitations. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC. Occupational therapy addresses physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement, performance and access to work and life activities that affect health, well-being and quality of life. A RLD certified occupational therapy assistant (COTA) may perform occupational therapy procedures and related tasks pursuant to a therapy intervention plan written by the supervising OT as allowed by RLD licensure.

(c) Speech-language pathology (SLP): SLP service, also known as speech therapy, is a skilled therapy service, provided by a speech-language pathologist that involves the non-medical application of principles, methods and procedures for the diagnosis, counseling, and instruction related to the development of and disorders of communication including speech, fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction and sensory-motor competencies. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC. Speech-language pathology services are also used when an eligible recipient requires the use of assistive technology or an augmentative communication device. For example, SLP services are intended to improve, maintain or minimize the loss of communication skills; treat a specific condition clinically related to an intellectual developmental disability of the eligible recipient; or improve or maintain the eligible recipient's ability to safely eat food, drink liquids or manage oral secretions while minimizing the risk of aspiration or other potential injuries or illness related to swallowing disorders.

(5) Living supports: Living supports are residential habilitation services, available up to 24 hours a day, that are individually tailored to assist an eligible recipient 18 year and older who is assessed to need daily support or supervision with the acquisition, retention, or improvement of skills related to living in the community to prevent institutionalization. Living supports include residential-type instruction intended to increase and promote independence and to support an eligible recipient to live as independently as possible in the community in a setting of their own choice. Living support services assist and encourage an eligible recipient to grow and develop, to gain autonomy, self-direct and pursue their own interests and goals. Living supports includes support to individuals to access: healthcare, dietary, nursing, therapy and behavior supports through telehealth and in person appointments; generic and natural supports, standard utilities including internet services, assistive and remote technology, transportation, employment, and opportunities to establish or maintain meaningful relationships throughout the community. Living supports providers are also required to coordinate and collaborate with nursing, behavior support consultants, dieticians, therapists and therapy assistants to implement plans including aspiration risk management plans. Living supports providers are also required to coordinate and collaborate with behavior support consultants to implement positive behavior support plans. Living support providers take positive steps to protect and promote the dignity, privacy, legal rights, autonomy and individuality of each eligible recipient who receives services. Services promote inclusion in the community and an eligible recipient is afforded the opportunity to be involved in the community and actively participate using the same resources and doing the same activities as other community members. Living supports providers are responsible for providing an appropriate level of services and supports up to 24 hours per day, seven days per week. Room and board costs are reimbursed through the eligible recipient's social security insurance (SSI) or other personal accounts and cannot be paid through the DDW. Living support services for eligible recipients must comply with 8.314.5.10 NMAC. Living supports consists of family living, supported living, and intensive medical living as follows.

(a) Family living (FL): Family living is intended for an eligible recipient who is assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family living is a residential habilitation service that is intended to increase and promote independence and to provide the skills necessary to prepare an eligible recipient to live on their own in a non-

residential setting. Family living services are designed to address assessed needs and identified individual eligible recipient outcomes. Family living is direct support and assistance that is provided to no more than two eligible recipients with intellectual or developmental disabilities at a time furnished by a natural or host family member, or companion who meets the requirements and is approved to provide family living services in the eligible recipient's home or the home of the family living direct support personnel. The eligible recipient lives with the paid direct support personnel. The FL provider agency is responsible for providing nutritional services from a registered dietician or licensed nutritionist. All FL providers must be adult nursing services (ANS) providers and deliver budgeted nursing services including nursing assessment and on call. The provider agency is responsible for up to 750 hours of substitute coverage for the primary direct support personnel to receive sick leave and time off as needed. An exception may be granted by DOH if three eligible recipients are in the residence, but only two of the three are on the DDW and the arrangement is approved by DOH based on the home study documenting the ability of the family living provider to serve more than two eligible recipients in the residence; or there is documentation that identifies the eligible recipients as siblings or there is documentation of the longevity of a relationship (e.g., copies of birth certificates or social history summary). Documentation shall include a statement of justification from a social worker, psychologist, and any other pertinent professionals working with the eligible recipients. Family living services cannot be provided in conjunction with any other living supports service, respite, or additional nutritional counseling accessed through the person's budget. Family living provider must arrange transportation for all medical appointments, household functions and activities, and to-and-from day services and other meaningful community options. The family living services provider agency shall complete all DOH requirements for approval of each direct support personnel, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home or other significant event. The content and procedures used by the provider agency to conduct home studies shall be approved by DOH and must include assessment of environmental safety.

(b) Supported living (SL): Supported living is intended for an eligible recipient who is assessed to need residential-type habilitation support to ensure health and safety. Supported living is a living habilitation support service that is intended to increase and promote independence and to provide the skills necessary to prepare an eligible recipient to live on their own in a non-residential setting. Supported living services are designed to address assessed needs and identified individual eligible recipient outcomes. The service is provided to two to four eligible recipients in a community residence. Prior authorization is required from DOH for an eligible recipient to receive this service when living alone. The SL provider agency is responsible for providing nutritional services from a registered dietician or licensed nutritionist based on the person's needs. All SL providers must provide needed nursing services including on call based on the person's needs. The SL provider must arrange transportation to all medical appointments, household functions and activities, and to-and-from day services and other meaningful community options. Supported living services cannot be provided in conjunction with any other living supports service, respite, or additional nutritional counseling assessed through the person's budget.

(c) Intensive medical living supports: An intensive medical living supports agency provides residential-type supports for an eligible recipient in a supported living environment who requires daily direct skilled nursing, in conjunction with community living supports that promote health and assist the eligible recipient to acquire, retain or improve skills necessary to live in the community and prevent institutionalization, consistent with their ISP. An eligible recipient must meet criteria for intensive medical living supports according to DDW service definitions and DDW standards for this service and they require nursing care, ongoing assessment, clinical oversight and health management that must be provided directly by a MAD recognized RN or LPN, see 8.314.5.10 NMAC.

(i) These medical needs include: skilled nursing interventions; delivery of treatment; monitoring for change of condition; and adjustment of interventions and revision of services and plans based on assessed clinical needs.

(ii) In addition to providing support to an eligible recipient with chronic health conditions, intensive medical living supports are available to an eligible recipient who meets a high level of medical acuity and require short-term transitional support due to recent illness or hospitalization. This service will afford the core living support provider the time to update health status information and health care plans, train staff on new or exacerbated conditions and assure that the home environment is appropriate to meet the needs of the eligible recipient. Short-term stay in this model may also be utilized by an eligible recipient who meets the criteria that is living in a family setting when the family needs a substantial break from providing direct service. Both types of short-term placements require prior approval from DOH. In order to accommodate referrals for short-term stays, each approved intensive medical living supports provider must maintain at least one bed available for such short-

term placements. If the short-term stay bed is occupied, additional requests for short-term stay will be referred to other providers of this service.

(iii) The intensive medical living supports provider will be responsible for providing the appropriate level of supports, 24 hours per day seven days a week, including necessary levels of skilled nursing based on assessed need of the eligible recipient. Daily nursing visits are required; however, a RN or a LPN under a RN's supervision is not required to be present in the home during periods of time when skilled nursing services are not required or when an eligible recipient is out in the community. An on-call RN or LPN, under the supervision of a RN must be available to staff during periods when a RN or a LPN under a RN's supervision is not present. Intensive medical living supports require supervision by a RN, and must comply with 8.314.5.10 NMAC.

(iv) Direct support personnel will provide services that include training and assistance with ADLs such as bathing, dressing, grooming, oral care, eating, transferring, mobility and toileting. These services also include training and assistance with instrumental activities of daily living (IADL) including housework, meal preparation, medication assistance, medication administration, shopping, and money management.

(v) The intensive medical living supports provider will be responsible for providing access to customized community support and employment as outlined in the eligible recipient's ISP. This includes any skilled nursing needed by the eligible recipient to participate in customized community support and development and employment services. The intensive medical living provider must arrange transportation for all medical appointments, household functions and activities, and to-and-from day services and other meaningful community options.

(vi) Intensive medical living supports providers must comply with 8.314.5.10 NMAC.

(6) Customized community supports (CCS): CCS consists of individualized services and supports that enable an eligible recipient to acquire, maintain, and improve opportunities for independence, community integration and employment. Customized community supports services are designed around the preferences and choices of each eligible recipient and offer skill training and supports to include: adaptive skill development; adult educational supports; citizenship skills; communication; social skills, socially appropriate behaviors; self-advocacy, informed choice; community integration and relationship building. This service provides the necessary support to develop social networks with community organizations to increase the eligible recipient's opportunity to expand valued social relationships and build connections within communities. This service helps to promote self-determination, increases independence and enhances the eligible recipient's ability to interact with and contribute to their community. Customized community supports are intended to be provided in the community to the fullest extent possible. Customized community supports must not duplicate services available through the New Mexico public education department or the Individuals with Disabilities Education Act (IDEA).

(a) Based on assessed needs, customized community supports services may include personal support, nursing oversight, medication assistance or administration, and integration of strategies in the therapy and healthcare plans into the eligible recipient's daily activities.

(b) The customized community supports provider may provide fiscal management for the payment of adult education opportunities as determined necessary for the eligible recipient.

(c) Customized community supports services may be provided regularly or intermittently based on the needs of the eligible recipient and are provided during the day, evenings and weekends. Customized community supports are not limited to specific hours or days of the week and should be provided in alignment with the persons desired outcomes.

(d) Customized community supports may be provided in a variety of settings to include the community, classroom, remotely and at site-based locations, depending on the ISP and the particular type of service chosen within CCS. Services provided in any location are required to provide opportunities that lead to participation and inclusion in the community or support the eligible recipient to increase their growth and development.

(e) Pre-vocational and vocational services are not covered under customized community supports.

(f) Customized community supports services must be provided in accordance with 8.314.5.10 NMAC.

(7) Community integrated employment (CIE): Community integrated employment is intended to provide supports that result in jobs in the community which increase economic independence, self-reliance, social connections, and the ability to grow within a career. CIE consists of intensive, ongoing services that support individuals to achieve competitive integrated employment or business ownership who, because of their

disabilities, might otherwise not be able to succeed without supports to perform in a competitive work setting or own a business. Community integrated employment results in employment alongside non-disabled coworkers within the general workforce or in business ownership. This service may also include small group employment including mobile work crews or enclaves. An eligible recipient is supported to explore and seek opportunity for career advancement through growth in wages, hours, experience or movement from group to individual employment. Each of these activities is reflected in individual career plans. Community integrated employment services must not duplicate services offered through the New Mexico public education department (PED), the Individuals with Disabilities Education Act (IDEA), the New Mexico division of vocational rehabilitation (DVR), the Rehabilitation Act, New Mexico department of workforce solutions (DWS), or the Workforce Innovation and Opportunities Act (WIOA). Compensation shall comply with state and federal laws including the Fair Labor Standards Act. DDW funds (e.g., the provider agency's reimbursement) may not be used to pay the eligible recipient for work. CIE services shall be provided based on the interests of the person and desired outcomes listed in the ISP. Employment services are to be available 365 days a year, 24 hours a day. Community integrated employment services must comply with 8.314.5.10 NMAC. Community integrated employment consists of job development, self-employment, short term job coaching, job maintenance, job aid, intensive community integrated employment and group community integrated employment models.

(a) Job development services through the DDW can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in the Individuals with Disabilities Education Act (IDEA) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). Job development may include but is not limited to, activities to assist an individual to plan for, accommodate, explore and obtain CIE.

(b) Short term job coaching services through the DDW can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in the Individuals with Disabilities Education Act (IDEA) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). Short term job coaching services may include but are not limited to, activities to assist an individual to learn, accommodate and perform work duties, and maintain employment.

(c) Job maintenance is intended to be used as the long-term supports once all available funding and services through vocational rehabilitation or the educational systems has been utilized. Job maintenance is provided on a one-to-one ratio. Job maintenance services may include, but are not limited to, activities to assist the individual to accommodate, maintain employment and career advancement.

(d) Self-employment: Services through the DDW can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in the Individuals with Disabilities Education Act (IDEA) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). Self-employment services are intended to be used as the long-term supports once all available funding and services through vocational rehabilitation or the educational systems have been utilized. Self-employment does not preclude employment in the other models. Self-employment may include but is not limited to development of a business plan, conducting market analysis, and establishing and supporting the infrastructure for a successful business.

(e) Job aid: One to one personal care services in an individual, community integrated employment setting for people who require assistance with activities of daily living (ADLs) during work hours to maintain successful employment as job supports are reduced.

(f) Intensive community integrated employment (ICIE): Services for people who are working in an individual, community integrated employment setting and require more than 40 hours of staff supports per month to maintain their employment. ICIE is the same scope of services as outlined in 8.314.5.10 NMAC.

(g) Group community integrated employment: Group community integrated employment is when more than one eligible recipient works in an integrated setting with staff supports on site. Regular and daily contact with non-disabled coworkers or the public occurs. Group community integrated employment services may include but are not limited to activities to assist the individual to accommodate, maintain and advance from group to individual employment.

(8) **Behavioral support consultation services:** The behavior support consultation supports the person's successful achievement of vision-driven desired outcomes. Behavior support consultation services identify behaviors that impact quality of life and provide specific prevention and intervention strategies to manage and lessen the risks these behaviors present. This service is provided by an authorized behavior support consultant and includes a positive behavior supports assessment and positive behavior support plan development;

interdisciplinary team (IDT) training and technical assistance; and monitoring of an individual's behavioral support services. Services may be provided in person for training, evaluation or monitoring and remotely via telehealth as needed. Annual assessments require an in person interview or observation except when conducted during declared state or national emergencies or pandemics. Behavioral support services include:

(a) Assessment of the person and their environment, including barriers to independent functioning;

(b) Design and testing of strategies to address concerns and build on strengths and skills for independence;

(c) Writing and training in the implementation of plans in a way that the person and direct support personnel (DSP) can understand and implement them.

(d) Behavioral support consultation services must comply with 8.314.5.10 NMAC.

(9) Nutritional counseling services: Nutritional counseling services include the assessment, evaluation, collaboration, planning, teaching, consultation and implementation and monitoring of a nutritional plan and menu services that supports the eligible recipient to attain or maintain the highest practicable level of health. It may be provided by a registered/licensed dietician (RD/LD) or licensed nutritionist (LN). This service may be delivered in person or via telehealth. The RD/LD/LN is an active member of the IDT and addresses overall nutritional needs, diet, tube feeding, weight loss or gain, wounds and a variety complex medical or behavioral conditions that have or may impact the persons overall health. These nutritional counseling services are in addition to those nutritional or dietary services allowed in the eligible recipient's medicaid state plan benefit, or other funding source. This service does not include oral-motor skill development services, such as those services provided by a speech pathologist. Nutritional counseling cannot be billed as a separate service during the hours of living supports. Nutritional counseling services must comply with 8.314.5.10 NMAC.

(10) Environmental modification services: Environmental modifications services include the purchasing and installing of equipment or making physical adaptions to an eligible recipient's residence that are necessary to ensure the health, welfare and safety of the eligible recipient or enhance their access to the home environment and increase their ability to act independently.

(a) Adaptations, installations and modifications include:

(i) heating and cooling adaptations;

(ii) fire safety adaptations;

(iii) turnaround space adaptations;

(iv) specialized accessibility, safety adaptations or additions;

(v) installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;

(vi) installation of trapeze and mobility tracks for home ceilings;

(vii) installation of ramps;

(viii) widening of doorways or hallways;

(ix) modification of bathroom facilities (roll-in showers, sink, bathtub and toilet modification, water faucet controls, floor urinals and bidet adaptations and plumbing);

(x) purchase or installation of air filtering devices;

(xi) purchase or installation of lifts or elevators;

(xii) purchase and installation of glass substitute for windows and doors;

(xiii) purchase and installation of modified switches, outlets or environmental controls for home devices; and

(xiv) purchase and installation of alarm and alert systems or signaling devices.

(b) Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the eligible recipient. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to an eligible recipient's residence or to configure a bathroom to accommodate a wheelchair).

(c) Environmental modification services must be provided in accordance with applicable federal, state and local building codes.

(d) Environmental modification services must comply with 8.314.5.10 NMAC.

(11) Crisis supports: Crisis supports are services that provide intensive supports by appropriately trained staff to an eligible recipient experiencing a behavioral or medical crisis either within the

eligible recipient's present residence or in an alternate residential setting. Crisis support must comply with 8.314.5.10 NMAC.

(a) Crisis supports in the eligible recipient's residence: These services provide crisis response staff to assist in supporting and stabilizing the eligible recipient while also training and mentoring staff or family members, who normally support the eligible recipient, in order to remediate the crisis and minimize or prevent recurrence.

(b) Crisis supports in an alternate residential setting: These services arrange an alternative residential setting and provide crisis response staff to support the eligible recipient in that setting, to stabilize and prepare the eligible recipient to return home or to move into another permanent location. In addition, staff will arrange to train and mentor staff or family members who will support the eligible recipient long-term once the crisis has stabilized, in order to minimize or prevent recurrence of the crisis.

(c) Crisis response staff will deliver such support in a way that maintains the eligible recipient's normal routine to the maximum extent possible. This includes support during attendance at employment or customized community supports services, which may be billed on the same dates and times of service as crisis supports.

(d) This service requires prior written approval and referral from the bureau of behavioral support (BBS). Crisis supports are designed to be a short-term response (two to 90 calendar days).

(e) The timeline may exceed 90 calendar days under extraordinary circumstances, with approval from the BBS in which case duration and intensity of the crisis intervention will be assessed weekly by BBS staff.

(12) Non-medical transportation: Non-medical transportation services assists the eligible recipient in accessing other waiver supports and non-waiver activities identified in their ISP. Non-medical transportation enables the eligible recipient to gain physical access to non-medical community services and resources promoting the eligible recipient opportunity and responsibility in carrying out their ISP activities. This service is to be considered only when transportation is not available through the medicaid state plan or when other arrangements cannot be made. Non-medical transportation includes mileage reimbursement and funding to purchase a pass for public transportation for the eligible recipient. Non-medical transportation provider services must comply with 8.314.5.10 NMAC.

(13) Supplemental dental care: Supplemental DDW dental care services are provided for an eligible recipient that requires routine oral health care more frequently than the coverage provided under other MAP benefit plans. Supplemental dental care provides one oral examination and one cleaning once every ISP year to an eligible recipient for the purpose of preserving or maintaining oral health. The supplemental dental care service must comply with 8.314.5.10 NMAC.

(14) Assistive technology: Assistive technology (AT) purchasing agent service is intended to support the access of low tech devices that increase the eligible recipient's physical and communicative participation in functional activities at home and in the community. Items purchased through the assistive technology service assist the eligible recipient to meet outcomes outlined in their ISP, increase functional participation in employment, community activities, activities of daily living, personal interactions, or leisure activities, or increase the eligible recipient's safety during participation of the functional or leisure activity.

(a) The assistive technology service allows an eligible recipient to purchase or obtain needed items to develop low-tech augmentative communication, environmental access, mobility systems and other functional assistive technology, not covered through the eligible recipient's medicaid state plan benefits.

(b) Assistive technology may be accessed through an approved waiver provider acting as a purchasing agent for technology vendors whose products meet definition and needs or directly through an approved technology provider who is the direct vendor of the service and approved DDW Provider.

(c) Assistive technology must comply with 8.314.5.10 NMAC.

(15) Independent living transition services: Independent living transition services are one-time set-up expenses for an eligible recipient who transitions from a 24 hour living supports setting into a home or apartment of their own with intermittent support that allows them to live more independently in the community. The service covers expenses associated with security deposits that are required to obtain a lease on an apartment or home, set-up fees or deposits for utilities (telephone, internet, electricity, heating, etc.), and furnishings to establish safe and healthy living arrangements, such as a bed, chair, dining table and chairs, eating utensils and food preparation items, and a cell phone. The service also covers services necessary for the eligible recipient's health and safety such as initial or one-time fees associated with the cost of paying for pest control, allergen control or cleaning services prior to occupancy. Independent living transition services must comply with 8.314.5.10 NMAC.

(16) Remote personal support technology: Remote personal support technology is an electronic device or monitoring system that supports individuals to be independent in the community or in their place of residence with limited assistance or supervision of paid staff. This service provides up to 24-hour alert, monitoring or remote personal emergency response capability, remote prompting or in-home reminders, or environmental controls for independence through the use of technologies. The service is intended to promote independence and quality of life, to offer opportunity to live safely and as independently as possible in one's home, and to ensure the health and safety of the individual in services. Remote personal support technology is available to individuals who may want to live independently in their own homes, may have a demonstrated need for timely response due to health or safety concerns, or may be afforded increased independence from staff supervision in residential services. The use of technology should ease life activities for individuals and their families. Remote personal support technology includes development of individualized response plans with the installation of the electronic device or sensors, monthly maintenance, rental or subscription fees. This service is not intended to provide for paid, in-person on-site response. On-site response must be planned through response plans that are developed using natural or other paid supports for on-site response. Remote personal support technology may be accessed through an approved waiver provider acting as a purchasing agent for technology vendors whose products meet definition and needs or directly through an approved technology provider who is the direct vendor of the service and approved DDW provider.

(17) Preliminary risk screening and consultation related to inappropriate sexual behavior (PRSC): PRSC is designed to assess continued risk of sexually inappropriate or offending behavior in persons who exhibit or have a history of exhibiting risk factors for these types of behaviors. This service is part of a variety of behavior support services (including BSC and socialization & sexuality education) that promotes community safety and reduces the impact of interfering behaviors that compromise the person's quality of life. PRSC is provided by a licensed mental health professional who has been trained and approved as a risk evaluator by the BBS.

(a) The key functions of PRSC are to:

(i) provide a structured screening of the eligible recipient's behaviors that may be sexually inappropriate;

(ii) develop and document recommendations of the eligible recipient in the form of a report or consultation notes;

(iii) develop and periodically review risk management plans for the eligible recipient, when recommended; and

(iv) provide consultation regarding the management and reduction of the eligible recipient's sexually inappropriate behavioral incidents that may pose a health and safety risk to the eligible recipient or others.

(b) Preliminary risk screening and consultation related to inappropriate sexual behavioral services must comply with 8.314.5.10 NMAC.

(18) Socialization and sexuality education service: Socialization and sexuality education in the form of the friends & relationships course (FRC) is a comprehensive lifelong adult education program that teaches students knowledge and skills to increase social networks with healthy, meaningful relationships and to increase personal safety including decreasing interpersonal and intimate violence in relationships, sexual victimization, exploitation and abuse. This enhances their ability to develop close friendships and romantic relationships. The FRC involves the person's network of support (natural supports, paid supports, teachers, nurses, family members, guardians, friends, advocates, or other professionals) teaching them to support the social and sexual lives of persons with I/DD, through participation in classes, and by using trained and paid self-advocates as role models and peer mentors in classes. Socialization and sexuality education services must comply with 8.314.5.10 NMAC.

(19) Customized in-home supports: Customized in-home support services is not a residential habilitation service and is intended for an eligible recipient that does not require the level of support provided under living supports services. Customized in-home supports provide an eligible recipient the opportunity to design and manage the supports needed to live in their own home or family home. Customized in-home supports include a combination of instruction and personal support activities provided intermittently to assist the eligible recipient with ADLs, meal preparation, household services, and money management. The services and supports are individually designed to instruct or enhance home living skills, community skills and to address health and safety of the eligible recipient, as needed. This service provides assistance with the acquisition, improvement or retention of skills that provides the necessary support to achieve personal outcomes that enhance the eligible recipient's ability to live independently in the community. Services are delivered by a direct support professional in the individuals own

home or family home in the community. Services may be provided as part of on-site response plan with use of remote personal support technology. This service is intended to provide intermittent support and cannot be provided 24 hours a day/seven days a week. Customized in-home support services must comply with 8.314.5.10 NMAC.
[8.314.5.15 NMAC - Rp, 8.314.5.15 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.16 NON-COVERED SERVICES: Only those services listed in the DDW benefit package may be reimbursed through the DDW. Room, board and ancillary services are not covered under DDW services. An eligible recipient may access, as medically necessary, all medicaid state plan benefits in addition to their DDW services. If the eligible recipient is an enrolled member of a HCA managed care organization (MCO), they may access, as medically necessary, the benefits listed in 8.308.9 NMAC.
[8.314.5.16 NMAC - Rp, 8.314.5.16 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.17 INDIVIDUALIZED SERVICE PLAN (ISP):

A. CMS requires a person-centered service plan for every individual receiving HCBS. The ISP must be developed annually through an ongoing person-centered planning process. The ISP development must:

(1) Involve those whom the participant wishes to attend and participate in developing the service plan and are provided adequate notice;

(2) Use assessed needs to identify services and supports;

(3) Include individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others;

(4) Identify roles and responsibilities of IDT members responsible for implementing the plan;

(5) Include the timing of the plan and how and when it is updated, including response to changing circumstances and needs; and

(6) Outline how the individual is informed of available services funded by the DDW as well as other natural and community resources.

B. The IDT must review the eligible recipient's person-centered plan every 12 months or more often if indicated.

C. The IDT is responsible for compiling clinical documentation to justify the requested services and budget to the OR for adult recipients excluding class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990).

D. The person-centered service plan must consist of the following:

(1) identifies risks and includes a plan to reduce any risks;

(2) incorporates other health concerns (e.g. mental health, chemical health, chronic medical conditions, etc.);

(3) is written in plain language;

(4) records the alternative HCBS that were considered by the person;

(5) includes natural supports and services;

(6) includes strategies for solving conflict or disagreement within the process, including any conflict of interest guidelines for planning participants;

(7) identifies who is responsible for monitoring implementation of the plan;

(8) includes the person's strengths;

(9) describes goals or skills that are related to the person's preferences;

(10) includes a global statement about the person's self-determined goals and aspirations;

(11) details what is important to the person; and

(12) includes a method for the individual to request updates to the plan, as needed.

E. Upon completion of the ISP by the IDT, the case manager shall develop a budget to be evaluated in accordance with the outside reviewer (OR) process; see Subsection D of 8.314.5.18 NMAC.

F. Upon completion of the ISP by the IDT, the case manager shall develop a budget to be evaluated in accordance with the medicaid third party assessor (TPA) review process for class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990).

G. All services must be provided as specified in the ISP.

H. The case manager must conduct a pre ISP meeting annually with the recipient to evaluate and plan for upcoming ISP term. The CM is required to meet with the DD Waiver participant and guardian prior to the ISP meeting. The CM reviews current assessment information, prepares for the meeting, creates a plan with the person

to facilitate or co-facilitate the meeting if desired, discusses the budget, reviews the current secondary freedom of choice forms, and facilitates greater informed participation in ISP development by the person.
[8.314.5.17 NMAC - Rp, 8.314.5.17 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services, including services covered under the DDW, are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made; see 8.310.2 NMAC. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. MAD prior authorization: To be eligible for DDW services, a MAD eligible recipient must require the level of care (LOC) of services provided in an ICF-IID. LOC determinations are made by MAD or its designee. The eligible recipient's person centered ISP must specify the type, amount and duration of services and meet clinical criteria. Certain procedures and services specified in the ISP may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. DOH prior authorization: Certain services are subject to utilization review by DOH.

C. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for MAD services. Providers must verify that individuals are eligible for MAD services, including DDW services or other health insurance prior to the time services are furnished. An eligible recipient may not be institutionalized, hospitalized, or receive personal care option (PCO) services or other HCBS waiver services at the time DDW services are provided, except for certain case management services that are required to coordinate discharge plans or transition of services to DDW services.

D. Outside review process: All services for DDW recipients excluding class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990) will be reviewed by an OR contracted by DOH. The OR will adhere to deadlines set forth in its contract with the DOH. The OR will apply the DDW clinical criteria to make a clinical determination on whether the requested services and service amounts are needed, and will recommend whether the requested annual budget and ISP should be approved. If the OR approves in whole or part the requested ISP and budget, the OR will send the approved portion of the budget to the medicaid TPA for entry into the medicaid management information system and issue a prior authorization to the case manager. If there is a denial in part or whole, the OR decision must be in writing, identify a list of all documents and input considered by the OR team during its review, and state the reasons for any denial of requested services. The eligible recipient, case manager, and guardian (if applicable) will be provided with this written determination and notice of an opportunity to request a fair hearing as well as an agency review conference.

(1) The eligible recipient, case manager, and guardian (if applicable) may submit to the OR additional information relating to support needs.

(2) The decision of the OR approving services requested by the DDW participant is binding on the State. However, the state may agree to overturn a decision to deny services requested by the DDW participant at a requested agency conference.

E. Reconsideration: Providers who disagree with the denial of a prior authorization request or other review decisions may request a reconsideration. See 8.350.2 NMAC, Reconsideration of Utilization Review Decisions.
[8.314.5.18 NMAC - Rp, 8.314.5.18 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.19 REIMBURSEMENT: DDW service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. A DDW provider must follow 8.302.2 NMAC, MAD billing instructions, utilization review instructions, and supplements. Reimbursement to providers of waiver services is made at a predetermined reimbursement rate.
[8.314.5.19 NMAC - Rp, 8.314.5.19 NMAC, 12/1/2018]

8.314.5.20 RIGHT TO A HCA ADMINISTRATIVE HEARING: An eligible recipient may request a HCA administrative hearing to appeal a decision of MAD or its third party assessor contractor, or the OR, that is an adverse action against the recipient. Prior to the fair hearing an eligible recipient may be offered an agency review conference. An agency review conference (AC) means an optional conference offered by the DOH to provide an opportunity to informally resolve a dispute over the denial, suspension, reduction, termination or modification of DDW benefits or services. An AC will be attended by the recipient and their authorized representative if applicable, representatives of the outside review, DOH and any other necessary parties. The recipient may also bring whomever

they wish to assist during the AC. The AC is optional and shall in no way delay or replace the fair hearing process or affect the deadline for a fair hearing request.

A. An authorized representative means any individual designated by the eligible recipient or their guardian, if applicable, to represent the recipient and act on their behalf. The authorized representative must provide formal documentation authorizing them to access the identified case information for this specific purpose. An authorized representative may be, but need not be, the recipient's guardian or attorney.

B. The DOH will issue written notification describing the outcome of the AC and any agreements within seven business days of the AC to the recipient, recipient's guardian if applicable, and case manager.

C. Unless the fair hearing request is withdrawn by the recipient or recipient's guardian or lawyer, any requested fair hearing will proceed. At the fair hearing the claimant may raise any relevant issue and present any relevant information that they choose. See 8.352.2 NMAC for a description of a claimant's HCA administrative hearing rights and responsibilities.

D. In addition to the requirements set forth in 8.352.2 NMAC, HCA and DOH shall take such actions as are necessary to assure the presence at the hearing of all necessary witnesses within DOH's control, including, when relevant to a denial of services or when requested by the claimant, a representative of the OR with knowledge of the claimant's case and the reason(s) for the denial, in whole or in part, of any requested services.

E. Denials of services through the exception authorization process or other actions during this process adverse to the participant can also be appealed through a fair hearing.

F. All HCA administrative hearings are conducted in accordance with state and federal law.

G. No ex parte communications with an HCA administrative law judge are permitted by any DDW participant or counsel regarding any pending case. The MAD director shall not have ex parte communications regarding any pending cases with any DDW participant or counsel involved in that case. The MAD director's decision shall be limited to an on the record review.

[8.314.5.20 NMAC - Rp, 8.314.5.20 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.21 CONTINUATION OF BENEFITS PURSUANT TO A TIMELY APPEAL AND A HCA ADMINISTRATIVE HEARING PROCEEDING: A continuation of an existing DDW benefit or benefits is automatically provided to an eligible recipient claimant pending the resolution of the outside review process and any subsequent fair hearing. The continuation of a benefit is only available to a claimant that is currently receiving the appealed benefits. The continuation of the benefits will be the same as the claimant's current allocation, budget or LOC unless a revision is agreed to in writing by the eligible recipient (or authorized representative) and DOH.

[8.314.5.21 NMAC - Rp, 8.314.5.21 NMAC, 12/1/2018]

HISTORY OF 8.314.5 NMAC:

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

ISD-Rule 310.2000, Coordinated Community In-Home Care Services, 3/19/1984.

History of Repealed Material:

ISD-Rule 310.2000, Coordinated Community In-Home Care Services, Repealed 1/18/1995.

8 NMAC 4.MAD.736.12 - Repealed 9/1/1998; and

8 NMAC 4.MAD.736.412 - Repealed 9/1/1998.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, Repealed 3/1/2007.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, filed 2/15/2007 - Repealed effective 11/1/2012.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, filed 10/2/2012 - Repealed effective 3/1/2016.

TITLE 8 SOCIAL SERVICES
CHAPTER 314 LONG TERM CARE SERVICES - WAIVERS
PART 6 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER

8.314.6.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.314.6.1 NMAC - Rp, 8.314.6.1 NMAC, 3/1/2016; A, 7/1/2024]

8.314.6.2 SCOPE: The rule applies to the general public.
[8.314.6.2 NMAC - Rp, 8.314.6.2 NMAC, 3/1/2016]

8.314.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Titles XI, XIX, and XXI of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.314.6.3 NMAC - Rp, 8.314.6.3 NMAC, 3/1/2016; A, 7/1/2024]

8.314.6.4 DURATION: Permanent.
[8.314.6.4 NMAC - Rp, 8.314.6.4 NMAC, 3/1/2016]

8.314.6.5 EFFECTIVE DATE: March 1, 2016, unless a later date is cited at the end of a section.
[8.314.6.5 NMAC - Rp, 8.314.6.5 NMAC, 3/1/2016]

8.314.6.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.314.6.6 NMAC - Rp, 8.314.6.6 NMAC, 3/1/2016]

8.314.6.7 DEFINITIONS:

A. Authorized annual budget (AAB): The eligible recipient works with their consultant to develop an annual budget request which is submitted to the third-party assessor (TPA) for review and approval. The total annual amount of the mi via services and goods includes the frequency, the amount, and the duration of the services and the cost of goods approved by the TPA. Once approved, this is the AAB.

B. Authorized representative: The individual designated to represent and act on the member's behalf. The eligible recipient or authorized representative must provide formal 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 eligible recipient. The eligible recipient's authorized representative may be a service provider (depending on what the eligible recipient or court order allows) for the eligible recipient. An authorized representative cannot approve their own timesheet. The authorized representative cannot serve as the eligible recipient's consultant.

C. Category of eligibility (COE): To qualify for medical assistance program (MAP) services, an applicant must meet financial criteria and belong to one of the groups that the New Mexico medical assistance division (MAD) has defined as eligible. An eligible recipient in the mi via program must belong to one of the MAP categories of eligibility (COE) described in 8.314.6.13 NMAC.

D. Centers for medicare and medicaid services (CMS): Federal agency within the United States department of health (DOH) and human services that works in partnership with New Mexico to administer medicaid and MAP services under HCA.

E. Consultant provider: An agency or an individual that provides consultant and support guide services to the eligible recipient that assist the eligible recipient (or the eligible recipient's family, personal representative or the authorized representative, as appropriate) in arranging for, directing and managing mi via services and supports, as well as developing, implementing and monitoring the service and support plan (SSP) and AAB.

F. Eligible recipient: An applicant meeting the financial and medical level of care (LOC) criteria who is approved to receive MAD services through the mi via program.

G. Employer of record (EOR): The employer of record (EOR) is the individual responsible for directing the work of mi via employees, including recruiting, hiring, managing and terminating all employees. The EOR tracks expenditures for employee payroll, goods, and services. EORs authorize the payment of timesheets by the financial management agency (FMA). An eligible recipient is required to have an EOR when they utilize employees for mi via services. An eligible recipient may be their own EOR unless the eligible recipient is a minor, or has a plenary or limited guardianship or conservatorship over financial matters in place. An eligible recipient may also designate an individual of their choice to serve as the EOR, subject to the EOR meeting the qualifications specified in this rule. A power of attorney (POA) or other legal instrument may not be used to assign the EOR responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR as designated in this rule.

H. Financial management agency (FMA): Contractor that helps implement the AAB by paying the eligible recipient's service providers and tracking expenses.

I. Home and community-based services (HCBS) waiver: A set of MAD services that provides alternatives to long-term care services in institutional settings, such as the mi via waiver program. CMS waives certain statutory requirements of the Social Security Act to allow HCA to provide an array of community-based options through these waiver programs.

J. Individual budgetary allotment (IBA): The maximum budget allotment available to an eligible recipient, determined by their age established level of care (LOC). Based on this maximum amount, the eligible recipient will develop a plan to meet their assessed functional, medical and habilitative needs to enable the eligible recipient to remain in their community.

K. Intermediate care facilities for individuals with intellectual disabilities (ICF/IID): Facilities that are licensed and certified to provide room and board, continuous active treatment and other services for eligible recipients with a primary diagnosis of intellectually disabled.

L. Legally responsible individual (LRI): A person who has a duty under state law to care for another person. This category typically includes: the parent (biological, legal, or adoptive) of a minor child, or a guardian who must provide care to an eligible recipient under 18 years of age or the spouse of an eligible recipient.

M. Level of care (LOC): The level of care an eligible recipient must meet to be eligible for the mi via program.

N. Mi via: Mi via is the name of the Section 1915 (c) MAD self-directed HCBS waiver program through which an eligible recipient has the option to access services to allow them to remain in the community.

O. Personal representative: The eligible recipient may select an individual to act as their personal representative for the purpose of offering support and assisting the eligible recipient understand their mi via services. The eligible recipient does not need a legal relationship with their personal representative. The personal representative will not have the authority to direct the member's mi via waiver services or make decisions on behalf of the eligible recipient. Directing services remains the sole responsibility of the eligible recipient or their authorized representative. The personal representative cannot serve as the eligible recipient's consultant and cannot approve their specific timesheet.

P. Reconsideration: An eligible recipient who disagrees with a clinical or medical utilization review decision or action may submit a written request to the third-party assessor for reconsideration of its decision. The eligible recipient or their authorized representative may submit the request for a reconsideration through the consultant or the consultant agency or may submit the request directly to MAD.

Q. Self-direction: The process applied to the service delivery system wherein the eligible recipient identifies, accesses and manages the services (among the MAD approved mi via waiver services and goods) that meet their assessed therapeutic, rehabilitative, habilitative, health or safety needs to support the eligible recipient to remain in their community.

R. Service and support plan (SSP): A plan that includes mi via services that meet the eligible recipient's needs that include: the projected amount, the frequency and the duration of the services; the type of provider who will furnish each service; other services the eligible recipient will access; and the eligible recipient's available supports that will compliment mi via services in meeting their needs.

S. Support guide: A function of the consultant provider that directly assists the eligible recipient in implementing the SSP to ensure access to mi via services and supports and to enhance success with self-direction. Support guide services provide assistance to the eligible recipient with employer or vendor functions or with other aspects of implementing their SSP.

T. Third-party assessor (TPA): The MAD contractor who determines and re-determines LOC and medical eligibility for mi via services. The TPA also reviews the eligible recipient's SSP and approves an AAB for the eligible recipient. The TPA performs utilization management duties of all mi via services.

U. **Waiver:** A program in which the CMS has waived certain statutory requirements of the Social Security Act to allow states to provide an array of HCBS options through MAD as an alternative to providing long-term care services in an institutional setting.
[8.314.6.7 NMAC - Rp, 8.314.6.7 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.8 [RESERVED]
[8.314.6.8 NMAC - Rp, 8.314.6.8 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.9 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER:

A. New Mexico's medicaid self-directed waiver program known as mi via is intended to provide a community-based alternative to institutional care that allows an eligible recipient to have control over services and supports. Mi via provides self-directed home and community-based services to eligible recipients who are living with developmental disabilities (DD), or medically fragile (MF) conditions. (See 42 CFR 441.300.)

B. The mi via program is for an eligible recipient who meets the LOC otherwise provided in an ICF/IID.

(1) DOH, at the direction of MAD, is responsible for the daily administration of the mi via program.

(2) Enrollment in mi via is limited to the number of federally authorized unduplicated eligible recipients and funding appropriated by the New Mexico legislature for this purpose.
[8.314.6.9 NMAC - Rp, 8.314.6.9 NMAC, 3/1/2016]

8.314.6.10 MI VIA CONTRACTED ENTITIES AND PROVIDERS SUPPORTING SELF-DIRECTED SERVICES: Services are to be provided in the least restrictive manner. HCA does not allow for the use of any restraints, restrictive interventions, or seclusions to an eligible mi via recipient. The following resources and services have been established to assist eligible recipients to self-direct services. These include the following:

A. **Consultant services:** Consultant services are direct services intended to educate, guide and assist the eligible recipient to make informed planning decisions about services and supports, to develop a SSP that is based on the eligible recipient's assessed disability-related needs and to assist the eligible recipient with quality assurance related to the SSP and AAB.

B. **Third-party assessor:** The TPA or MAD's designee is responsible for determining medical eligibility through a LOC assessment, assigning the applicable IBA, approving the SSP and authorizing an eligible recipient's annual budget in accordance with 8.314.6 NMAC and the mi via service standards. The TPA:

(1) determines medical eligibility using the LOC criteria in 8.314.6.13 NMAC; determinations are done initially for an eligible recipient who is newly enrolled in the mi via program and thereafter at least annually for currently enrolled mi via eligible recipients; the LOC assessment is done in person with the eligible recipient in their home, a location agreed upon by the eligible recipient and TPA and approved by HCA, or in an inpatient setting; the TPA may re-evaluate the LOC more often than annually if there is an indication that the eligible recipient's medical condition or LOC has changed;

(2) applies the information from the LOC documentation and the following assessments: long-term care assessment abstract (ICF/IID), the comprehensive individual assessment (CIA), or other MAD approved assessment tools, as appropriate for the COE, to assign the IBA for the eligible recipient that is medically eligible; and

(3) reviews and approves the SSP and the annual budget request resulting in an AAB, at least annually or more often if there is a change in the eligible recipient's circumstances, in accordance with 8.314.6 NMAC and mi via service standards.

C. **Financial management agent (FMA):** The FMA acts as the intermediary between the eligible recipient and the MAD payment system and assists the eligible recipient or the EOR with employer-related responsibilities. The FMA pays employees and vendors based upon an approved SSP and AAB. The FMA assures there is eligible recipient and program compliance with state and federal employment requirements, monitors, and makes available to the eligible recipient the reports related to utilization of services and budget expenditures. Based on the eligible recipient's approved individual SSP and AAB, the FMA must:

(1) verify that the recipient is eligible for MAD services prior to making payment for services;

(2) receive and verify that all required employee and vendor documentation and qualifications are in compliance with 8.314.6 NMAC and mi via service standards;

(3) establish an accounting for each eligible recipient's AAB;

(4) process and pay invoices for goods, services, and supports approved in the SSP and the AAB and supported by required documentation;

(5) process all payroll functions on behalf of the eligible recipient and EORs including:

(a) collect and process timesheets of employees;

(b) process payroll, withholding, filing, and payment of applicable federal, state and local employment-related taxes and insurance; and

(c) track and report disbursements and balances of the eligible recipient's AAB and provide a monthly report of expenditures and budget status to the eligible recipient and their consultant, and quarterly and annual documentation of expenditures to MAD;

(6) receive and verify employee and vendor agreements, including collecting required provider qualifications;

(7) monitor hours billed for services provided by the LRI and the total amounts billed for all goods and services during the month;

(8) answer inquiries from the eligible recipient and solve problems related to the FMA's responsibilities; and

(9) report to the consultant provider, MAD and DOH any concerns related to the health and safety of an eligible recipient or if the eligible recipient is not following the approved SSP and AAB.

[8.314.6.10 NMAC - Rp, 8.314.6.10 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.11 QUALIFICATIONS FOR ELIGIBLE INDIVIDUAL EMPLOYEES, INDEPENDENT PROVIDERS, PROVIDER AGENCIES, AND VENDORS:

A. Requirements for individual employees, independent providers, provider agencies and vendors: In order to be approved as an individual employee, an independent provider, including non-licensed homemaker or direct support worker, a provider agency, (excluding consultant providers which are covered in a different subsection) or a vendor, including those that provide professional services, each individual or entity must meet the general and service specific qualifications set forth in this rule initially and continually meet licensure requirements as applicable, and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the FMA. The provider agency is responsible to ensure that all agency employees meet the required qualifications. In order to be an authorized provider for the mi via program and receive payment for delivered services, the provider must complete and sign an employee or vendor provider agreement and all required tax documents. Individual employees may not provide more than 40 hours of services in a consecutive seven-day work week. The provider must have credentials verified by the eligible recipient or the EOR and the FMA.

(1) Prior to rendering services to an eligible mi via recipient as an independent contractor for homemaker or direct support worker, respite, community direct support, employment supports, and in-home living support provider, an individual seeking to provide these services must complete and submit a nature of services questionnaire to the FMA. The FMA will determine, based on the nature of services questionnaire if the relationship is that of an employee or an independent contractor.

(2) An authorized consultant provider must have a MAD approved provider participation agreement (PPA) and the appropriate approved developmental disabilities division (DDSD) agreement.

B. General qualifications:

(1) Individual employees, independent providers, including non-licensed homemaker/direct support workers who are employed by a mi via eligible recipient to provide direct services shall:

(a) be at least 18 years of age;

(b) be qualified to perform the service and demonstrate capacity to perform required tasks;

(c) be able to communicate successfully with the eligible recipient;

(d) prior to the initial hire and every three years after initial hire pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC; additionally employees must pass the employee abuse registry (EAR) pursuant to 7.1.12 NMAC, certified nurse aide registry pursuant to 16-12.20 NMAC, office of inspector exclusion list pursuant to section 1128B(f) of the Social Security Act; and the national sex offender registry pursuant to 6201 as federal authority for active programs.

(e) complete training on critical incident, abuse, neglect, and exploitation reporting;

(f) complete training specific to the eligible recipient's needs; an assessment of training needs is determined by the eligible recipient or their authorized representative; the eligible recipient is also

responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the eligible recipient's AAB; and

(g) meet any other service specific qualifications, as specified in this rule and its service standards.

(2) Vendors, including those providing professional services shall meet the following qualifications:

(a) shall be qualified to provide the service;

(b) shall possess a valid business license, if applicable;

(c) meet financial solvency, maintain and adhere to training requirements, record management, quality assurance policy and procedures, if applicable;

(d) be in good standing with and comply with their New Mexico practice board or other certification or licensing required to render mi via services in New Mexico; and

(e) must not have a DOH current adverse action against them.

(f) assure that employees of the vendor:

(i) are at least 18 years of age;

(ii) are qualified to perform the service and demonstrate capacity to perform required tasks;

(iii) are able to communicate successfully with the eligible recipient;

(iv) pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC;

(v) complete training on critical incident, abuse, neglect, and exploitation reporting;

(vi) complete training specific to the eligible recipient's needs; an assessment of training needs is determined by the eligible recipient or their authorized representative; the eligible recipient is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the eligible recipient's AAB; and

(g) meet any other service specific qualifications, as specified in this rule and its service standards.

(3) Qualified and approved relatives, authorized representatives or personal representatives may be hired as employees and paid for the provision of mi via services (except consultant and support guides, customized community group supports services, transportation services for a minor, and individual directed goods and services). The services must be identified in the eligible recipient's approved SSP and AAB, and the EOR is responsible for verifying that services have been rendered by completing, signing, and submitting documentation, including the timesheet, to the FMA. These services must be provided within the limits of the approved SSP and AAB and may not be paid in excess of 40 hours in a consecutive seven-day work week. LRIs, authorized representatives, personal representatives or relatives may not be both a paid employee for the eligible recipient and serve as the eligible recipient's EOR. An authorized or personal representative who is also an employee may not approve their own timesheet.

(4) A LRI may be hired and paid for provision of mi via services (except transportation services when requested for a minor, a consultant and support guide, and customized community group supports services, and related goods) under extraordinary circumstances (i) in order to assure the health and welfare of the eligible recipient and (ii) to avoid institutionalization when approved by DOH. MAD must be able to receive federal financial participation (FFP) for the services.

(a) Extraordinary circumstances include the inability of the LRI to find other qualified, suitable caregivers when the LRI would otherwise be absent from the home and, thus, the caregiver must stay at home to ensure the eligible recipient's health and safety.

(b) LRIs may not be paid for any services that they would ordinarily perform in the household for individuals of the same age who do not have a disability or chronic illness.

(c) Services provided by LRIs must:

(i) meet the definition of a service or support and be specified in the eligible recipient's approved SSP and AAB;

(ii) be provided by a parent or spouse who meets the provider qualifications and training standards specified in the mi via rule for that service; and

(iii) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service,and be approved by the TPA.

(d) A LRI who is a service provider must comply with the following:

(i) a parent, parents in combination, legal guardian of a minor, or a spouse of the eligible recipient, may not provide more than 40 hours of services in a consecutive seven-day work week; for parents or legal guardians of the eligible recipient, 40 hours is the total amount of service regardless of the number of eligible recipients under the age of 21 who receive services through the mi via program;

(ii) planned work schedules must be identified in the approved SSP and AAB, and variations to the schedule must be reported to the eligible recipient's consultant and noted and supplied to the FMA when billing; and

(iii) timesheets and other required documentation must be maintained and submitted to the FMA for hours paid.

(e) An eligible recipient must be offered a choice of providers. There must be written approval from DOH when a provider is chosen who is:

(i) a parent or legal guardian of an eligible recipient who is a minor; or

(ii) the eligible recipient's spouse.

(f) This written approval must be documented in the SSP.

(g) The FMA monitors, on a monthly basis, hours billed for services provided by the LRI and the total amounts billed for all goods and services during the month.

(5) Once enrolled, providers, vendors and contractors receive a packet of information from the eligible recipient or FMA, including billing instructions, and other pertinent materials. Mi via eligible recipients or EOR's or authorized representatives are responsible for ensuring that providers, vendors and contractors have received these materials and for updating them as new materials are received from MAD and DOH. MAD makes available on its website, and in hard copy format, information necessary to participate in medical assistance programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. DOH makes available on its website information, instructions and guidance on its administrative requirements for the mi via program. When enrolled, an eligible recipient or their authorized representative, or the provider, vendor or contractor receives instruction on how to access these documents. It is the responsibility of the eligible recipient or authorized representative, or the provider, vendor, or contractor to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The eligible recipient or authorized representative, or the provider, vendor, or contractor must contact HCA or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials.

(a) No employee of any type may be paid in excess of 40 hours within the established consecutive seven day work week for any one eligible recipient or EOR.

(b) No provider agency is permitted to perform both LOC assessments and provide any services for the eligible recipients.

(c) Providers may market their services, but are prohibited from soliciting eligible recipients under any circumstances such as offering an eligible recipient or their authorized representative gratuities in the form of entertainment, gifts, financial compensation to alter that eligible recipient's selection of provider agencies, service agreements, medication, supplies, goods or services.

(d) Those signing a payment request form for vendor services rendered to an eligible recipient may not serve as an employee, contractor or subcontractor of that vendor for that eligible recipient. An eligible recipient who does not have an authorized representative providing oversight of the eligible recipient's financial matters may sign off on the payment request form.

(6) The EOR is the individual responsible for directing the work of the eligible recipient's employees. An eligible recipient is required to have an EOR when utilizing employees. The EOR may be the eligible recipient or a designated qualified individual. A recipient through the use of the mi via EOR questionnaire will determine if an individual meets the requirements to serve as an EOR. The recipient's consultant will provide them with the questionnaire. The questionnaire shall be completed by the recipient with assistance from the consultant upon request. The consultant shall maintain a copy of the completed questionnaire in the recipient's file. When utilizing both vendors and employees, an EOR is required for oversight of employees and to sign payment request forms for vendors. The EOR must be documented with the FMA, whether the EOR is the eligible recipient or a designated qualified individual. A POA or other legal instrument may not be used to assign the EOR responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR as designated in 8.314.6 NMAC.

(a) An eligible recipient that has a plenary or limited guardianship or conservatorship over the eligible recipient's financial matters may not be their own EOR nor sign payment vendor request forms for vendors.

(b) A person under the age of 18 years may not be an EOR.

(c) An EOR who lives outside New Mexico shall reside within 100 miles of the New Mexico state border. Any out of state EOR residing beyond this radius who has been approved prior to the effective date of this rule may continue to serve as the EOR.

(d) The eligible recipient's provider may not also be their EOR nor sign payment vendor request forms for vendors.

(e) An EOR whose performance compromises the health, safety or welfare of the eligible recipient, may have their status as an EOR terminated.

(f) An EOR may not be paid for any other services utilized by the eligible recipient for whom they are the EOR, whether as an employee of the eligible recipient, a vendor, or an employee or contactor, or subcontractor of an agency. An EOR makes important determinations about what is in the best interest of the eligible recipient, and should not have any conflict of interest. An EOR assists in the management of the eligible recipient's budget and should have no personal benefit connected to the services requested or approved on the budget.

(g) An EOR is not required if an eligible recipient is utilizing only vendors for services; however, an EOR can be identified by an eligible recipient to assist with the use of vendors. In some instances an EOR for vendor services may be required by MAD. A recipient utilizing vendors only who selects not to have an EOR will submit documentation to the FMA identifying an authorized signer who will be responsible for signing payment request forms. The authorized signer for vendor services rendered to an eligible recipient may not serve as an employee, contractor or subcontractor of that vendor for that eligible recipient. An eligible recipient who does not have a plenary or limited guardianship or conservatorship providing oversight of the eligible recipient's financial matters may be their own authorized signer for the payment request form. A POA may not be used to assign the responsibilities of the authorized signer, in part or in full, to another individual and may not be used to circumvent the requirements of the authorized signer as designated in this rule.

(h) An EOR, or authorized signer, is required to complete and provide documents to the FMA according to the timelines and rules established by the state. Documents include, but are not limited to: vendor and employee enrollment agreements, vendor information forms, criminal background check forms, timesheets, payment request forms, invoices, and other documents needed by the FMA to enroll and process payment to employees and vendors. The mi via program requires that employee timesheets be submitted online unless the recipient has an approved exception from HCA.

C. Service specific qualifications for consultant services providers: In addition to general requirements, a consultant provider shall ensure that all individuals hired or contracted to provide consultant services meet the criteria specified in this section and comply with all applicable NMAC MAD rules and mi via service standards.

(1) Consultant providers shall:

(a) possess a minimum of a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field, and have one year of supervised experience working with people living with disabilities; or

(b) have a minimum of six years of direct experience related to the delivery of social services to people living with disabilities; and

(c) be employed by an enrolled mi via consultant provider agency; and

(d) complete all required mi via program orientation and training courses; and

(e) be at least 21 years of age.

(2) Consultant providers may also use non-professional staff to carry out support guide functions. Support guides provide more intensive supports, as detailed in the service section of these rules. Support guides help the eligible recipient more effectively self-direct services when there is an identified need for this type of assistance. Consultant providers shall ensure that non-professional support staff:

(a) are supervised by a qualified consultant as specified in this rule;

(b) have experience working with people living with disabilities;

(c) demonstrate the capacity to meet the eligible recipient's assessed needs related to the implementation of the SSP;

(d) possess knowledge of local resources, community events, formal and informal community organizations and networks;

(e) are able to accommodate a varied, flexible and on-call type of work schedule in order to meet the needs of the eligible recipient; and

(f) complete training on self-direction and incident reporting; and

(g) be at least 18 years of age.

D. Service specific qualifications for personal plan facilitation providers: In addition to general MAD requirements, a personal plan facilitator agency must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. Personal plan facilitators must possess the following qualifications in addition to the general qualifications:

(1) have at least one year of experience working with persons with disabilities; and

(2) be trained and mentored in the planning tool(s) used; and

(3) have at least one year experience in providing the personal plan facilitation service.

E. Service specific qualification for living supports providers: In addition to general MAD requirements, the following types of providers must meet additional qualifications specific to the type of services provided.

(1) Qualifications of homemaker direct support service providers: Provider agencies must be homemaker agencies certified by the MAD or its designee or a home health agency holding a New Mexico home health agency license. A homemaker and home health agency must hold a current business license when applicable, and meet financial solvency, training, records management, and quality assurance rules and requirements.

(2) Qualifications of home health aide service providers: Home health or homemaker agencies must hold a New Mexico current home health agency, rural health clinic, or federally qualified health center license. Home health aides must have successfully completed a home health aide training program, as described in 42 CFR 484.36(a)(1) and (2) or have successfully completed a home health aide training program pursuant to 7.28.2.30 NMAC. Home health aides must also be supervised by a registered nurse (RN) licensed in New Mexico. Such supervision must occur at least once every 60 calendar days in the eligible recipient's home, and shall be in accordance with the New Mexico Nurse Practice Act and be specific to the eligible recipient's SSP.

(3) Qualifications of in-home living supports providers: Provider agencies must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. In-home living agency staff and its direct staff rendering the service must have one year of experience working with people with disabilities. In-home living support agencies must assure appropriate staff for a 24 hour response capability to address scheduled or unpredictable needs related to health, safety, or security in order to meet the needs of the recipient. In-home living support agencies are not fiscal intermediaries and cannot bill nor be paid for work that the recipient or EOR are responsible for as required by Paragraph (6) of Subsection B of 8.314.6.11 NMAC and the mi via service standards.

F. Service specific qualifications for community membership support providers: In addition to general MAD requirements, the following types of providers must meet additional qualifications specific to the type of services provided. An agency providing community membership services must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements.

(1) Qualifications of supported employment providers:

(a) A job developer, whether an agency or individual provider, must:

(i) be at least 21 years of age;

(ii) pass criminal background check and abuse registry screen;

(iii) have experience developing and using job and task analyses;

(iv) have experience working with the division of vocational rehabilitation (DVR), a traditional DD waiver employment provider, an independent living center or other organization that provides employment supports or services for people with disabilities and be trained on the purposes, functions and general practices of entities such as the department of workforce solutions navigators, one-stop career centers, business leadership network, chamber of commerce, job accommodation network, small business development centers, local businesses, retired executives, DDSD resources, and have substantial knowledge of the Americans with Disabilities Act (ADA); and

(v) complete training on critical incident, abuse, neglect, and exploitation.

(b) Job coaches whether an agency or individual provider, must:

(i) be at least 18 years of age;

(ii) have a high school diploma or GED;

(iii) pass criminal background check and abuse registry screen;

(iv) be qualified to perform the service;

(v) have experience with providing employment supports and training methods;

(vi) be knowledgeable about business and employment resources;

(vii) have the ability to successfully communicate with the employer and with the eligible recipient and their coworkers to develop and encourage natural supports on the job; and

(viii) complete training on critical incident, abuse, neglect, and exploitation.

(2) Qualifications of customized community group supports providers: Agencies providing community group support services must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. Providers, whether an agency staff or an individual provider must meet the following qualifications:

(i) must be at least 18 years of age;

(ii) pass criminal background check and abuse registry screen;

(iii) demonstrate capacity to perform required tasks;

(iv) complete training on critical incident, abuse, neglect, and exploitation reporting; and

(v) have the ability to successfully communicate with the eligible recipient.

G. Service specific qualifications for providers of health and wellness supports: In addition to the general MAD qualifications, the following types of providers must meet additional qualifications specific to the type of services provided.

(1) Qualifications of extended state plan skilled therapy providers for adults: Physical and occupational therapists, speech/language pathologists, physical therapy assistants and occupational therapy assistants must possess a therapy license in their respective field from the New Mexico regulation and licensing department (RLD). Speech clinical fellows must possess a clinical fellow license from the New Mexico RLD.

(2) Qualifications of behavior support consultation providers: Behavior support consultation provider agencies shall have a current business license issued by the state, county or city government, if required. Behavior support consultation provider agencies shall comply with all applicable federal, state, and rules and procedures regarding behavior consultation. Providers of behavior support consultation services must possess qualifications in at least one of the following areas:

(a) a licensed psychiatrist by their New Mexico practice board;

(b) a regulation and licensing department (RLD) licensed clinical psychologist;

(c) a RLD licensed psychologist associate, (masters or Ph.D. level);

(d) a RLD licensed independent social worker (LISW);

(e) a RLD licensed master social worker (LMSW);

(f) a RLD licensed professional clinical counselor (LPCC);

(g) a licensed clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) who is certified in psychiatric nursing by a national nursing organization who can furnish services to adults or children as their certification permits;

(h) a RLD licensed marriage and family therapist (LMFT); or

(i) a RLD licensed practicing art therapist (LPAT) by RLD.

(3) Qualifications of nutritional counseling providers: Nutritional counseling providers must maintain a current registration as dietitians by the commission on dietetic registration of the American dietetic association and licensed by the RLD, (Nutrition and Dietetics Practice Act Section 61-7A-7 et seq. NMSA 1978).

(4) Qualifications of private duty nursing providers for adults: Direct nursing services are provided by individuals who are currently licensed as registered or practical nurses by the New Mexico state board of nursing, (Sections 61-3-14 and 61-3-18 NMSA 1978).

(5) Qualifications of specialized therapy providers: For each type of specialized therapy providers, the provider must hold the appropriate New Mexico licensure or certification for the services they render to an eligible recipient:

(a) a RLD license in acupuncture and oriental medicine;

(b) a license or certification with the appropriate specialized training and clinical experience and supervision whose scope of practice includes biofeedback;

(c) a RLD license in chiropractic medicine;

(d) a license or certification for which they have appropriate specialized training and clinical experience and whose scope of practice includes cognitive rehabilitation therapy;

(e) a RLD license in a physical therapy, or occupational therapy, or speech therapy and whose scope of practice includes hippotherapy with the appropriate specialized training and experience;

(f) a RLD license in massage therapy;

(g) a RLD license in naprapathic medicine;

(h) a master's or a higher level behavioral health degree with specialized play therapy training, clinical experience and supervision and whose RLD license's scope of practice includes play therapy; and

(i) a native American healer who is recognized as a traditional healer within their community.

H. Service specific qualifications for other supports providers: In addition to the general MAD qualifications, the following types of providers must meet additional qualifications specific to the type of services provided.

(1) Qualifications of transportation providers:

(a) Individual transportation providers must:

(i) possess a valid New Mexico driver's license with the appropriate classification;

(ii) complete training on critical incident, abuse, neglect and exploitation reporting procedures; and

(iii) have a current insurance policy and vehicle registration.

(b) Transportation vendors must hold a current business license and tax identification number. Each agency will ensure any vehicle used to transport an eligible recipient is equipped with an up-to-date first aid kit. Each agency will ensure transportation drivers meet the following qualifications:

(i) holds a valid New Mexico driver's license of the appropriate classification to transport an eligible recipient;

(ii) holds a current vehicle insurance policy meeting New Mexico's insurance mandates in place for the vehicle used to transport an eligible recipient; and

(iii) holds a New Mexico vehicle registration for the vehicle used to transport an eligible recipient.

(2) Q**ualifications of emergency response providers:** Emergency response providers must comply with all laws, rules and regulations of the state of New Mexico.

(3) Qualifications of respite providers: Respite services may be provided by eligible individual respite providers; RN or practical nurses (LPN); or respite provider agencies. Individual RN or LPN providers must be licensed by the New Mexico board of nursing as an RN or LPN. Respite provider agencies must hold a current business license, and meet financial solvency, training, records management and quality assurance rules and requirements.

(4) Qualifications of individual directed goods and services vendors: Individual directed goods and services vendors must hold a current business license and tax identification for New Mexico and the federal government. Vendors for individual directed goods and services are retail stores, community health centers, or medical supply stores.

(5) Qualifications of environmental modifications providers: Environmental modification providers must possess an appropriate plumbing, electrician, contractor or other appropriate New Mexico licensure.

[8.314.6.11 NMAC - Rp, 8.314.6.11 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.12 RECORDKEEPING AND DOCUMENTATION RESPONSIBILITIES: Service providers and vendors who furnish goods and services to mi via eligible recipients are reimbursed by the FMA and must comply with all applicable NMAC MAD rules and service standards. The FMA, consultants and service providers must maintain records, which are sufficient to fully disclose the extent and nature of the goods and services provided to the eligible recipients, as detailed in applicable NMAC MAD provider rules and comply with random and targeted audits conducted by MAD and DOH or their audit agents. MAD or its designee will seek recoupment of funds from service providers when audits show inappropriate billing for services. Mi via vendors who furnish goods and services to mi via eligible recipients and bill the FMA must comply with all MAD PPA requirements and NMAC MAD rules and requirements, including but not limited to 8.310.2 NMAC and 8.321.2 NMAC and 8.302.1 NMAC.

[8.314.6.12 NMAC - Rp, 8.314.6.12 NMAC, 3/1/2016]

8.314.6.13 ELIGIBILITY REQUIREMENTS FOR RECIPIENT ENROLLMENT IN MI VIA: Enrollment in the mi via program is contingent upon the applicant meeting the eligibility requirements as described

in this rule, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated eligible recipients. When sufficient funding as well as waiver positions are available, DOH will offer the opportunity to eligible recipients to select mi via. Once an allocation has been offered to the applicant, they must meet certain medical and financial criteria in order to qualify for mi via enrollment located in 8.290.400 NMAC. The eligible recipient must meet the LOC required for admittance to an ICF-IID. After initial eligibility has been established for a recipient, on-going eligibility must be determined on an annual basis.
[8.314.6.13 NMAC - Rp, 8.314.6.13 NMAC, 3/1/2016]

8.314.6.14 ELIGIBLE RECIPIENT AND EOR RESPONSIBILITIES: Mi via eligible recipients have certain responsibilities to participate in the program. Failure to comply with these responsibilities or other program rules and service standards can result in termination from the program. The eligible recipient and EOR, or authorized signer if the recipient has vendors only, have the following responsibilities:

A. To maintain eligibility the recipient must complete required documentation demonstrating medical and financial eligibility both upon application and annually at recertification, meet in person with the TPA for a comprehensive LOC assessment in the eligible recipient's home, or in a location approved by the state and seek assistance with the application and the recertification process as needed from a mi via consultant.

B. To participate in the mi via program, the eligible recipient must:

(1) comply with applicable NMAC rules to include this rule, mi via service standards and requirements that govern the program;

(2) collaborate with the consultant to determine support needs related to the activities of self-direction;

(3) collaborate with the consultant to develop an SSP using the IBA in accordance with applicable NMAC rules to include this rule and service standards;

(4) use mi via program funds appropriately by only requesting and purchasing goods and services covered by the mi via program in accordance with program rules which are identified in the eligible recipient's approved SSP;

(5) comply with the approved SSP and not exceed the AAB;

(a) if the eligible recipient does not adequately allocate the resources contained in the AAB resulting in a premature depletion of the AAB amount during an SSP year due to mismanagement or failure to properly track expenditures, the failure to properly allocate does not substantiate a claim for a budget increase (i.e., if all of the AAB is expended within the first three months of the SSP year, it is not justification for an increase in the budget for the SSP year);

(b) revisions to the AAB may occur within the SSP year, and the eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect;

(i) the SSP must be amended first to reflect a change in the eligible recipient's needs or circumstances before any revisions to the AAB can be requested;

(ii) other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review within the last 60 calendar days of the budget year;

(c) no mi via program funds can be used to purchase goods or services prior to TPA approval of the SSP and annual budget request;

(d) any funds not utilized within the SSP and AAB year cannot be carried over into the following year;

(6) access consultant services based upon identified need(s) in order to carry out the approved SSP;

(7) collaborate with the consultant to appropriately document service delivery and maintain those documents for evidence of services received;

(8) report concerns or problems with any part of the mi via program to the consultant or if the concern or problem is with the consultant, to DOH;

(9) work with the TPA agent by attending scheduled meetings, in the eligible recipient's home if necessary and providing documentation as requested;

(10) respond to requests for additional documentation and information from the consultant provider, FMA, and the TPA within the required deadlines;

(11) report to the local HCA income support division (ISD) office within 10 calendar days any change in circumstances, including a change in address, which might affect eligibility for the program; changes in address or other contact information must also be reported to the consultant provider and the FMA within 10 calendar days;

(12) report to the TPA and consultant provider if hospitalized for more than three consecutive nights so that an appropriate LOC can be obtained;

(13) keep track of all budget expenditures and assure that all expenditures are within the AAB;

(14) have monthly contact and meet face-to-face quarterly with the consultant; and

(15) have an EOR if utilizing employees for services; the eligible recipient may be their own EOR unless the eligible recipient is a minor, or they have a plenary or limited guardianship or conservatorship over financial matters; an eligible recipient may also designate an individual of their choice to serve as the EOR, subject to the EOR meeting the qualifications specified in this rule. If the recipient is using vendors only and selects not to have an EOR then the recipient will identify an authorized signer for payment request forms; the eligible recipient may be their own authorized signer unless the eligible recipient is a minor, or they have a plenary or limited guardianship or conservatorship over financial matters. A POA or other legal instrument may not be used to assign the EOR, or authorized signer, responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR, or authorized signer, as designated in this rule.

C. Additional responsibilities of the eligible recipient or EOR, or authorized signer, are detailed below:

(1) Submit all required documents to the FMA according to the timelines and rules established by the state to meet employer-related responsibilities. This includes, but is not limited to, documents for payment to employees and vendors and payment of taxes and other financial obligations within required timelines. The EOR is responsible for submitting mi via employee timesheets online unless the recipient has an approved exception from HCA.

(2) Report any incidents of abuse, neglect or exploitation to the appropriate state agency.

(3) Arrange for the delivery of services, supports and goods.

(4) Hire, manage, and terminate employees.

(5) Maintain records and documentation for at least six years from first date of service and ongoing.

D. **Voluntary termination:** An eligible recipient has a choice of receiving services through the non-self-directed waiver or through the mi via HCBS waiver. If the eligible recipient wishes to change to the non-self-directed HCBS waiver, a waiver change must occur in accordance with the mi via NMAC rule and mi via service standards. Transitions can only occur at the first of a month.

E. **Involuntary termination:** A mi via eligible recipient may be terminated involuntarily by MAD and DOH and offered services through a non-self-directed waiver or the medicaid state plan under the following circumstances.

(1) The eligible recipient refuses to comply with this rule and mi via service standards after receiving focused technical assistance on multiple occasions, support from the program staff, consultant, or FMA, which is supported by documentation of the efforts to assist the eligible recipient.

(2) The eligible recipient is in immediate risk to their health or safety by continued self-direction of services, e.g., the eligible recipient is in imminent risk of death or serious bodily injury related to participation in the mi via program. Examples include but are not limited to the following.

(a) The eligible recipient refuses to include and maintain services in their SSP and AAB that would address health and safety issues identified in their medical assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, consultant, or FMA.

(b) The eligible recipient is experiencing significant health or safety needs, and, after a referral to the state contractor for level of risk determination and assistance, refuses to incorporate the contractor's recommendations into their SSP and AAB.

(c) The eligible recipient exhibits behaviors which endanger himself or herself or others.

(3) The eligible recipient misuses mi via funds following repeated and focused technical assistance and support from the consultant or FMA, which is supported by documentation.

(4) The eligible recipient commits medicaid fraud.

(5) When DOH is notified the eligible recipient continues to utilize either an employee or a vendor, or both who have consistently been substantiated against for abuse, neglect, exploitation while providing mi via services after notification of this on multiple occasions by DOH.

(6) The eligible recipient who is involuntarily terminated from the mi via program will be offered a non self-directed waiver alternative. If transfer to another waiver is authorized and accepted by the eligible recipient, they will continue to receive the services and supports from mi via until the day before the new waiver services start. This will ensure that no break in service occurs. The mi via consultant and the case manager in the

new waiver will work closely together with the eligible recipient to ensure that the eligible recipient's health and safety is maintained.
[8.314.6.14 NMAC - Rp, 8.314.6.14 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA: The services covered by the mi via program are intended to provide a community-based alternative to institutional care for an eligible recipient that allows greater choice, direction and control over services and supports in a self-directed environment. Mi via services must specifically address a therapeutic, rehabilitative, habilitative, health or safety need that results from the eligible recipient's qualifying condition. The mi via program is the payor of last resort. The coverage of mi via services must be in accordance with 8.314.6 NMAC and mi via service standards. Waiver recipients in all living arrangements are assessed individually and service plan development is individualized. The TPA will assess the service plans of recipients living in the same residence to determine whether or not there are services that are common to more than one recipient living in the same household in order to determine whether one or more employees may be needed to ensure that individual different cognitive, clinical, and habilitative needs are met. Mi via services must be provided in integrated settings and facilitate full access to the community; ensure the recipient receives services in the community to the same degree of access as those individuals not receiving HCBS services; maximize independence in making life choices; be chosen by the recipient in consultation with the guardian as applicable; ensure the right to privacy, dignity, respect, and freedom from coercion and restraint; optimize recipient initiative, autonomy and independence in making life choices; provide an opportunity to seek competitive employment; and facilitate choice of service and who provides them.

A. General requirements regarding mi via covered services. To be considered a covered service under the mi via program, the following criteria must be met. Services, supports and goods must:

(1) directly address the eligible recipient's qualifying condition or disability;

(2) meet the eligible recipient's clinical, functional, medical or habilitative needs;

(3) be designed and delivered to advance the desired outcomes in the eligible recipient's service and support plan; and

(4) support the eligible recipient to remain in the community and reduce the risk of institutionalization.

B. Consultant pre-eligibility and enrollment services: Consultant pre-eligibility and enrollment services are intended to provide information, support, guidance, and assistance to an individual during the medicaid financial and medical eligibility process. The level of support provided is based upon the unique needs of the individual. When an opportunity to be considered for mi via program services is offered to an individual, they must complete a primary freedom of choice form. The purpose of this form is for the individual to select a consultant provider. The chosen consultant provider offers pre-eligibility and enrollment services as well as on-going consultant services. Once the individual is determined to be eligible for mi via services, the consultant service provider will continue to render consultant services to the newly enrolled eligible recipient as set forth in the consultant service standards.

C. Consultant services: Consultant services are required for all mi via eligible recipients to educate, guide, and assist the eligible recipients to make informed planning decisions about services and supports. The consultant helps the eligible recipient develop the SSP based on their assessed needs. The consultant assists the eligible recipient with implementation and quality assurance related to the SSP and AAB. Consultant services help the eligible recipient identify supports, services and goods that meet their needs, meet the mi via requirements and are covered mi via services. Consultant services provide support to eligible recipients to maximize their ability to self-direct their mi via services.

(1) Contact requirements: Consultant providers shall make contact with the eligible recipient in person or by telephone at least monthly for a routine follow-up. Consultant providers shall meet face-to-face with the eligible recipient at least quarterly; one visit must be conducted in the eligible recipient's home at least annually. During monthly contact the consultant:

(a) reviews the eligible recipient's access to services and whether they were furnished per the SSP;

(b) reviews the eligible recipient's exercise of free choice of provider;

(c) reviews whether services are meeting the eligible recipient's needs;

(d) reviews whether the eligible recipient is receiving access to non-waiver services per the SSP;

(e) reviews activities conducted by the support guide, if utilized;

(f) documents changes in status;

(g) monitors the use and effectiveness of the emergency back-up plan;

(h) documents and provides follow up, if necessary, if challenging events occur that prevent the implementation of the SSP;

(i) assesses for suspected abuse, neglect, or exploitation and report accordingly; if not reported, takes remedial action to ensure correct reporting;

(j) documents progress of any time sensitive activities outlined in the SSP;

(k) determines if health and safety issues are being addressed appropriately; and

(l) discusses budget utilization concerns.

(2) Quarterly visits will be conducted for the following purposes:

(a) review and document progress on implementation of the SSP;

(b) document usage and effectiveness of the emergency backup plan;

(c) review SSP and budget spending patterns (over and under-utilization);

(d) assess quality of services, supports and functionality of goods in accordance with the quality assurance section of the SSP and any applicable sections of the mi via rules and service standards;

(e) document the eligible recipient's access to related goods identified in the SSP;

(f) review any incidents or events that have impacted the eligible recipient's health, welfare or ability to fully access and utilize support as identified in the SSP; and

(g) other concerns or challenges, including but not limited to complaints, eligibility issues, and health and safety issues, raised by the eligible recipient, authorized representative or personal representative.

(3) **Change of consultants:** Consultants are responsible for assisting eligible recipients to transition to another consultant provider when requested. Transition from one consultant provider to another can only occur at the first of the month.

(4) **Critical incident management responsibilities and reporting requirements:** The consultant provider shall report incidents of abuse, neglect, exploitation, suspicious injury, environmental hazards, and eligible recipient death as directed by the appropriate state agency(ies). The consultant provider shall provide training to eligible recipients EOR, authorized representatives or other designated individuals regarding recognizing and reporting critical incidents. Critical incidents include abuse, neglect, exploitation, suspicious injury, environmental hazards and eligible recipient deaths. The consultant provider shall maintain a critical incident management system to identify, report, and address critical incidents. The consultant provider is responsible for follow-up and assisting the eligible recipient to help ensure health and safety when a critical incident has occurred. Critical incident reporting requirements for mi via eligible recipients who have been designated with an ICF/IID LOC, critical incidents should be directed in the following manner.

(a) DOH triages, and investigates all reports of alleged abuse, neglect, exploitation, suspicious injury, environmental hazards, and eligible recipient deaths for mi via services and eligible recipients to include expected and unexpected deaths. The reporting of these critical incidents is mandated for all those providing mi via services pursuant to 7.1.14 NMAC. Any critical incidents must be reported to the children, youth and families department (CYFD) child protective services (CPS) or the DOH division of health improvement (DHI) incident management bureau (IMB) for eligible recipients under 18 years. For eligible recipient's 18 years and older, IMB is contacted to report any critical incidents. The reporter must then fax DHI the abuse, neglect and exploitation or report of death form within 24 hours of a verbal report. If the reporter has internet access, the report form shall be submitted via DHI's website. Anyone may report an incident; however, the person with the most direct knowledge of the incident is the individual who is required to report the incident.

(b) With respect to mi via services provided by any employee, contractor, vendor or other community-based waiver service agency having a provider agreement with DOH, any suspected abuse, neglect, exploitation, suspicious injury, environmental hazard, eligible recipient death must be reported to the CYFD/CPS or DHI/IMB for the eligible recipient under 18 years or to IMB for eligible recipients age 18 years or older. See Sections 27-7-14 through 27-7-31 NMSA 1978 (Adult Protective Services Act) and in Sections 32A-4-1 through 32A-4-34 NMSA 1978 (Child Abuse and Neglect Act).

(5) **Conflict of interest:** An eligible recipient's consultant may not serve as the eligible recipient's EOR, authorized representative or personal representative for whom they are the consultant. A consultant may not be paid for any other services utilized by the eligible recipient for whom they are the consultant, whether as an employee of the eligible recipient, a vendor, an employee or subcontractor of an agency. A consultant may not provide any other paid mi via services to an eligible recipient unless the recipient is receiving consultant services from another agency. The consultant agency may not provide any other direct services for an eligible recipient that has an approved SSP, an approved budget, and is actively receiving services in the mi via program.

The consultant agency may not employ as a consultant any immediate family member or guardian for an eligible recipient of the mi via program that is served by the consultant agency. A consultant agency may not provide guardianship services to an eligible recipient receiving consultant services from that same agency. The consultant agency may not provide any direct support services through any other type of 1915 (c) Home and Community Based Waiver Program. A consultant agency shall not engage in any activities in their capacity as a provider of services to an eligible recipient that may be a conflict of interest. As such a consultant agency shall not hold a business or financial interest in an affiliated agency that is paid to provide direct care for any individuals receiving mi via services. An affiliated agency is defined as a direct service agency providing mi via services that has a marital, domestic partner, blood, business interest or holds financial interest in providing direct care for individuals receiving mi via services. Affiliated agencies must not hold a business or financial interest in any entity that is paid to provide direct care for any individuals receiving HCBS services. Any direct service agency or consultant agency that has been referred to the DOH internal review committee (IRC) or is on a moratorium will not be approved to provide mi via services.

D. Personal plan facilitation: Personal plan facilitation supports planning activities that may be used by the eligible recipient to develop their SSP as well as identify other sources of support outside the SSP process. This service is available to an eligible recipient one time per budget year.

(1) In the scope of personal planning facilitation, the personal plan facilitator will:

(a) meet with the eligible recipient and their family (or authorized representative, or personal representative as appropriate) prior to the personal planning session to discuss the process, to determine who the eligible recipient wishes to invite, and determine the most convenient date, time and location; this meeting preparation shall include an explanation of the techniques the facilitator is proposing to use or options if the facilitator is trained in multiple techniques; the preparation shall also include a discussion of the role the eligible recipient prefers to play at the planning session, which may include co-facilitation of all or part of the session;

(b) arrange for participation of invitees and location;

(c) conduct the personal planning session;

(d) document the results of the personal planning session and provide a copy to the eligible recipient, their authorized representative, or personal representative, the consultant and any other parties the eligible recipient would like to receive a copy.

(2) Elements of this report shall include:

(a) recommended services to be included in the SSP;

(b) services from sources other than MAD to aid the eligible recipient;

(c) long-term goals the eligible recipient wishes to pursue;

(d) potential resources, especially natural supports within the eligible recipient's community that can help the eligible recipient to pursue their desired outcomes(s)/goal(s); and

(e) a list of any follow-up actions to take, including timelines.

(3) Provide session attendees, including the eligible recipient, with an opportunity to provide feedback regarding the effectiveness of the session.

E. Living supports: Living supports are provided in the individual's own home or in the community and may not be provided in residential facilities or agency owned homes.

(1) Homemaker direct support services: Homemaker direct support services are provided on an episodic or continuing basis to assist an eligible recipient 21 years and older with activities of daily living, performance of general household tasks, and enable the eligible recipient to accomplish tasks they would normally do for himself or herself if they did not have a disability. Homemaker direct support services are provided in the eligible recipient's own home and in the community, depending on the eligible recipient's needs. The eligible recipient identifies the homemaker direct support worker's training needs, and, if the eligible recipient is unable to do the training for themselves, the eligible recipient arranges for the needed training. Services are not intended to replace supports available from a primary caregiver. Personal care services are covered under the medicaid state plan as enhanced early and periodic screening, diagnostic and treatment (EPSDT) benefits for mi via eligible recipients under 21 years of age and are not to be included in an eligible recipient's AAB.

(2) Home health aide services: Home health aide services provide total care or assist an eligible recipient 21 years and older in all activities of daily living. Home health aide services assist the eligible recipient in a manner that will promote an improved quality of life and a safe environment for the eligible recipient. Home health aide services can be provided in the eligible recipient's own home and outside the eligible recipient's home. Home health aide services under the waiver differ in nature, scope, supervisory arrangements, or provider type from home health aide services in the state plan. Home health aide services under the waiver provide total care or assistance to a recipient in all activities of daily living in a manner that will promote an improved quality of life

and a safe environment to support the recipient's independence and health needs in the home and in the community. Home health aide services can be provided on a long-term basis for the recipient's habilitative supports whereas, state plan home health aide services address acute conditions; the purpose of which is curative and restorative, with the goal of assisting the recipient to return to an optimum level of functioning and to facilitate timely discharge of the recipient to self-care or to care by their family. Home health aide services are not duplicative of homemaker services. Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Homemakers do not have this ability to perform such tasks. Home health aides are supervised by a RN. Supervision must occur at least once every 60 calendar days in the eligible recipient's home and be in accordance with the New Mexico Nurse Practice Act, Section 61-3-4 et seq. NMSA 1978.

(3) In-home living supports: In-home living supports are related to the eligible recipient's qualifying condition or disability and enable them to live in their apartment or house. Services must be provided in the home or apartment owned or leased by the eligible recipient or in the eligible recipient's home, not to include homes or apartments owned by agency providers. Service coordination and nursing services are not included in this service.

(a) These services and supports are provided in the eligible recipient's own home and are individually designed to instruct or enhance home living skills as well as address health and safety.

(b) In-home living supports include assistance with activities of daily living and assistance with the acquisition, restoration, or retention of independent living skills. This service is provided on a regular basis at least four or more hours per day one or more days per week and may be up to 24 hours per day as specified in the eligible recipient's SLRISP.

(c) Eligible recipients receiving in-home living supports may not use homemaker and direct support home health aide services or respite because they duplicate in-home living supports.

F. Community membership supports:

(1) Community direct support: Community direct support providers deliver support to the eligible recipient to identify, develop and maintain community connections and access social and educational options. This service does not include formal educational (including home schooling and tutoring related activities), or vocational services related to traditional academic subjects or vocational training.

(a) The community direct support provider may be a skilled independent contractor or a hired employee depending on the level of support needed by the eligible recipient to access the community.

(b) The community direct support provider may instruct and model social behavior necessary for the eligible recipient to interact with community members or in groups, provide assistance in ancillary tasks related to community membership, provide attendant care and help the eligible recipient schedule, organize and meet expectations related to chosen community activities.

(c) Community direct support services include:

(i) provide assistance to the eligible recipient outside of their residence;

(ii) promote the development of social relationships and build connections within local communities;

(iii) support the eligible recipient in having frequent opportunities to expand roles in the community to increase and enhance natural supports, networks, friendships and build a sense of belonging; and

(iv) assist in the development of skills and behaviors that strengthen the eligible recipient's connection with their community.

(d) The skills to assist someone in a community setting may be different than those for assisting an eligible recipient at home. The provider will:

(i) demonstrate knowledge of the local community and resources within that community that are identified by the eligible recipient on the SSP; and

(ii) be aware of the eligible recipient's barriers to communicating and maintaining health and safety while in the community setting.

(2) Employment supports: The objective of employment supports services is to provide assistance that will result in community employment jobs for an eligible recipient which increases economic independence, self-reliance, social connections and the ability to grow within their career. Employment supports services are geared to place and support an eligible recipient with disabilities in competitive, integrated employment settings with non-disabled co-workers within the general workforce; or assist the eligible recipient in business ownership. Employment supports include job development and job coaching supports after available vocational rehabilitation supports have been exhausted, including programs funded under Section 110 of the Rehabilitation Act

of 1973 or the Individuals with Disabilities Education Act (IDEA) to an eligible recipient. Employment Services are to be individualized to meet the needs of the recipient and not the needs of a group.

(a) Job development is a service provided to an eligible recipient by a skilled individual. The service has several components:

(i) conducting situational and or vocational assessments;

(ii) developing and identifying community based job opportunities that are in line with the eligible recipient's skills and interests;

(iii) supporting the eligible recipient in gainful skills or knowledge to advocate for theirself in the workplace;

(iv) promoting career exploration for the eligible recipient based on interests within various careers through job sampling, job trials or other assessments as needed;

(v) arranging for or providing benefits counseling;

(vi) facilitating job accommodations and use of assistive technology such as communication devices for the eligible recipient's use;

(vii) providing job site analysis (matching workplace needs with those of the eligible recipient); and

(viii) assisting the eligible recipient in gaining or increasing job seeking skills (interview skills, resume writing, work ethics, etc.).

(b) The job coach provides the following services:

(i) training the eligible recipient to perform specific work tasks on the job;

(ii) vocational skill development to the eligible recipient;

(iii) employer consultation specific to the eligible recipient;

(iv) eligible recipient co-worker training;

(v) job site analysis for an eligible recipient;

(vi) education of the eligible recipient and co-workers on rights and responsibilities;

(vii) assistance with or utilization of community resources to develop a business plan if the eligible recipient elects to start their own business;

(viii) conduct market analysis and establish the infrastructure to support a business specific for the eligible recipient; and

(ix) increasing the eligible recipient's capacity to engage in meaningful and productive interpersonal interactions co-workers, supervisors and customers.

(c) Employment supports will be provided by staff at current or potential work sites. When employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by the eligible recipient receiving mi via services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Federal financial participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

(i) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(ii) payments that are passed through to users of supported employment programs; or

(iii) payments for training that is not directly related to the eligible recipient's supported employment program; and

(iv) FFP cannot be claimed to defray expenses associated with an eligible recipient's start-up or operation of their business.

(3) Customized community group supports: Customized community group supports can include participation in congregate community day programs and community centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills for an eligible recipient. Customized community group supports may include adult day habilitation programs, and other day support models. Customized community group supports are provided in integrated community settings such as day programs and community centers which can take place in non-institutional and non-residential settings. These services are available at least four or more hours per day one or more days per week. Service hours and days are specified in the eligible recipient's SSP.

G. Health and wellness:

(1) Extended skilled therapy for eligible recipients 21 years and older: Extended skilled therapy for adults may include physical therapy, occupational therapy or speech language therapy when skilled therapy services under the medicaid state plan are exhausted or are not a covered benefit. Eligible recipients 21 years and older in the mi via program access therapy services under the state medicaid plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to eligible recipients 21 years and older in the mi via program focus on improving functional independence, health maintenance, community integration, socialization, and exercise, or enhance support and normalization of family relationships.

(a) Physical therapy: Diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy activities do the following:

(i) increase, maintain or reduce the loss of functional skills;

(ii) treat a specific condition clinically related to the eligible recipient's disability;

(iii) support the eligible recipient's health and safety needs; or

(iv) identify, implement, and train on therapeutic strategies to support the eligible recipient and their family or support staff consistent with the eligible recipient's SSP desired outcomes and goals.

(b) Occupational therapy: Diagnosis, assessment, and management of functional limitations intended to assist the eligible recipient to regain, maintain, develop, and build skills that are important for independence, functioning, and health. Occupational therapy services typically include:

(i) customized treatment programs to improve the eligible recipient's ability to perform daily activities;

(ii) comprehensive home and job site evaluations with adaptation recommendations;

(iii) skills assessments and treatment;

(iv) assistive technology recommendations and usage training;

(v) guidance to family members and caregivers;

(vi) increasing or maintaining functional skills or reducing the loss of functional skills;

(vii) treating specific conditions clinically related to the eligible recipient's developmental disability;

(viii) support for the eligible recipient's health and safety needs; and

(ix) identifying, implementing, and training therapeutic strategies to support the eligible recipient and their family or support staff consistent with the eligible recipient's SSP desired outcomes and goals.

(c) Speech and language pathology: Diagnosis, counseling and instruction related to the development and disorders of communication including speech fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal, and sensor motor competencies. Speech language pathology is also used when an eligible recipient requires the use of an augmentative communication device. Based upon therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group. Services are intended to:

(i) improve or maintain the eligible recipient's capacity for successful communication or to lessen the effects of the loss of communication skills; or

(ii) improve or maintain the eligible recipient's ability to eat foods, drink liquids, and manage oral secretions with minimal risk of aspiration or other potential injuries or illness related to swallowing disorders;

(iii) provide consultation on usage and training for augmentative communication devices;

(iv) identify, implement and train therapeutic strategies to support the eligible recipient and their family or support staff consistent with the eligible recipient's SSP desired outcomes and goals.

(d) Behavior support consultation: Behavior support consultation services consist of functional support assessments, positive behavior support plan that is part of the eligible recipient's treatment plan development, and training and support coordination for the eligible recipient's related to behaviors that

compromise the eligible recipient's quality of life. Based on the eligible recipient's SSP, services are delivered in an integrated, natural setting, or in a clinical setting. Behavior support consultation:

(i) informs and guides the eligible recipient's service and support employees or vendors toward understanding the contributing factors to the eligible recipient's behavior;

(ii) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s);

(iii) supports effective implementation based on a functional assessment and support plans;

(iv) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues, and to limit the need for psychotherapeutic medications; and

(v) monitors and adapts support strategies based on the response of the eligible recipient and their service and support providers in order for services to be provided in the least restrictive manner; HCA does not allow the use of any restraints, restrictive interventions, or seclusion to an eligible recipient.

(e) Nutritional counseling: Nutritional counseling services include assessment of the eligible recipient's nutritional needs, development or revision of the eligible recipient's nutritional plan, counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan.

(f) Private duty nursing for adults: Private duty nursing for eligible recipients 21 years or older includes activities, procedures, and treatment for the eligible recipient's physical condition, physical illness or chronic disability. Services include medication management, administration and teaching, aspiration precautions, feeding tube management, gastrostomy and jejunostomy care, skin care, weight management, urinary catheter management, bowel and bladder care, wound care, health education, health screening, infection control, environmental management for safety, nutrition management, oxygen management, seizure management and precautions, anxiety reduction, staff supervision, behavior and self-care assistance.

(2) Specialized therapies: Specialized therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. Experimental or investigational procedures, technologies or therapies and those services covered as a medicaid state plan benefit are excluded. Services in this category include the following therapies:

(a) Acupuncture: Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or behavioral health condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits. See 16.2.1 NMAC.

(b) Biofeedback: Biofeedback uses visual, auditory or other monitors to provide eligible recipients with physiological information of which they are normally unaware. This technique enables an eligible recipient to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

(c) Chiropractic: Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis, for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health. See 16.4.1 NMAC.

(d) Cognitive rehabilitation therapy: Cognitive rehabilitation therapy services are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome an eligible recipient's specific cognitive problems.

(e) Hippotherapy: Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve

functional outcomes. Hippotherapy applies multidimensional movement of a horse for an eligible recipient with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the eligible recipient use cognitive functioning, especially for sequencing and memory. An eligible recipient with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production. Hippotherapy must be performed by a RLD licensed physical therapist, occupational therapist, or speech therapist.

(f) Massage therapy: Massage therapy is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, an eligible recipient's ability to be more independent in the performance of activities of daily living; thereby, decreasing dependency upon others to perform or assist with basic daily activities. See 16.7.1 NMAC.

(g) Naprapathy: Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles, and tendons) interfere with nerve, blood, and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function. See 16.6.1 NMAC.

(h) Native American healers: Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support eligible recipients in their communities by addressing their physical, emotional and spiritual health. Treatments may include prayer, dance, ceremony, song, plant medicines, foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel or other sacred objects.

(i) Play therapy: Play therapy is a variety of play and creative arts techniques utilized to alleviate chronic, mild and moderate psychological and emotional conditions for an eligible recipient that are causing behavioral problems or are preventing the eligible recipient from realizing their potential. The play therapist works integratively using a wide range of play and creative arts techniques, mostly responding to the eligible recipient's direction.

H. Other supports:

(1) Transportation: Payment for transportation is limited to the costs of transportation needed to access waiver services, activities, and resources identified in the recipient's SSP. Transportation services are offered to enable eligible recipients to gain access to services, activities, and resources, as specified by the SSP. Transportation services under the waiver are offered in accordance with the eligible recipient's SSP. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the medicaid state plan are to transport eligible recipients to medically necessary physical and behavioral health services. Non-medical transportation services enable recipients to gain access to waiver and non-medical community services, events, activities and resources as specified in the recipient's SSP related to community resources and services, work, volunteer sites, homes of local family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events. Payment for mi via transportation services is made to the eligible recipient's individual transportation employee or to a public or private transportation service vendor. Payment cannot be made to the eligible recipient. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge shall be identified in the SSP and utilized. Transportation services for minors cannot be provided by a LRI as these are services a LRI would ordinarily provide for household members of the same age who do not have a disability of chronic illness.

(2) Emergency response services: Emergency response services provide an electronic device that enables the eligible recipient to secure help in an emergency at home and avoid institutionalization. The eligible recipient may also wear a portable help button to allow for mobility. The system is connected to the eligible recipient's phone and programmed to signal a response center when a help button is activated. The response center is staffed by trained professionals. Emergency response services include:

(a) testing and maintaining equipment;

(b) training eligible recipients, caregivers and first responders on use of the equipment;

(c) 24-hour monitoring for alarms;

(d) checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.;

(e) reporting emergencies and changes in the eligible recipient's condition that may affect service delivery; and

(f) ongoing emergency response service is covered, but initial set up and installation is not.

(3) Respite: Respite is a flexible family support service, the primary purpose of which is to provide intermittent support to the recipient and give the unpaid primary caregiver relief from their duties on a short-term basis. Respite is provided on a short-term basis to allow the recipient's primary unpaid caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency. Services must only be provided on an intermittent or short-term basis because of the absence or need for relief of those persons normally providing care to the recipient. If there is a paid primary caregiver residing with the eligible recipient providing living supports or community membership supports, or both, respite services cannot be utilized. Respite services include assisting the eligible recipient with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities; assisting the eligible recipient to enhance self-help skills, leisure time skills and community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the eligible recipient to make their own choices with regard to daily activities. Respite services are furnished on a short-term basis and can be provided in the eligible recipient's home, the provider's home, in a community setting of the family's choice (e.g., community center, swimming pool and park) or at a center in which other individuals are provided care. FFP is not claimed for the cost of room and board as part of respite services. Respite cannot be used for purposes of day-care nor can it be provided to school age children during school (including home school) hours.

(4) Individual directed goods and services: Individual directed goods and services are equipment, supplies or services, not otherwise provided through mi via, the medicaid state plan, or medicare. Individual directed goods and services must directly relate to the member's qualifying condition or disability. Individual directed goods and services must explicitly address a clinical, functional, medical, or habilitative need and:

(a) Individual directed goods and services must address a need identified in the eligible recipient's SSP and meet the following requirements:

(i) supports the eligible recipient to remain in the community and reduces the risk for institutionalization; and

(ii) promote personal safety and health; and afford the eligible recipient an accommodation for greater independence; and

(iii) decrease the need for other medicaid services; and

(iv) accommodate the eligible recipient in managing their household or facilitate activities of daily living.

(b) Individual directed goods and services must be documented in the SSP, comply with Subsection D of 8.314.6.17 NMAC, and be approved by the TPA. The cost and type of related good is subject to approval by the TPA. Eligible recipients are not guaranteed the exact type and model of individual directed good or service that is requested. If the eligible recipient requests a good or service, the consultant TPA and MAD can work with the eligible recipient to find other, including less costly, alternatives.

(c) The individual directed goods and services must not be available through another source and the eligible recipient must not have the personal funds needed to purchase the goods or services.

(d) These items are purchased from the eligible recipient's AAB and advance outcomes in the eligible recipient's SSP.

(e) Experimental or prohibited treatments and goods are excluded.

(f) Services and goods that are recreational or diversional in nature are excluded. Recreational and diversional in nature is defined as inherently and characteristically related to activities done for enjoyment.

(g) Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of federal financial participation (FFP) for waiver services.

(5) Environmental modifications: Environmental modification services include the purchase and installation of equipment or making physical adaptations to the eligible recipient's residence that are

necessary to ensure the health, safety, and welfare of the eligible recipient or enhance the eligible recipient level of independence.

(a) Singular or in combination of adaptations include:

(i) the installation of ramps;

(ii) widening of doorways and hallways;

(iii) installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;

(iv) installation of lifts or elevators; modifications of a bathroom facility, such as roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals, bidet adaptations and plumbing;

(v) turnaround space adaptations;

(vi) specialized accessibility and safety adaptations or additions;

(vii) trapeze and mobility tracks for home ceilings; automatic door openers and doorbells;

(viii) voice-activated, light-activated, motion-activated, and other such electronic devices;

(ix) fire safety adaptations;

(x) air filtering devices; heating and cooling adaptations;

(xi) glass substitute for windows and doors;

(xii) modified switches, outlets or environmental controls for home devices; and alarm and alert systems or signaling devices.

(b) All services shall be provided in accordance with applicable federal, state, and local building codes.

(c) Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the eligible recipient, such as fences, storage sheds or other outbuildings. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

(d) The environmental modification provider must:

(i) ensure proper design criteria is addressed in the planning and design of the adaptation;

(ii) be a licensed and insured contractor or approved vendor that provides construction and remodeling services;

(iii) provide administrative and technical oversight of construction projects;

(iv) provide consultation to family members, mi via providers and contractors concerning environmental modification projects to the eligible recipient's residence; and

(v) inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

(e) Environmental modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects.

(f) Environmental modification services are limited to $5,000 every five years. An eligible recipient transferring into the mi via program will carry their history for the previous five years of MAD reimbursed environmental modifications. Environmental modifications must be approved by the TPA.

(g) Environmental modifications are paid from a funding source separate from the AAB.

[8.314.6.15 NMAC - Rp, 8.314.6.15 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.16 NON-COVERED SERVICES: The waiver does not pay for the purchase of goods or services that a household without a person with a disability would be expected to pay for as a routine household or personal expense. Non-covered services include, but are not limited to the following:

A. services covered by the medicaid state plan (including EPSDT), MAD school-based services, medicare and other third-parties; the TPA may verify that a good or service is not covered by another payor source by requesting a denial letter;

B. any service or good, the provision of which would violate federal or state statutes, regulations, rules or guidance;

C. formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the public education department (PED), division of vocational rehabilitation (DVR);

D. food and shelter expenses:

(1) including property-related costs, such as rental or purchase of real estate and furnishing, maintenance, utilities and utility deposits; and

(2) related administrative expenses; utilities include gas, electricity, propane, fire wood, wood pellets, water, sewer, and waste management;

E. experimental or investigational services, procedures or goods, as defined in 8.310.2 NMAC;

F. home schooling materials or related supplemental materials and activities;

G. any goods or services that are considered recreational or diversional in nature as defined in Subparagraph (f) of Paragraph (4) of Subsection (H) of 8.314.6.15 NMAC including but not limited to tickets for movies, theatrical and musical performances, sporting events; zoos, or museums;

H. personal goods or items not related to the disability;

I. animals and costs of maintaining animals including the purchase of food, veterinary visits, grooming and boarding but with the exception of training and certification for service dogs;

J. gas cards and gift cards;

K. purchase of insurance, such as car, cell phone, health, life, burial, renters, home-owners, service warrantees or other such policies;

L. purchase of a vehicle, and long-term lease or rental of a vehicle;

M. purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items;

N. firearms, ammunition or other weapons;

O. gambling, games of chance (such as bingo or lottery), alcohol, tobacco, or similar items;

P. vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses; mileage or driver time reimbursement for vacation travel by automobile;

Q. purchase of usual and customary furniture and home furnishings, *unless* adapted to the eligible recipient's disability or use, or of specialized benefit to the eligible recipient's condition; requests for adapted or specialized furniture or furnishings must include a recommendation from the eligible recipient's health care provider and, when appropriate, a denial of payment from any other source;

R. regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, *except* upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the eligible recipient's qualifying condition or disability;

S. regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, *except* upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the eligible recipient's qualifying condition or disability; requests must include documentation that the adapted vehicle is the eligible recipient's primary means of transportation;

T. clothing and accessories, except adaptive clothing or accessories based on the eligible recipient's disability or condition;

U. training expenses for paid employees;

V. conference or class fees may be covered for eligible recipients or unpaid caregivers, but costs associated with such conferences or class cannot be covered, including airfare, lodging or meals;

W. consumer electronics such as computers, including laptops or any electronic tablets, printers and fax machines, or other electronic equipment that does not meet the criteria specified in Subsection A of 8.314.6.15 NMAC; no more than one of each type of item may be purchased at one time; and consumer electronics may not be replaced more frequently than once every three years; an eligible recipient transferring into the mi via program will carry their history for the previous three years of MAD reimbursed consumer electronics;

X. cell phone services that include more than one cell phone line per eligible recipient; cell phone service, including cell phone service that includes data, is limited to the cost of one hundred dollars per month;

Y. dental services utilizing mi via individual budgetary allotments.

[8.314.6.16 NMAC - Rp, 8.314.6.16 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.17 SERVICE AND SUPPORT PLAN (SSP) AND AUTHORIZED ANNUAL BUDGET(AAB): A SSP and an annual budget request are developed at least annually by the eligible recipient in collaboration with the eligible recipient's consultant and others that the eligible recipient invites to be part of the process. The consultant serves in a supporting role to the eligible recipient, assisting the eligible recipient to understand the mi via

program, and with developing and implementing the SSP and the AAB. The SSP and annual budget request are developed and implemented as specified in 8.314.6 NMAC and mi via service standards and submitted to the TPA for final approval. Upon final approval the annual budget request becomes an AAB.

A. SSP development process: For development of the participant-centered service plan, the planning meetings are scheduled at times and locations convenient to the eligible recipient. This process obtains information about eligible recipient strengths, capacities, preferences, desired outcomes and risk factors through the LOC assessment and the planning process that is undertaken between the consultant and eligible recipient to develop their SSP. If the eligible recipient chooses to purchase personal plan facilitation services, that assessment information would also be used in developing the SSP.

(1) Assessments:

(a) Assessment activities that occur prior to the SSP meeting assist in the development of an accurate and functional plan. The functional assessments conducted during the LOC determination process address the following needs of a person: medical, behavioral health, adaptive behavior skills, nutritional, functional, community/social and employment; LOC assessments are conducted in person and take place in the eligible recipient's home, or in a HCA approved location.

(b) Assessments occur on an annual basis or during significant changes in circumstance or at the time of the LOC determination. After the assessments are completed, the results are made available to the eligible recipient and their consultant for use in planning.

(c) The eligible recipient and the consultant will assure that the SSP addresses the information and concerns, if any, identified through the assessment process.

(2) Pre-planning:

(a) The consultant contacts the eligible recipient upon their choosing enrollment in the mi via program to provide information regarding this program, including the range and scope of choices and options, as well as the rights, risks, and responsibilities associated with self-direction.

(b) The consultant discusses areas of need to address on the eligible recipient's SSP. The consultant provides support during the annual re-determining process to assist with completing medical and financial eligibility in a timely manner.

(c) Personal plan facilitators are optional supports. To assist in pre-planning, the eligible recipient is also able to access an approved provider to develop a personal plan.

(3) SSP components: The SSP contains:

(a) the mi via services that are furnished to the eligible recipient, the projected amount, frequency and duration, and the type of provider who furnishes each service;

(i) the SSP must describe in detail how the services or goods relate to the eligible recipient's qualifying condition or disability;

(ii) the SSP must describe how the services and goods support the eligible recipient to remain in the community and reduce their risk of institutionalization; and

(iii) the SSP must specify the hours of services to be provided and payment arrangements;

(b) other services needed by the mi via eligible recipient regardless of funding source, including state plan services;

(c) informal supports that complement mi via services in meeting the needs of the eligible recipient;

(d) methods for coordination with the medicaid state plan services and other public programs;

(e) methods for addressing the eligible recipient's health care needs when relevant;

(f) quality assurance criteria to be used to determine if the services and goods meet the eligible recipient's needs as related to their qualifying condition or disability;

(g) information, resources or training needed by the eligible recipient and service providers;

(h) methods to address the eligible recipient's health and safety, such as emergency and back-up services; and

(i) the IBA.

(4) Service and support plan meeting:

(a) The eligible recipient receives an LOC assessment and local resource manual prior to the SSP meeting.

(b) The eligible recipient may begin planning and drafting the SSP utilizing those tools prior to the SSP meeting.

(c) During the SSP meeting, the consultant assists the eligible recipient to ensure that the SSP addresses the eligible recipient's goals, health, safety and risks. The eligible recipient and their consultant will assure that the SSP addresses the information and concerns identified through the assessment process. The SSP must address the eligible recipient's health and safety needs before addressing other issues. The consultant ensures that:

(i) the planning process addresses the eligible recipient's needs and goals in the following areas: health and wellness and accommodations or supports needed at home and in the community;

(ii) services selected address the eligible recipient's needs as identified during the assessment process; needs not addressed in the SSP will be addressed outside the mi via program;

(iii) the outcome of the assessment process for assuring health and safety is considered in the plan;

(iv) services do not duplicate or supplant those available to the eligible recipient through the medicaid state plan or other programs;

(v) services are not duplicated in more than one service code;

(vi) job descriptions are complete for each provider and employee in the plan; a job description will include frequency, intensity and expected outcomes for the service;

(vii) the quality assurance section of the SSP is complete and specifies the roles of the eligible recipient, consultant and any others listed in this section;

(viii) the responsibilities are assigned for implementing the plan;

(ix) the emergency and back-up plans are complete; and

(x) the SSP is submitted to the TPA after the SSP meeting, in compliance with mi via rules and service standards.

B. Individual budgetary allotment (IBA): Each eligible recipient's annual IBA is determined by MAD or its designee as follows.

(1) Budgetary allotments are based on calculations developed by MAD for each mi via population group, utilizing historical traditional waiver care plan authorized budgets within the population, minus the case management costs, and minus a ten percent discount.

(2) The determination of each eligible recipient's sub-group is based on a comprehensive assessment. The eligible recipient then receives the IBA available to that category of need, according to the eligible recipient's age.

(3) An eligible recipient has the authority to expend the IBA through an AAB that is to be expended on a monthly basis and in accordance with the mi via rules and program service standards.

(a) The state and CMS approves a range of rates, as applicable, for mi via services wherein each recipient or EOR can self-direct and establish their own rate with a particular provider of a service. The current rate schedule is available on the HCA website. Mi via recipients, or EORs, are required to negotiate and determine the rate for their employees and services within the range of rates established by the state. Justification for paying more than the established rates must be submitted, in writing, to the TPA for consideration. The established rate may not be exceeded in order to pay for additional services the employee or provider may provide which are outside the scope of the specific service for which the employee or provider is approved; nor can a rate exception be approved for credentials that exceed those required to provide the service unless the credentials specifically meet criteria below. To exceed the established range of rates the following criteria must be met:

(i) behavioral conditions: the recipient's behaviors are of a severity that pose considerable risk to the eligible recipient, caregivers or the community; and require a frequency and intensity of assistance to ensure the eligible recipient's health and safety in the home or the community or supervision or consultation requiring specialized or unique behavioral supports; these services cannot be accessed through other services; or

(ii) medical conditions: the recipient has ongoing need for intense medical supports including oxygen monitoring, diabetic monitoring, skin breakdown, J and G tube feedings, ostomy and urology care, catheter insertion, digital extractions, suctioning, nebulizer treatments, routine order treatments in the prevention of infections, and responsive awareness to severe allergic reactions; or

(iii) specialized supports: in order to support the recipient's inclusion in the community the recipient requires specialized support that can enhance communicative or functional skills such as american sign language or programming of adaptive communication devices; or

(iv) location: the recipient lives in a geographic location, within New Mexico, with limited providers. The recipient, or guardian, has researched multiple providers and has been unable to identify another provider in the geographic location available to provide the service within the range of rates. The service goal must specify the recipient's need for this service and contact with available local provider within six months of the date of request including reason why alternate providers are not available.

(b) The AAB shall contain goods and services necessary for health and safety (i.e., direct care services and medically related goods) which will be given priority over goods and services that are non-medical or not directly related to health and safety. This prioritization applies to the IBA, AAB, and any subsequent modifications.

C. SSP review criteria: Services and related goods identified in the eligible recipient's requested SSP may be considered for approval if the following requirements are met:

(1) the services or goods must be responsive to the eligible recipient's qualifying condition or disability and must address the eligible recipient's clinical, functional, medical or habilitative needs; and

(2) the services or goods must accommodate the eligible recipient in managing their household; or

(3) the services or goods must facilitate activities of daily living; or

(4) the services or goods must promote the eligible recipient's personal health and safety; and

(5) the services or goods must afford the eligible recipient an accommodation for greater independence; and

(6) the services or goods must support the eligible recipient to remain in the community and reduce his/her risk for institutionalization; and

(7) the services or goods must be documented in the SSP and advance the desired outcomes in the eligible recipient's SSP; and

(8) the SSP contains the quality assurance criteria to be used to determine if the service or goods meet the eligible recipient's need as related to the qualifying condition or disability; and

(9) the services or goods must decrease the need for other MAD services; and

(10) the eligible recipient receiving the services or goods does not have the funds to purchase the services or goods; or

(11) the services or goods are not available through another source; the eligible recipient must submit documentation that the services or goods are not available through another source, such as the medicaid state plan or medicare; and

(12) the service or good is not prohibited by federal regulations, NMAC rules, billing instructions, standards, and manuals; and

(13) each service or good must be listed as an individual line item whenever possible; however, when a service or a good are 'bundled' the SSP must document why bundling is necessary and appropriate.

D. Budget review criteria: The eligible recipient's proposed annual budget request may be considered for approval, if all of the following requirements are met:

(1) the proposed annual budget request is within the eligible recipient's IBA; and

(2) the proposed rate for each service is within the mi via range of rates for that chosen service; and

(3) the proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and

(4) the estimated cost of the service or good is specifically documented in the eligible recipient's budget worksheets; and

(5) no employee exceeds 40 hours paid work in a consecutive seven-day work week.

E. Modification of the SSP:

(1) The SSP may be modified based upon a change in the eligible recipient's needs or circumstances, such as a change in the eligible recipient's health status or condition or a change in the eligible recipient's support system, such as the death or disabling condition of a family member or other individual who was providing services.

(2) If the modification is to provide new or additional services than originally included in the SSP, these services must not be able to be acquired through other programs or sources. The eligible recipient must document the fact that the services are not available through another source.

(3) The eligible recipient must provide written documentation of the change in needs or circumstances as specified in the mi via service standards. The eligible recipient submits the documentation to the consultant. The consultant initiates the process to modify the SSP by forwarding the request for modification to the TPA for review.

(4) The SSP must be modified before there is any change in the AAB.

(5) The SSP may be modified once the original SSP has been submitted and approved. Only one SSP revision may be submitted at a time, e.g., a SSP revision may not be submitted if an initial SSP request or prior SSP revision request is under initial review by the TPA. This requirement also applies to any re-consideration of the same revision request. Other than for critical health and safety reasons, neither the SSP nor the AAB may be modified within 60 calendar days of expiration of the current SSP.

F. Modifications to the eligible recipient's annual budget: Revisions to the AAB may occur within the SSP year, and the eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. The SSP must be amended first to reflect a change in the eligible recipient's needs or circumstances before any revisions to the AAB can be requested.

(1) Budget revisions involve requests to add new goods or services to a budget or to reallocate funds from any line item to another approved line item. Budget revisions must be submitted to the TPA for review and approval. Other than for critical health and safety reasons for the eligible recipient, budget revisions may not be submitted to the TPA for review within the last 60 calendar days of the budget year.

(2) The amount of the AAB cannot exceed the eligible recipient's annual IBA. The rare exception would be the eligible recipient whose assessed or documented needs, based on their qualifying condition, cannot be met within the annual IBA, in which case the eligible recipient would initiate a request for an adjustment through their consultant.

(3) Mi via budgets are developed by service. A recipient may request an increase to their budget above their annual IBA, or AAB, as applicable if services necessary for health and safety cannot be met within the IBA, or AAB. Prioritization, as described in Subparagraph (b) of Paragraph (3) of Subsection B of 8.314.6.17 NMAC applies. Requests for additional funding are built in the annual budget and are specific to the service that is being requested. If the eligible recipient requests an increase in their budget above their annual IBA, or AAB, as applicable, the eligible recipient must show at least one of the following four circumstances related to the specific service for which an increase to the additional funding is being requested:

(a) chronic physical condition: the eligible recipient has one or more chronic physical conditions, which are identified during the initial or reevaluation of the LOC, that result in a prolonged dependency on medical services or care, for which daily intervention is medically necessary; and the eligible recipient's needs cannot be met within the assigned IBA or other current resources, including natural supports, medicaid state plan services, medicare or other sources; the eligible recipient must submit a written, dated, and signed evaluation or letter from a medical doctor (MD), doctor of osteopathy (DO), a certified nurse practitioner (CNP) or a physician assistant (PA) that documents the chronic physical condition in the eligible recipient's health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the chronic physical conditions are characterized by at least one of the following:

(i) a life-threatening condition with frequent or constant periods of acute exacerbation that places the eligible recipient at risk for institutionalization; that could result in the eligible recipient's inability to remember to self-administer medications accurately even with the use of assistive technology devices; or that requires a frequency and intensity of assistance, supervision, or consultation to ensure the eligible recipient's health and safety in the home or in the community; or which, in the absence of such skilled intervention, assistance, medical supervision or consultation, would require hospitalization or admission to a NF or ICF-IID;

(ii) the need for administration of specialized medications, enteral feeding or treatments that are ordered by a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant; which require frequent and ongoing management or monitoring or oversight of medical technology;

(b) change in physical status: the eligible recipient has experienced a deterioration or permanent change in their health status such that the eligible recipient's needs for services and supports can no longer be met within the IBA, current AAB or other current resources, including natural supports, medicaid state plan services, medicare or other sources; the eligible recipient must submit a written, dated, and signed evaluation or letter from a MD, OD, CNP, or PA that documents the change in the eligible recipient's health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the eligible recipient may submit additional supportive documentation by others involved in the eligible recipient's care, such as a current individual service plan (ISP) if

the eligible recipient is transferring from another waiver, a recent evaluation from a specialist or therapist, a recent discharge plan, relevant medical records or other documentation or recent statements from family members, friends or other support individuals; types of physical health status changes that may necessitate an increase in the IBA or current AAB are as follows:

(i) the eligible recipient now requires the administration of medications via intravenous or injections on a daily or weekly basis;

(ii) the eligible recipient has experienced recent onset or increase in aspiration of saliva, foods or liquids;

(iii) the eligible recipient now requires external feedings, e.g. naso-gastric, percutaneous endoscopic gastrostomy, gastric-tube or jejunostomy-tube;

(iv) the eligible recipient is newly dependent on a ventilator;

(v) the eligible recipient now requires suctioning every two hours, or more frequently, as needed;

(vi) the eligible recipient now has seizure activity that requires continuous monitoring for injury and aspiration, despite anti-convulsant therapy; or

(vii) the eligible recipient now requires increased assistance with activities of daily living as a result of a deterioration or permanent changes in their physical health status;

(c) chronic or intermittent behavioral conditions or cognitive difficulties: the eligible recipient has chronic or intermittent behavioral conditions or cognitive difficulties, which are identified during the initial or reevaluation LOC assessment, or the eligible recipient has experienced a change in their behavioral health status, for which the eligible recipient requires additional services, supports, assistance, or supervision to address the behaviors or cognitive difficulties in order to keep the eligible recipient safe; these behaviors or cognitive difficulties are so severe and intense that they result in considerable risk to the eligible recipient, caregivers or the community; and require a frequency and intensity of assistance, supervision or consultation to ensure the eligible recipient's health and safety in the home or the community; in addition, these behaviors are likely to lead to incarceration or admission to a hospital, nursing facility or ICF-IID; require intensive intervention or medication management by a doctor or behavioral health practitioner or care practitioner which cannot be effectively addressed within the IBA, current AAB or other resources, including natural supports, the medicaid state plan services, medicare or other sources;

(i) examples of chronic or intermittent behaviors or cognitive difficulties are such that the eligible recipient injures themselves frequently or seriously; has uncontrolled physical aggression toward others; disrupts most activities to the extent that their SSP cannot be implemented or routine activities of daily living cannot be carried out; withdraws personally from contact with most others; or leaves or wanders away from the home, work or service delivery environment in a way that puts themselves or others at risk;

(ii) the eligible recipient must submit a written, dated, and signed evaluation or letter from a licensed MD, doctor of osteopathy (DO), CNP, physician assistant (PA), psychiatrist, or RLD licensed psychologist that documents the change in the eligible recipient's behavioral health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the eligible recipient may submit additional supportive documentation including a current ISP if the eligible recipient is transferring from another waiver, a positive behavioral support plan or assessment, recent notes, a summary or letter from a behavioral health practitioner or professional with expertise in intellectual or developmental disabilities, recent discharge plan, recent recommendations from a rehabilitation facility, any other relevant documentation or recent statements from family members, friends or other support individuals involved with the eligible recipient.

(d) change in natural supports: the eligible recipient has experienced a loss, as a result of situations such as death, illness, or disabling condition, of their natural supports, such as family members or other community resources that were providing direct care or services, whether paid or not. This absence of natural supports or other resources is expected to continue throughout the period for which supplemental funds are requested. The type, intensity or amount of care or services previously provided by natural supports or other resources cannot be acquired within the IBA and are not available through the medicaid state plan services, medicare, other programs or sources in order for the eligible recipient to live in a home and community-based setting.

(4) The eligible recipient is responsible for tracking all budget expenditures and assuring that all expenditures are within the AAB. The eligible recipient must not exceed the AAB within any SSP year. The eligible recipient's failure to properly allocate the expenditures within the SSP year resulting in the depletion of the AAB, due to mismanagement of or failure to track the funds, prior to the calendared expiration date does not

substantiate a claim for a budget increase (i.e., if all of the AAB is expended within the first three months of the SSP year, it is not justification for an increase in the annual budget for that SSP year). Amendments to the AAB may occur within the SSP year and the eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. Amendments to the AAB must be preceded by an amendment to the SSP.

(5) The AAB may be revised once the original annual budget request has been submitted and approved. Only one annual budget revision request may be submitted at a time, e.g., an annual budget revision request may not be submitted if a prior annual budget revision request is under initial review by the TPA. The same requirement also applies to any reconsideration of the same revision request.

G. SSP and annual budget supports: As specified in 8.314.6 NMAC and its service standards, the eligible recipient is assisted by their consultant in development and implementation of the SSP and AAB. The FMA assists the eligible recipient with implementation of the AAB.

H. Submission for approval: The TPA must approve the SSP and associated annual budget request (resulting in an AAB). The TPA must approve certain changes in the SSP and annual budget request, as specified in 8.314.6 NMAC and mi via service standards and in accordance with 8.302.5 NMAC.

(1) At any point during the SSP and associated annual budget utilization review process, the TPA may request additional documentation from the eligible recipient. This request must be in writing and submitted to both the eligible recipient and the consultant provider. The eligible recipient has seven working days from the date of the initial request to respond with additional documentation. The TPA will issue a second request for information on the seventh day if information was not received and issue a final request for information 14 working days after the initial request. The eligible recipient has a total of 21 working days to respond with additional documentation. Failure by the eligible recipient to submit the requested information may subject the SSP and annual budget request to denial.

(2) Services cannot begin and goods may not be purchased before the start date of the approved SSP and AAB or approved revised SSP and revised AAB.

(3) Any revisions requested for other than critical health or safety reasons within 60 calendar days of expiration of the SSP and AAB are subject to denial for that reason.

[8.314.6.17 NMAC - Rp, 8.314.6.17 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services, including services covered under the mi via program, are subject to utilization review for medical necessity and program requirements. Reviews by MAD or its designees may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made in accordance with 8.310.2 NMAC.

A. Prior authorization: Services, supports, and goods specified in the SSP and AAB require prior authorization from HCA/MAD or its designee. The SSP must specify the type, amount and duration of services. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: To be eligible for mi via program services, eligible recipients must require the LOC of services provided in an ICF-IID. Prior authorization of services does not guarantee that applicants or eligible recipients are eligible for MAP or mi via services.

C. Reconsideration: If there is a disagreement with a prior authorization denial or other review decision, the consultant provider on behalf of the eligible recipient, can request reconsideration from the TPA that performed the initial review and issued the initial decision. Reconsideration must be requested within 30-calendar days of the date on the denial notice, must be in writing and provide additional documentation or clarifying information regarding the eligible recipient's request for the denied services or goods.

D. Denial of payment: If a service, support, or good is not covered under the mi via program, the claim for payment may be denied by MAD or its designee. If it is determined that a service is not covered before the claim is paid, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

[8.314.6.18 NMAC - Rp, 8.314.6.18 NMAC, 3/1/2016]

8.314.6.19 REIMBURSEMENT:

A. Mi via eligible recipients must follow all billing instructions provided by the FMA to ensure payment of service providers, employees, and vendors.

B. Claims must be billed to the FMA per the billing instructions. Reimbursement to a service provider and a vendor in the mi via program is made, as follows:

(1) mi via service provider and vendor must enroll with the FMA;

(2) the eligible recipient receives instructions and documentation forms necessary for a service provider's and a vendor's claims processing;

(3) an eligible recipient must submit claims for payment of their mi via service provider and vendor to the FMA for processing; claims must be filed per the billing instructions provided by the FMA;

(4) the eligible recipient and their mi via service provider and vendor must follow all FMA billing instructions; and

(5) reimbursement of a mi via service provider and vendor is made at a predetermined reimbursement rate negotiated by the eligible recipient with the mi via service provider or vendor, approved by the TPA contractor, and documented in the SSP and in the mi via provider or vendor agreement; at no time can the total expenditure for services exceed the eligible recipient's AAB.

C. The FMA must submit claims that have been paid by the FMA on behalf of eligible recipient to the MAD fiscal contractor for processing.

D. Reimbursement may not be made directly to the eligible recipient, either to reimburse them for expenses incurred or to enable the eligible recipient to pay a service provider directly.

[8.314.6.19 NMAC - Rp, 8.314.6.19 NMAC, 3/1/2016]

8.314.6.20 RIGHT TO A HCA ADMINISTRATIVE HEARING:

A. MAD must grant an opportunity for a HCA administrative hearing as described in 8.314.6.20 NMAC in the following circumstances and pursuant to 42 CFR Section 431.220(a)(1) and (2), Section 27-3-3 NMSA 1978 and 8.352.2 NMAC:

(1) when an applicant has been determined not to meet the LOC requirement for mi via program services;

(2) when an applicant has not been given the choice of HCBS as an alternative to institutional care;

(3) when an applicant is denied the services of their choice or the provider of their choice;

(4) when an eligible recipient's services are denied, suspended, reduced or terminated;

(5) when an eligible recipient has been involuntarily terminated from the program;

(6) when an eligible recipient's request for a budget adjustment has been denied; and

(7) when any other adverse action is taken by MAD against the eligible recipient, see 8.352.2 NMAC.

B. DOH and its counsel, if necessary, shall participate in any relevant HCA administrative hearing involving an eligible recipient. HCA's office of general counsel may elect to participate in the administrative hearing. See 8.352.2 NMAC for a complete description, instructions, and hearing process of a HCA administrative hearing for an eligible recipient.

[8.314.6.20 NMAC - Rp, 8.314.6.20 NMAC, 3/1/2016]

8.314.6.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to an eligible recipient who requests a HCA administrative hearing within the timeframe defined in 3.352.2 NMAC. The notice will include information on the right to continue the eligible recipient's benefits and on their responsibility for repayment if the HCA administrative final hearing decision is not in the eligible recipient's favor. See 8.352.2 NMAC for a complete description of the continuation of benefits process of a HCA administrative hearing for an eligible recipient.

B. The continuation of a benefit is only available to an eligible recipient that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the eligible recipient's current allocation, budget or LOC. The continuation budget may not be revised until the conclusion of the HCA administrative hearing process unless one of the criteria to modify the budget in 8.314.6.17 NMAC is met. See 8.352.2 NMAC for a complete description, instructions and process of a HCA administrative hearing and continuation of benefits process of a MAP eligible recipient.

[8.314.6.21 NMAC - Rp, 8.314.6.21 NMAC, 3/1/2016]

8.314.6.22 GRIEVANCE/COMPLAINT SYSTEM: An eligible recipient has the opportunity to register a grievance or complaint concerning the mi via program. An eligible recipient may register complaints via e-mail, mail or phone. Complaints will be referred to the appropriate division or as appropriate referred to MAD for resolution. The filing of a complaint or grievance does not preclude an eligible recipient from pursuing a HCA

administrative hearing. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for requesting a HCA administrative hearing.
[8.314.6.22 NMAC - Rp, 8.314.6.22 NMAC, 3/1/2016]

HISTORY OF 8.314.6 NMAC:

History of Repealed Material:
8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, filed 11/16/2006 - Repealed effective 4/1/2011.
8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, filed 3/15/2011 - Repealed effective 10/15/2012.
8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, filed 10/2/2012 - Repealed effective 3/1/2016.

TITLE 8 SOCIAL SERVICES
CHAPTER 314 LONG TERM CARE SERVICES - WAIVERS
PART 7 SUPPORTS WAIVER

8.314.7.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.314.7.1 NMAC - N, 4/1/2021; A, 7/1/2024]

8.314.7.2 SCOPE: The rule applies to the general public.
[8.314.7.2 NMAC - N, 4/1/2021]

8.314.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Titles XI, XIX, and XXI of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.314.7.3 NMAC - N, 4/1/2021; A, 7/1/2024]

8.314.7.4 DURATION: Permanent.
[8.314.7.4 NMAC - N, 4/1/2021]

8.314.7.5 EFFECTIVE DATE: April 1, 2021, unless a later date is cited at the end of a section.
[8.314.7.5 NMAC - N, 4/1/2021]

8.314.7.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.314.7.6 NMAC - N, 4/1/2021]

8.314.7.7 DEFINITIONS:

A. Activities of daily living (ADLs): Basic personal everyday activities that include bathing, dressing, transferring (e.g., from bed to chair), toileting, mobility and eating.

B. Adult: An individual who is 18 years of age or older.

C. Agency-based: Supports waiver service delivery model offered to an eligible recipient who does not want to direct their supports waiver services. Agency-based services are provided by an agency with an approved agreement with department of health (DOH) to provide supports waiver services.

D. Authorized annual budget (AAB): The total approved annual amount of the community support services and goods which includes the frequency, the amount, and the duration of the waiver services and the cost of waiver goods approved by the third-party assessor (TPA).

E. Authorized representative: The individual designated to represent and act on the recipient's behalf. The authorized representative does not have budget or employer authority. The eligible recipient or authorized representative must provide legal documentation authorizing the named individual or individuals 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 other legal designation. The eligible recipient's authorized representative may not be a service provider. The authorized representative may not approve their own timesheets. The authorized representative cannot serve as the eligible recipient's community supports coordinator.

F. Category of eligibility (COE): To qualify for a medical assistance program (MAP), an applicant must meet financial criteria and belong to one of the groups that the New Mexico medical assistance division (MAD) has defined as eligible. An eligible recipient in the supports waiver program must belong to the MAP categories of eligibility (COE) described in 8.314.7.9 NMAC.

G. Centers for medicare and medicaid services (CMS): Federal agency within the United States department of health and human services that works in partnership with New Mexico to administer medicaid and MAP services under HCA.

H. Child: An individual under the age of 18. For purpose of early periodic screening, diagnosis, and treatment (EPSDT) services eligibility "child" is defined as an individual under the age of 21.

I. Community supports coordinator (CSC): An agency or an individual that provides case management services to the eligible recipient that assist the eligible recipient in arranging for, directing and managing supports waiver program services and supports, as well as developing, implementing and monitoring the individual service plan (ISP) and AAB.

J. Electronic visit verification (EVV): A telephone and computer-based system that electronically verifies the occurrence of HCA selected service visits and documents the precise time the service begins and ends.

K. Eligible recipient: An applicant meeting the financial and medical level of care (LOC) criteria who is approved to receive MAD services through the supports waiver.

L. Employer of record (EOR): The employer of record (EOR) is the individual responsible for directing the work of the support's waiver employees, including recruiting, hiring, managing and terminating employees. The EOR is responsible for directing the work of any vendors contracted to perform services. The EOR tracks expenditures for employee payroll, goods, and services. EORs authorize the payment of timesheets and vendor payment requests by the financial management agency (FMA). An eligible recipient may be their own EOR unless the eligible recipient is a minor or has a plenary or limited guardianship or conservatorship over financial matters in place. An EOR must be the waiver participant or an EOR must be a legal representative of the recipient.

M. Financial management agency (FMA): HCA contractor that helps implement the AAB by paying the eligible recipient's service providers and tracking expenses.

N. Individual budgetary allotment (IBA): The maximum budget allotment available to an eligible recipient. The maximum IBA under the supports waiver is $10,000 dollars. Based on this maximum amount, the eligible recipient will develop a plan to meet their assessed functional, medical, and habilitative needs to enable the recipient to remain in the community.

O. Individual service plan (ISP): The ISP is the name of the person-centered plan for the supports waiver. The ISP includes waiver services that meet the eligible recipient's needs including: the projected amount, the frequency and the duration of the waiver services; the type of provider who will furnish each waiver service; other services the eligible recipient will access; and the eligible recipient's available supports that will complement waiver services in meeting their needs.

P. Intermediate care facilities for individuals with intellectual disabilities (ICF/IID): Facilities that are licensed and certified by the New Mexico department of health to provide room and board, continuous active treatment and other services for eligible MAD recipients with a primary diagnosis of intellectually disabled.

Q. Legal representative: A person that is a legal guardian, conservator, power of attorney or otherwise has a court established legal relationship with the eligible recipient. The eligible recipient must provide certified documentation to the community support coordinator provider and FMA of the legal status of the representative and such documentation will become part of the eligible recipient's file.

R. Level of care (LOC): The level of care an eligible recipient must meet to be eligible for the supports waiver program.

S. Participant directed: Supports waiver service delivery model wherein the eligible recipient identifies, accesses and manages the employees and vendors of services (among the state-determined waiver services and goods) that meet their assessed therapeutic, rehabilitative, habilitative, health or safety needs to support the eligible recipient to remain in their community.

T. Person-centered planning (PCP): Person-centered planning is a process that places a person at the center of planning their life and supports. It is an ongoing process that is the foundation for all aspects of the supports waiver and provider's work with individuals with intellectual/developmental disabilities (I/DD). The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the eligible recipient. The process may include other persons, freely chosen by the eligible recipient who are able to serve as important contributors to the process. It involves person-centered thinking, person-centered service planning and person-centered practice. The PCP enables and assists the recipients' strengths, capacities, preferences, needs, and desired outcomes of the eligible recipient.

U. Reconsideration: A written request by an eligible recipient who disagrees with a clinical/medical utilization review decision or action submitted to the third-party assessor for reconsideration of the decision. The eligible recipient or their authorized representative may submit the request for a reconsideration through the community support coordinator or the community support coordinator agency may submit the request directly to MAD.

V. Third-party assessor (TPA): The MAD contractor who determines and re-determines LOC and medical eligibility for the supports waiver program. The TPA also reviews the eligible recipient's ISP and approves the AAB for the eligible recipient. The TPA performs utilization management duties for all supports waiver services.

W. **Waiver:** A program in which the federal government has waived certain statutory requirements of the Social Security Act to allow states to provide an array of home and community-based service options through MAD as an alternative to providing long-term care services in an institutional setting.
[8.314.7 NMAC - N, 4/1/2021]

8.314.7.8 **MISSION STATEMENT:** To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.314.7.8 NMAC - N, 4/1/2021]

8.314.7.9 **SUPPORTS WAIVER HOME AND COMMUNITY-BASED SERVICES:**

A. New Mexico's supports waiver is designed to provide temporary assistance to those on the developmental disabilities (DD) waiver wait list. It is intended to provide support services to eligible recipients to enable work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across the lifespan. The services provided are intended to build on each eligible recipient's current support structures through person-centered planning to work toward individually defined life outcomes, focusing on developing the eligible recipient's abilities for self-determination, community living and participation, and economic self-sufficiency. An eligible recipient has a choice of receiving services through the agency-based service delivery model or the participant directed service delivery model.

B. The program is operated by the developmental disabilities supports division (DDSD), at the direction of the New Mexico health care authority (HCA) medical assistance division (HCA/MAD).
[8.314.7.9 NMAC - N, 4/1/2021]

8.314.7.10 **ELIGIBLITY REQUIREMENTS FOR RECIPIENT ENROLLMENT:** Enrollment in the supports waiver is contingent upon the applicant meeting the eligibility requirements, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated eligible recipients. When sufficient funding is available, DOH will offer the supports waiver to eligible recipients on the DD wait list. Once an offer has been given to the applicant, they must meet certain medical and financial criteria in order to qualify for enrollment. Eligible recipients must meet the following eligibility criteria: financial eligibility criteria determined in accordance with 8.290.400 NMAC; the eligible recipient must meet the level of care (LOC) required for admittance to an intermediate care facility for individuals with intellectual disabilities (ICF/IID); and additional specific criteria as specified in the categories below.
[8.314.7.10 NMAC - N, 4/1/2021]

8.314.7.11 **ELIGIBLE RECIPIENT RESPONSIBILITIES:** Supports waiver eligible recipients have responsibilities to participate in the program. Failure to comply with these responsibilities or other program rules and service standards can result in termination from the program. The eligible recipient has the following responsibilities:

A. To maintain eligibility the recipient must complete required documentation demonstrating medical and financial eligibility both upon application and annually at recertification, and seek assistance with the application and the recertification process as needed from a community supports coordinator (CSC).

B. To participate in the supports waiver program, the eligible recipient must:

(1) comply with applicable NMAC rules to include this rule and supports waiver service standards and requirements that govern the program;

(2) collaborate with the CSC to choose between the agency-based or participant directed service delivery models, and determine support needs related to planning and self direction as applicable;

(3) collaborate with the CSC to develop an ISP and budget using the IBA in accordance with applicable NMAC rules to include this rule and supports waiver service standards;

(4) use supports waiver program funds appropriately by only requesting and purchasing goods and services covered by the supports waiver program in accordance with program rules which are identified in the eligible recipient's approved ISP and budget;

(5) comply with the approved ISP and not exceed the AAB;

(a) if the eligible recipient, due to mismanangement or failure to properly track expenditures, prematurely depletes the AAB amount during an ISP year, the failure to properly manage the AAB does not substantiate a claim for a budget increase (e.g. if all of the AAB is expended within the first three months of the ISP year, it is not justification for an increase in the budget for the ISP year);

(b) revisions to the AAB may occur within the ISP year, and the eligible recipient is responsible for ensuring that all expenditures are in compliance with the most current AAB in effect;

(i) the ISP must be amended to reflect a change in the eligible recipient's needs or circumstances before any revisions to the AAB can be requested;

(ii) other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review within the last 60 calendar days of the budget year;

(c) no supports waiver program funds can be used to purchase goods or services prior to TPA approval of the ISP and annual budget request;

(d) any funds not utilized within the ISP and AAB year cannot be carried over into the following year;

(6) access CSC services based upon identified need(s) in order to carry out the approved ISP;

(7) collaborate with the CSC to appropriately document service delivery and maintain documents for evidence of services received;

(8) report concerns or problems with any part of the supports waiver program to the community supports coordinator or if the concern or problem is with the CSC, to DOH;

(9) work with the TPA by providing documentation and information as requested;

(10) respond to requests for additional documentation and information from the CSC provider, FMA, and the TPA within the required deadlines;

(11) report to the local HCA income support division (ISD) office within 10 calendar days any change in circumstances, including a change in address, which might affect eligibility for the program; changes in address or other contact information must also be reported to the CSC provider and the financial management agency (FMA) within 10 calendar days;

(12) report to the TPA and CSC provider if hospitalized for more than three consecutive nights so that an appropriate LOC can be obtained;

(13) have monthly contact and meet face-to-face quarterly with the CSC, as required by the DOH; and

(14) comply with all electronic visit verification (EVV) requirements.

C. Specific responsbilities for eligible recipient in participant directed service delivery model: In addition to the requirements in Subsection A and B of 8.314.7.11 NMAC, the eligible recipient must have an employer of record (EOR) to participate in the participant directed service delivery model. The EOR may be the eligible recipient unless the eligible recipient is a minor or has a plenary or limited guardianship or conservatorship over financial matters in place. An EOR must be the waiver participant or an EOR must be a legal representative of the recipient. The eligible recipient as their own EOR or the designated EOR must:

(1) direct the work of supports waiver employees, including recruiting, hiring, managing and terminating all employees;

(2) direct the work of any vendors contracted to perform services;

(3) track expenditures for employee payroll, goods, and services;

(4) authorize the payment of timesheets and vendor payment requests by the FMA;

(5) keep track of all budget expenditures and ensure that all expenditures are within the AAB;

(6) submit all required documents to the FMA to meet employer-related responsibilities. This includes, but is not limited to, documents for payment to employees and vendors and payment of taxes and other financial obligations within required timelines;

(7) complete all trainings within the required timeframes by the DOH or medical assistance division (MAD);

(8) ensure that all employees have registered and completed required trainings within the timeframes required by the DOH or MAD, identified in the ISP or identified by the EOR;

(9) report any incidents of abuse, neglect or exploitation to the appropriate state agency;

(10) arrange for the delivery of services, supports and goods;

(11) maintain records and documentation for at least six years from first date of service and ongoing; and

(12) comply with all electronic visit verification (EVV) requirements.

D. Voluntary termination: The supports waiver eligibile recipient may voluntarily terminate services through the supports waiver and will not lose their place on DD waiver wait list.

E. Involuntary termination: A supports waiver eligible recipient may be terminated involuntarily by MAD and DOH for the following:

(1) the eligible recipient refuses to comply with 8.314.7 NMAC and the supports waiver service standards, after receiving focused technical assistance from DOH and MAD program staff, CSC, or FMA, which is supported by documentation of the efforts to assist the eligible recipient;

(2) the eligible recipient is an immediate risk to their health or safety, imminent risk of death or serious bodily injury, by continued participant direction of services. Examples include but are not limited to the following:

(a) the eligible recipient refuses to include and maintain services in their ISP and AAB that would address health and safety issues identified in their ISP or challenges the ISP after repeated and focused technical assistance and support from program staff, CSC, or FMA;

(b) the eligible recipient is experiencing significant health or safety needs, and either refuses to incorporate a plan to address health and safety needs or document applicable choices in ISP;

(c) the eligible recipient exhibits behaviors which endanger themselves or others after repeated and focused technical assistance and support from program staff, CSC, or FMA.

(3) the eligible recipient misuses suppports waiver funds following repeated and focused technical assistance and support from the CSC or FMA, which is supported by documentation;

(4) the eligible recipient commits medicaid fraud;

(5) when the DOH is notified that the eligible recipient continues to utilize either an employee or a vendor, or both, who have consistently been substantiated against for abuse, neglect or exploitation while providing supports waiver services after notification of this by DOH;

(6) the eligible recipient who is involuntarily terminated from the supports waiver will remain on the DD waiver wait list, and will continue to have access to other medicaid benefits based on eligibility.
[8.314.7.11 NMAC - N, 4/1/2021]

8.314.7.12 SUPPORTS WAIVER CONTRACTED ENTITIES AND PROVIDERS: Services are to be provided in the least restrictive manner. The HCA does not allow for the use of any restraints, restrictive interventions, or seclusions to an eligible supports waiver recipient. The following resources and services have been established to assist eligible recipients to access supports waiver services through the agency-based service delivery model or the participant directed service delivery model. These include the following:

A. Community supports coordinator (CSC) services: CSC services are direct services intended to assist the eligible recipient in attaining and maintaining medical and financial eligibility; educating, guiding and assisting the eligible recipient to make informed planning decisions about service and supports; developing an ISP through a person-centered planning process; implementing and monitoring the ISP and AAB; and under the agency-based service delivery model, arranging for, directing, and managing supports waiver services and supports.

B. Financial management agency (FMA): For eligible recipients selecting the participant directed service delivery model, the FMA acts as the intermediary between the eligible recipient and the MAD payment system and assists the eligible recipient or the EOR with employer-related responsibilities. The FMA pays employees and vendors based upon an approved AAB. The FMA assures there is eligible recipient and program compliance with state and federal employment requirements and monitors and makes available to the eligible recipient the reports related to utilization of services and budget expenditures. Based on the eligible recipient's approved ISP and AAB, the FMA must:

(1) verify that the recipient is eligible for MAD services prior to making payment;

(2) receive and verify all required employee and vendor documentation;

(3) establish an accounting for each eligible recipient's AAB;

(4) process and pay invoices for goods, services and supports approved in the ISP and the AAB and supported by required documentation;

(5) process all payroll functions on behalf of the eligible recipient and EORs including:

(a) collect and process timesheets of employees;

(b) process payroll, withholding, filing, and payment of applicable federal, state and local employment-related taxes and insurance; and

(c) track and report disbursements and balances of the eligible recipient's AAB and provide a monthly report of expenditures and budget status to the eligible recipient and their CSC, and quarterly and annual documentation of expenditures to the MAD;

(6) receive and verify employee and vendor agreements, including collecting required provider qualifications;

(7) monitor hours, the total amounts billed for all goods and services during the month;

(8) process and report on employee background checks;

(9) answer inquiries from the eligible recipient and solve problems related to the FMA responsibilities; and

(10) report to the CSC provider, MAD and DOH any concerns related to the health and safety of an eligible recipient, or if the eligible recipient is not following the approved ISP and AAB.

C. Third-party assessor (TPA): The TPA or MAD's designee is responsible for determining medical eligibility through a LOC assessment, approving the ISP, and authorizing an eligible recipient's annual budget in accordance with 8.314.7 NMAC and the supports waiver service standards. The TPA:

(1) determines medical eligibility using the LOC criteria in 8.314.7.9 NMAC; determinations are completed initially for an eligible recipient who is newly enrolled in the supports waiver and thereafter at least annually for currently enrolled supports waiver eligible recipients. The TPA may re-evaluate LOC more often than annually if there is an indication that the eligible recipient's medical condition or LOC has changed; and

(2) approves the ISP and the annual budget request resulting in an AAB, at least annually or more often if there is a change in the eligible recipient's circumstances, in accordance with this NMAC and supports waiver service standards.

D. Conflict of interest: An eligible recipient's CSC may not serve as the eligible recipient's EOR, authorized representative or personal representative for whom they are the CSC. A CSC may not be paid for any other services utilized by the eligible recipient for whom they are the CSC, whether as an employee of the eligible recipient, a vendor, an employee or subcontractor of an agency. A CSC may not provide any other paid supports waiver services to an eligible recipient unless the recipient is receiving CSC services from another agency. The CSC agency may not provide any other direct services for an eligible recipient that has an approved ISP, an approved budget, and is actively receiving services in the supports waiver program. The CSC agency may not employ as a CSC any immediate family member or guardian for an eligible recipient of the supports waiver program that is served by the CSC agency. A CSC agency may not provide guardianship services to an eligible recipient receiving CSC services from that same agency. The CSC agency may not provide any direct support services through any other type of 1915 (c) developmental disabilities waiver program. A CSC agency shall not engage in any activities in their capacity as a provider of services to an eligible recipient that may be a conflict of interest. As such a CSC agency shall not hold a business or financial interest in an affiliated agency that is paid to provide direct care for any eligible recipients receiving supports waiver services. An affiliated agency is defined as a direct service agency providing supports waiver services that has a marital, domestic partner, blood, business interest or holds financial interest in providing direct care for eligible recipients receiving supports waiver services. Affiliated agencies must not hold a business or financial interest in any entity that is paid to provide direct care for any eligible recipients receiving home and community-based services (HCBS). Any direct service agency or CSC agency that has been referred to the DOH internal review committee (IRC) or is on a moratorium will not be approved to provide supports waiver services.

[8.314.7.12 NMAC - N, 4/1/2021]

8.314.7.13 QUALIFICATIONS FOR ELIGIBLE INDIVIDUAL EMPLOYEES, INDEPENDENT PROVIDERS, PROVIDER AGENCIES, AND VENDORS:

A. Agency-based service delivery model requirements for individual employees, independent providers, provider agencies and vendors: All supports waiver eligible providers under the agency-based model of service delivery must be approved by the DOH or its designee and have an approved MAD and DOH provider agreement. MAD through its designee, DOH/DDSD, must ensure that its subcontractors or employees meet all required qualifications. The provider agency must provide oversight of subcontractors and supervision of employees to ensure that all required MAD and DOH/DDSD qualifications; compliance with EVV requirements; all requirements outlined in the supports waiver services standards, applicable New Mexico administrative code (NMAC) rules, MAD supplements, and as applicable, the provider's New Mexico licensing board's scope of practice and licensure are met.

B. Participant directed service delivery model requirements for individual employees, independent providers, and vendors: In order to be approved to provide services under the participant directed service delivery model, provider agency, employees, vendors, or an independent provider, including non-licensed personal care or direct support worker, must meet the general and service specific qualifications set forth in this rule initially and continually meet licensure requirements as applicable, and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the FMA. In addition, to be an authorized provider for the supports waiver and receive payment for delivered services, the provider must complete a vendor or employee provider agreement and all required tax documents. The provider must have credentials verified by the eligible recipient or the employee of record (EOR) and the FMA. The provider agency is responsible to ensure that

all agency employees meet the required qualifications. Individual employees may not provide more than 40 hours of services in a consecutive seven-day work week.

(1) prior to rendering services to an eligible supports waiver recipient as a personal care or direct support worker, respite worker, customized community supports worker, or employment worker, an individual seeking to provide these services must complete and submit a nature of services questionnaire to the FMA. The FMA will determine, based on the nature of services questionnaire if the relationship is that of an employee or an independent contractor;

(2) an authorized CSC provider must have a MAD approved provider participation agreement (PPA) and the appropriate approved DOH/DDSD agreement.

C. General Qualifications agency-based and participant directed service delivery model providers:

(1) individual employees, independent providers, provider agencies, excluding CSC provider agencies, who are employed by a community supports waiver recipient to provide direct services shall:

(a) be at least 18 years of age;

(b) be qualified to perform the service and demonstrate capacity to perform required tasks;

(c) be able to communicate successfully with the eligible recipient;

(d) pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;

(e) complete all trainings as required by DOH/DDSD and complete training specific to the eligible recipient's needs as identified in the approved ISP;

(f) for participant directed, training needs on items identified in the individual service plan (ISP), and the training plan is determined by the eligible recipient or their legal representative for any training specific to the employee in addition to trainings required by DOH/DDSD; the eligible recipient is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the eligible recipient's AAB; and

(g) meet any other service specific qualifications, as specified in 8.314.7 NMAC and service standards.

(2) vendors, including those providing professional services:

(a) shall be qualified to provide the service;

(b) shall possess a valid business license, if applicable; and

(c) are required to follow the applicable licensing regulations set forth by the profession; refer to the appropriate New Mexico board of licensure for information regarding applicable licenses;

(3) qualified and approved relatives and legal guardians may be hired as employees and paid for the provision, of supports waiver services except for CSC services, customized community supports group services, non-medical transportation services for a minor, environmental modifications services, vehicle modifications services, behavior support consultation services, assistive technology and employment supports. A spouse may not provide transportation for adult participants. A relative or legal guardian may not provide services that the legal responsible individual would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness. A relative or legal guardian may not provide services that the legally responsible individual would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness;

(4) once enrolled, providers, vendors and contractors receive a packet of information from the eligible recipient or FMA including billing instructions, and other pertinent materials. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, an eligible recipient or legal representative, or provider, vendor or contractor receives instruction on how to access these documents. It is the responsibility of the eligible recipient or legal representative, or provider, vendor, or contractor to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The eligible recipient or legal representative, or provider, vendor, or contractor must contact HCA or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials;

(a) no provider of any type may be paid in excess of 40 hours within the established work week for any one eligible recipient or EOR when applicable;

(b) no provider agency is permitted to perform both LOC assessments and provide any services for the eligible recipients;

(c) providers may market their services but are prohibited from soliciting eligible recipients under any circumstances.

(5) **Employer of record:** The EOR is the individual responsible for directing the work of the eligible recipient's employees under the participant directed service delivery model. The EOR may be the eligible recipient or a legal representative of the recipient. A recipient through the use of the support's waiver EOR questionnaire will determine if an individual meets the requirements to serve as an EOR. The recipient's CSC will provide them with the questionnaire. The questionnaire shall be completed by the recipient with assistance from the CSC upon request. The CSC shall maintain a copy of the completed questionnaire in the recipient's file. The EOR does not have budget authority. When utilizing both vendors and employees, an EOR is required for oversight of employees and to sign payment request forms for vendors. The EOR must be documented with the FMA whether the EOR is the eligible recipient or a designated qualified individual.

(a) an eligible recipient that is the subject of a plenary or limited guardianship or conservatorship may not be their own EOR;

(b) a power of attorney or other legal instrument may not be used to assign EOR responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR as designated in 8.316.7 NMAC;

(c) a person under the age of 18 years may not be an EOR;

(d) an EOR who lives outside New Mexico shall reside within 100 miles of the New Mexico state border. If the eligible recipient wants to have an EOR who resides beyond this radius, the eligible recipient must obtain written approval from the DOH prior to the EOR performing any duties. This written approval must be documented in the ISP;

(e) the eligible recipient's provider may not also be their EOR;

(f) an EOR whose performance compromises the health, safety or welfare of the eligible recipient, may have their status as an EOR terminated;

(g) an EOR must be a legal representative if not the recipient; and

(h) an EOR may not be paid for any other services utilized by the eligible recipient for whom they are EOR, whether as an employee of the eligible recipient, a vendor, or an employee or contractor of an agency. An EOR makes important determinations about what is in the best interest of the eligible recipient and should not have any conflict of interest. An EOR assists in the management of the eligible recipient's budget and should have no personal benefit connected to the services requested or approved in the budget.

D. **Qualifications of assistive technology providers and vendors:** Must hold a current business license issued by the state, county or city government.

E. **Qualifications of behavior support consultation providers:** Behavior supports consultation provider agencies shall have a current business license issued by the state, county or city government, if required. Behavior supports consultation provider agencies shall comply with all applicable federal, state, and waiver rules and procedures regarding behavior support consultation, and must ensure that provider training is in accordance with the DOH/DDSD training policy. Providers of behavior support consultation must maintain a current New Mexico license with the appropriate professional field licensing body and have a minimum of one year of experience working with individuals with intellectual or developmental disabilities. Providers of behavior support consultation services must possess qualifications in at least one of the following areas:

(1) licensed clinical psychologist, licensed psychologist associate, (masters or Ph.D. level);

(2) licensed independent social worker (LISW) or a licensed clinical social worker (LCSW);

(3) licensed master social worker (LMSW);

(4) licensed mental health counselor LMHC);

(5) licensed professional clinical counselor (LPCC);

(6) licensed marriage and family therapist (LMFT); or

(7) licensed practicing art therapist (LPAT).

F. **Qualifications of the community support coordinator providers:** In addition to general requirements, a CSC provider shall ensure that all individuals hired, or contracted for CSC services meet the criteria specified in this section in addition to all applicable rules and service standards. Community supports coordinators shall:

(1) be at least 21 years of age;

(2) possess a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or related field; or have a minimum of six-years direct experience related to the delivery

of social services to people with disabilities;

(3) have at least one year of experience working with people with disabilities or I/DD;

(4) complete all trainings as required by DOH/DDSD;

(5) verification of provider qualifications; and

(6) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

G. Qualifications for customized community supports individual providers: For individual community supports providers the worker must meet the following requirements:

(1) be 18 years of age or older;

(2) demonstrate the capacity to perform required tasks;

(3) be able to communicate successfully with the eligible recipient;

(4) complete all training requirements as required by DOH/DDSD; and

(5) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC; and

(6) meet any other service qualifications, as specified in the regulations.

H. Qualifications for customized community supports group providers: Provider agencies must meet requirements including a business license, accreditation with the commission on accreditation of rehabilitation facilities (CARF) international, employment and community services or the council on quality and leadership, quality assurances, financial solvency, training requirements, records management, quality assurance policy and processes. The agency staff must meet the following requirements:

(1) be at least 18 years of age;

(2) have at least one year of experience working with people with disabilities;

(3) be qualified to perform the service and demonstrate capacity to perform required tasks;

(4) be able to communicate successfully with the eligible recipient;

(5) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

(6) complete specific training based on needs identified in the ISP and by the recipient; and

(7) meet any other service qualifications, as specified in the regulations.

I. Qualifications of personal care service providers: In addition to general MAD requirements, the direct support providers must meet additional qualifications specific to the type of services provided. Provider agencies must be homemaker/personal care agencies certified by the MAD or its designee or a homemaker/personal care agency holding a New Mexico homemaker/personal care agency license. A homemaker/personal care agency must hold a current business license when applicable, and meet financial solvency, training, records management, and quality assurance rules and requirements. Personal care direct support workers must:

(1) be at least 18 years of age;

(2) demonstrate capacity to perform required tasks;

(3) be able to communicate successfully with the eligible recipient;

(4) complete all trainings as required by DOH/DDSD; and

(5) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

J. Qualifications of employment supports providers:

(1) A job developer, whether an agency or individual provider, must:

(a) be at least 21 years of age;

(b) complete all training requirements by DOH/DDSD;

(c) have a high school diploma or GED;

(d) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC;

(e) have experience in developing and using job and task analysis;

(f) have knowledge of the Americans with Disabilities Act (ADA);

(g) have knowledge and experience working with the department of vocational rehabilitation (DVR) office; and

(h) have experience with or knowledge of the purposes, functions, and general practices of entities such as department of labor navigators one-stop career centers, business leadership network, chamber of commerce job accommodation network, small business development centers, retired executives, local business community agencies, and DDSD resources.

(2) Job coaches whether agency or individual provider, must:

(a) be at least 18 years of age;

(b) complete all training requirements by DOH/DDSD;

(c) have a high school diploma or GED; and

(d) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

K. Qualifications of environmental modifications providers: Environmental modification providers must possess an appropriate plumbing, electrician, contractor license; appropriate technical certification to perform the modification; and, hold a current business license issued by the state, county or city government.

L. Qualifications of non-medical transportation providers: Individual transportation providers must possess a valid New Mexico driver's license with the appropriate classification, be free of physical or mental impairment that would adversely affect driving performance, have no driving while intoxicated (DWI) convictions or chargeable (at fault) accidents within the previous two years, have a current insurance policy and vehicle registration. Transportation vendors must hold a current business license and tax identification number. Each agency will ensure drivers meet the following qualifications:

(1) be at least 18 years old;

(2) possess a valid, appropriate New Mexico driver's license;

(3) have a current insurance policy and vehicle registration; and

(4) must complete all training requirements as required by DOH/DDSD.

M. Qualifications of respite providers: Respite services may be provided by eligible individual respite providers. Respite provider agencies must hold a current business license, and meet financial solvency, training, records management and quality assurance rules and requirements. In addition, for participant-directed services, the eligible recipient or their representative evaluates training needs based on the needs identified in the ISP and by the recipient, provides or arranges for training, as needed, and supervises the worker. Respite worker must:

(1) be 18 years of age or older;

(2) demonstrate capacity to perform required tasks;

(3) be able to communicate successfully with the eligible recipient;

(4) pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC; and

(5) complete all training requirements as required by DOH/DDSD.

N. Qualifications of vehicle modification providers: Vehicle modification providers must possess an appropriate mechanic or body work license; appropriate technical certification to perform the modification; and, hold a current business license issued by the state, county or city government.

[8.314.7.13 NMAC - N, 4/1/2021]

8.314.7.14 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA: The services covered by the supports waiver are intended to provide a community-based alternative to institutional care for an eligible recipient that allow greater choice, direction and control over services and supports in an agency-based service delivery model or participant directed service delivery model. These services must specifically address a therapeutic, rehabilitative, habilitative, health or safety need that results from the eligible recipient's qualifying condition. The supports waiver is the payor of last resort. The coverage of the services must be in accordance with the supports waiver rules and service standards. Supports waiver services must be provided in an integrated setting and facilitate full access to the community; ensure the eligible recipient receives services in the community to the same degree of access as those individuals not receiving HCBS services; maximize independence in making life choices; be chosen by the eligible recipient in consultation with the guardian as applicable; ensure the right to privacy, dignity, respect, and freedom from coercion and restraint; optimize recipient employment; and facilitate choice of services and who provides them.

A. General requirements regarding supports waiver covered services: To be considered a covered service under the supports waiver, the following criteria must be met. Services, supports and goods must:

(1) directly address the eligible recipient's qualifying condition or disability;

(2) meet the eligible recipient's clinical, functional, medical or habilitative needs;

(3) be designed and delivered to advance the desired outcomes in the eligible recipient's service and support plan; and

(4) support the eligible recipient to remain in the community and reduce the risk of institutionalization.

B. Assistive technology: Assistive technology (AT) is an item, piece of equipment, or product system used to increase, maintain, or improve functional capabilities. AT services allow for the evaluation and purchase of the AT based on the needs of the eligible recipient and, not covered through the eligible recipient's state plan benefits. Evaluation of the assistive technology needs of the participant include a functional evaluation of the impact of the provision of the appropriate assistive technology to the participant. Services consist of selecting, designing, fitting, customization, adapting, applying, maintaining, and repair or repairing assistive technology devices. AT services also include training or technical assistance for the participant, or where appropriate, the family members, guardians, advocates, or authorized representatives of the participant, or professionals or direct service providers involved in the major life functions of the participant. AT includes remote personal support technology. Remote personal support technology is an electronic device or monitoring system that supports eligible recipients to be independent in their home or community. This service may provide up to 24-hour alert, monitoring or personal emergency response capability, prompting or in-home reminders, or monitoring for environmental controls for independence through the use of technologies. Remote monitoring is prohibited in eligible recipient's bedrooms and bathrooms. This service is not intended to provide for paid, in-person on-site response. On-site response must be planned through back up plans that are developed using natural or other paid supports. Assistive technology services are limited to $5,000 every five years.

C. Behavior support consultation: Behavior support consultation services consist of functional support assessments, treatment plan development, and training and support coordination for the eligible recipient related to behaviors that compromise the eligible recipient's quality of life.

D. Community supports coordinator: Community support coordination services are intended to educate, guide and assist the eligible recipient to make informed planning decisions about services and supports, and monitor those services and supports. Specific waiver function(s) that CSC providers have are:

(1) monitor service delivery and conduct face-to-face visits including home visits at least quarterly;

(2) complete process to evaluate/re-evaluate level of care (medical eligibility);

(3) educate, train and assist eligible recipient (and guardian, employer of record) about participant direction or agency-based service delivery models (includes adherence to standards, review of rights, recognizing and reporting critical incidents);

(4) provide support and assistance during the medical and financial eligibility process;

(5) develop the person-centered plan with the eligible recipient; to include revising the plan as needed;

(6) serve as an advocate for the eligible recipient to enhance their opportunity to be successful with participant-direction or agency-based program; and

(7) supports the recipient with identifying resources outside of the supports waiver that may assist with meeting the recipient's needs.

E. Customized community supports individual: Customized community supports consist of individualized services and support that enable an individual to acquire, maintain, and improve opportunities for independence, community membership, and inclusion. The provider may be a skilled independent contractor or a hired employee depending on the level of support needed by the eligible recipient to access the community. Customized community supports services are designed around the preferences and choices of each individual and offers skill training and supports to include: adaptive skill development, adult educational supports, citizenship skills, communication, social skills, socially appropriate behaviors, self-advocacy, informed choice, community inclusion, arrangement of transportation, and relationship building. Customized community support services provide help to the individual to schedule, organize and meet expectations related to chosen community activities. All services are provided in a community setting with the focus on community exploration and true community inclusion.

F. Customized community supports group: Customized community supports can include participation in congregate community day programs and centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills for an eligible recipient. Customized community supports may include adult day habilitation, adult day health and other day

support models. Customized community supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings.

G. Employment support: Individual community integrated employment offers one-to-one support to an eligible recipient placed in inclusive jobs or self-employment in the community and support is provided at the worksite as needed for the eligible recipient to learn and perform the tasks associated with the job in the workplace. The provider agency is encouraged to develop natural supports in the workplace to decrease the reliance of paid supports.

H. Environmental modifications: Services include the purchase and installation of equipment or making physical adaptations to an eligible recipient's residence that are necessary to ensure the health, welfare and safety of the eligible recipient or enhance the eligible recipient's level of independence.

(1) adaptations include: installation of ramps; widening of doorways and hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; installation of lifts or elevators; modification of bathroom facilities such as roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing; turnaround space adaptations; specialized accessibility and safety adaptations or additions; trapeze and mobility tracks for home ceilings; automatic door openers or doorbells; voice-activated, light-activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating or cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems or signaling devices;

(2) environmental modifications are limited to $5,000 every five years;

(3) all services shall be provided in accordance with federal, state, and local building codes;

(4) excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the eligible recipient, such as fences, storage sheds, or other outbuildings. Adaptations that add to the square footage of the home are excluded for this benefit except when necessary to complete an adaptation.

I. Personal care services: Personal care services are provided on an intermittent basis to assist an eligible recipient 21 years and older with a range of activities of daily living, performance of incidental homemaker and chore service tasks if they do not comprise of the entirety of the service, and enable the eligible recipient to accomplish tasks they would normally do for themselves if they did not have a disability. Personal care direct support services are provided in the eligible recipient's own home and in the community, depending on the eligible recipient's needs. The eligible recipient identifies the personal care direct support worker's training needs through the ISP in addition to required training, and, if the eligible recipient or EOR for the participant directed service delivery model or agency is unable to do the training for themselves, the eligible recipient or EOR for the participant directed service delivery model or agency arranges for the needed training. Supports shall not replace natural supports available such as the eligible recipient's family, friends, and individuals in the community, clubs, and organizations that are able and consistently available to provide support and service to the eligible recipient. Personal care services are covered under the medicaid state plan as enhanced early and periodic screening, diagnostic and treatment (EPSDT) benefits for supports waiver eligible recipients under 21 years of age and are not to be included in an eligible recipient's AAB.

J. Non-medical transportation: Transportation services are offered to enable eligible recipients to gain access to services, activities, and resources, as specified by the ISP. Transportation services under the waiver are offered in accordance with the eligible recipient's ISP. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the medicaid state plan are to transport eligible recipients to medically necessary physical and behavioral health services. Payment for supports waiver transportation services is made to the eligible recipient's individual transportation provider or employee or to a public or private transportation service vendor. Payment cannot be made to the eligible recipient. Non-medical transportation services for minors is not a covered service as these are services that a legally responsible individual (LRI) would ordinarily provide for household members of the same age who do not have a disability or chronic illness. Payment cannot be made to the eligible recipient. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge shall be identified in the ISP and utilized.

K. Vehicle modifications: Vehicle adaptations or alterations to an automobile or van that is the eligible recipient's primary means of transportation in order to accommodate the special needs of the eligible recipient. Vehicle adaptations are specified by the service plan as necessary to enable the eligible recipient to integrate more fully into the community and to ensure the health, welfare and safety of the eligible recipient. The vehicle that is adapted may be owned by the eligible recipient, a family member with whom the eligible recipient lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the

eligible recipient and is not a paid provider of services. Vehicle modifications are limited to $5,000 every five years. Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services. Vehicle accessibility adaptations consist of installation, repair, maintenance, training on use of the modifications and extended warranties for the modifications. The following are specifically excluded:

(1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the eligible recipient;

(2) purchase or lease of a vehicle; and

(3) regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

L. **Respite:** Respite is a family support service, the primary purpose of which is to give the primary, unpaid caregiver time away from their duties on a short-term basis. Respite services include assisting the eligible recipient with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities; assisting the eligible recipient to enhance self-help skills, leisure time skills and community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the eligible recipient to make their own choices with regard to daily activities. Respite services are furnished on a short-term basis and can be provided in the eligible recipient's home, the provider's home, or in a community setting of the family's choice (e.g., community center, swimming pool and park).
[8.314.7.14 NMAC - N, 4/1/2021]

8.314.7.15 **NON-COVERED SERVICES:** The waiver does not pay for the purchase of goods or services that a household without a person with a disability would be expected to pay for as a routine household or personal expense. If the eligible recipient requests a specific good or service, the CSC and the state can workwith the eligible recipient to find other, including less costly, alternatives. Non-covered services include, but are not limited to the following:

A. Services covered by the medicaid state plan (including EPSDT), MAD school-based services, medicare and other third parties.

B. Any service or good, the provision of which would violate federal or state statutes, regulations or guidance.

C. Formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the public education department (PED), division of vocational rehabilitation (DVR.

D. Food and shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing, maintenance, utilities and utility deposits, and related administrative expenses; utilities include gas, electricity, propane, firewood, wood pellets, water, sewer, and waste management.

E. Experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC.

F. Any goods or services that are to be used for recreational or diversional purposes.

G. Personal goods or items not related to the disability.

H. Animals and costs of maintaining animals including the purchase of food, veterinary visits, grooming and boarding except for training and certification for service dogs.

I. Gas cards and gift cards.

J. Purchase of insurance, such as car, health, life, burial, renters, homeowners, service warranties or other such policies.

K. Purchase of a vehicle, and long-term lease or rental of a vehicle.

L. Purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items.

M. Firearms, ammunition or other weapons.

N. Vacation expenses, including airline tickets, cruise ship or other means of transport, guided.

O. Meals, hotel, lodging or similar recreational expenses.

P. Purchase of usual and customary furniture and home furnishings, *unless* adapted to the eligible recipient's disability or use, or of specialized benefit to the eligible recipient's condition; requests for adapted or specialized furniture or furnishings must include a recommendation from the eligible recipient's health care provider and, when appropriate, a denial of payment from any other source.

Q. Regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, *except* upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the eligible recipient's qualifying condition or disability.

R. Regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, *except* upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the eligible recipient's qualifying condition or disability; requests must include documentation that the adapted vehicle is the eligible recipient's primary means of transportation.

S. Clothing and accessories, except specialized clothing based on the eligible recipient's disability or condition.

T. Training expenses for paid employees.

U. Costs associated with such conferences or class cannot be covered, including airfare, lodging or meals; consumer electronics such as computers, printers and fax machines, or other electronic equipment that does not meet the criteria specified in Subsection A of 8.314.6.14 NMAC; no more than one of each type of item may be purchased at one time; and consumer electronics may not be replaced more frequently than once every three years.

V. Cell phone services that include fees for data unless data is for an app specifically approved through supports waiver funds; or more than one cell phone line per eligible recipient.

[8.314.7.15 NMAC - N, 4/1/2021]

8.314.7.16 INDIVIDUAL SERVICE PLAN (ISP) AND AUTHORIZED ANNUAL BUDGET(AAB): An ISP and an AAB request are developed at least annually by the eligible recipient in collaboration with the eligible recipient's CSC and others that the eligible recipient invites to be part of the process. The CSC serves in a supporting role to the eligible recipient, assisting the eligible recipient to understand the supports waiver program, and with developing and implementing the ISP and the AAB. The ISP and annual budget request are developed and implemented as specified in 8.314.7. NMAC and supports waiver service standards and submitted to the TPA or MAD's designee for final approval. Upon final approval the annual budget request becomes an AAB.

A. ISP development process: For development of the person-centered service plan, the planning meetings are scheduled at times and locations convenient to the eligible recipient. This process obtains information about eligible recipient strengths, capacities, preferences, desired outcomes and risk factors through the LOC assessment process and the planning process that is undertaken between the CSC and eligible recipient to develop their ISP.

(1) Assessments:

(a) assessment activities that occur prior to the ISP meeting assist in the development of an accurate and functional plan. The functional assessments conducted during the LOC determination process address the following needs of a person: medical, behavioral health, adaptive behavior skills, nutritional, functional, community/social and employment;

(b) assessments occur on an annual basis or during significant changes in circumstance or at the time of the LOC determination. After the assessments are completed, the results are made available to the eligible recipient and their CSC for use in planning;

(c) the eligible recipient and the CSC will assure that the ISP addresses the information and concerns, if any, identified through the assessment process.

(2) Pre-planning:

(a) the CSC contacts the eligible recipient upon their choosing enrollment in the supports waiver program to provide information regarding this program, including the range and scope of choices and options, as well as the rights, risks, and responsibilities associated with participation in the supports waiver;

(b) the CSC discusses areas of need to address on the eligible recipient's ISP. The CSC provides support during the annual re-determination process to assist with completing medical and financial eligibility in a timely manner;

(3) ISP components: The ISP contains:

(a) the supports waiver services that are furnished to the eligible recipient, the projected amount, frequency and duration, and the type of provider who furnishes each service;

(i) the ISP must describe in detail how the services or goods relate to the eligible recipient's qualifying condition or disability;

(ii) the ISP must describe how the services and goods support the eligible recipient to remain in the community and reduce their risk of institutionalization; and

(iii) the ISP must specify the hours of services to be provided and payment arrangements.

(b) other services needed by the supports waiver eligible recipient regardless of funding source, including state plan services;

(c) informal supports that complement supports waiver services in meeting the needs of the eligible recipient;

(d) methods for coordination with the medicaid state plan services and other public programs;

(e) methods for addressing the eligible recipient's health care needs when relevant;

(f) quality assurance criteria to be used to determine if the services and goods meet the eligible recipient's needs as related to their qualifying condition or disability;

(g) information, resources or training needed by the eligible recipient and service providers;

(h) methods to address the eligible recipient's health and safety, such as emergency and back-up services.

(4) **Individual service plan meeting:**

(a) the eligible recipient receives a LOC assessment and local resource manual and person-centered planning documents prior to the ISP meeting;

(b) the eligible recipient may begin planning and drafting the ISP utilizing those tools prior to the ISP meeting;

(c) during the ISP meeting, CSC assists the eligible recipient to ensure that the ISP addresses the eligible recipient's goals, health, safety and risks. The eligible recipient and their CSC will assure that the ISP addresses the information, goals and concerns identified in the person-centered planning process. The ISP must address the eligible recipient's health and safety needs before addressing other issues. The CSC ensures that:

(i) the planning process addresses the eligible recipient's needs and goals in the following areas: health and wellness and accommodations or supports needed at home and in the community;

(ii) services selected address the eligible recipient's needs as identified during the assessment process; needs not addressed in the ISP will be addressed outside the supports waiver program;

(iii) the outcome of the assessment process for assuring health and safety is considered in the plan;

(iv) services do not duplicate or replace those available to the eligible recipient through the medicaid state plan or other programs;

(v) services are not duplicated in more than one service code;

(vi) job descriptions are complete for each provider and employee in the plan; a job description will include frequency, intensity and expected outcomes for the service;

(vii) the quality assurance section of the ISP is complete and specifies the roles of the eligible recipient, community supports coordinator and any others listed in this section;

(viii) the responsibilities are assigned for implementing the plan;

(ix) the emergency and back-up plans are complete; and

(x) the ISP is submitted to the TPA after the ISP meeting, in compliance with supports waiver rules and service standards.

B. **ISP review criteria:** Services and related goods identified in the eligible recipient's requested ISP may be considered for approval if the following requirements are met:

(1) the services or goods must be responsive to the eligible recipient's qualifying condition or disability and must address the eligible recipient's clinical, functional, medical or habilitative needs; and

(2) the services or goods must accommodate the eligible recipient in managing their household; or

(3) the services or goods must facilitate activities of daily living;

(4) the services or goods must promote the eligible recipient's personal health and safety; and

(5) the services or goods must afford the eligible recipient an accommodation for greater independence; and

(6) the services or goods must support the eligible recipient to remain in the community and reduce their risk for institutionalization; and

(7) the services or goods must be documented in the ISP and advance the desired outcomes in the eligible recipient's ISP; and

(8) the ISP contains the quality assurance criteria to be used to determine if the service or goods meet the eligible recipient's need as related to the qualifying condition or disability; and

(9) the services or goods must decrease the need for other MAD services; and

(10) the eligible recipient receiving the services or goods does not have the funds to purchase the services or goods; or

(11) the services or goods are not available through another source; the eligible recipient must submit documentation that the services or goods are not available through another source, such as the medicaid state plan or medicare; and

(12) the service or good is not prohibited by federal regulations, NMAC rules, billing instructions, standards, and manuals; and

(13) each service or good must be listed as an individual line item whenever possible; however, when a service or a good are 'bundled' the ISP must document why bundling is necessary and appropriate.

C. Budget review criteria: The eligible recipient's proposed annual budget request may be considered for approval, if all the following requirements are met:

(1) the proposed annual budget request is within the supports waiver IBA;

(2) the rate for each service is included;

(3) the proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good;

(4) the estimated cost of the service or good is specifically documented in the eligible recipient's budget worksheets; and

(5) no employee exceeds 40 hours paid work in a consecutive seven-day work week.

D. Modification of the ISP:

(1) The ISP may be modified based upon a change in the eligible recipient's needs or circumstances, such as a change in the eligible recipient's health status or condition or a change in the eligible recipient's support system, such as the death or disabling condition of a family member or other individual who was providing services.

(2) If the modification is to provide new or additional services than originally included in the ISP, these services must not be able to be acquired through other programs or sources. The eligible recipient must document the fact that the services are not available through another source. The new or additional services are subject to utilization review for medical necessity and program requirements as per 8.314.7.17 NMAC.

(3) The CSC initiates the process to modify the ISP by forwarding the request for modification to the TPA for review.

(4) The ISP must be modified before there is any change in the AAB.

(5) The ISP may be modified once the original ISP has been submitted and approved. Only one ISP revision may be submitted at a time, e.g.; an ISP revision may not be submitted if an initial ISP request or prior ISP revision request is under initial review by the TPA. This requirement also applies to any re-consideration of the same revision request. Other than for critical health and safety reasons, neither the ISP nor the AAB may be modified within 60 calendar days of the expiration of the current ISP.

[8.314.7.16 NMAC - N, 4/1/2021]

8.314.7.17 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services, including services covered under the supports waiver program, are subject to utilization review for medical necessity and program requirements. Reviews by MAD or its designees may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made in accordance with 8.310.2 NMAC.

A. Prior authorization: Services, supports, and goods specified in the ISP and AAB require prior authorization from HCA/MAD or its designee. The ISP must specify the type, amount and duration of services. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: To be eligible for supports waiver program services, eligible recipients must require the LOC of services provided in an ICF-IID. Prior authorization of services does not guarantee that applicants or eligible recipients are eligible for medical assistance program (MAP) or supports waiver services.

C. Reconsideration: If there is a disagreement with a prior authorization denial or other review decision, the community supports coordinator provider on behalf of the eligible recipient, can request reconsideration from the TPA that performed the initial review and issued the initial decision. Reconsideration must be requested within 30-calendar days of the date on the denial notice, must be in writing and provide additional documentation or clarifying information regarding the eligible recipient's request for the denied services or goods.

D. Denial of payment: If a service, support, or good is not covered under the supports waiver program, the claim for payment may be denied by MAD or its designee. If it is determined that a service is not

covered before the claim is paid, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.
[8.314.7.17 NMAC - N, 4/1/2021]

8.314.7.18 RECORDKEEPING AND DOCUMENTATION RESPONSIBILITIES: Service providers and vendors who furnish goods and services to supports waiver eligible recipients are reimbursed by the financial management agency (FMA) and must comply with all applicable New Mexico administrative code (NMAC), medical assistance division (MAD) rules and service standards. The FMA, community supports coordinators (CSC) and service providers must maintain records, which are sufficient to fully disclose the extent and nature of the goods and services provided to the eligible recipients, as detailed in applicable NMAC, MAD provider rules and comply with random and targeted audits conducted by MAD and department of health (DOH) or their audit agents. MAD or its designee will seek recoupment of funds from service providers when audits show inappropriate billing for services. Supports waiver vendors who furnish goods and services to supports waiver eligible recipients and bill the FMA must comply with all MAD provider participation agreement (PPA) requirements and NMAC, MAD rules and requirements, including but not limited to 8.310.2 NMAC and 8.321.2 NMAC and 8.302.1 NMAC.
[8.314.7.18 NMAC - N, 4/1/2021]

8.314.7.19 REIMBURSEMENT: Health care to MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD.

A. Agency-based service delivery model provider reimbursement: Upon approval of a New Mexico MAD 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 MAP eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the health care authority/medical assistance division (HCA/MAD) website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including New Mexico administrative code (NMAC) rules, billing instructions, utilization review instructions, service definitions and service standards and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

B. Participant directed service delivery model provider and vendor reimbursement: Supports waiver eligible recipients must follow all billing instructions provided by the FMA to ensure payment of service providers, employees, and vendors. Claims must be billed to the FMA per the billing instructions. Reimbursement to a service provider and a vendor in the supports waiver program is made, as follows:

(1) supports waiver service provider and vendor must enroll with the FMA;

(2) the eligible recipient receives instructions and documentation forms necessary for a service provider's and a vendor's claims processing;

(3) an eligible recipient must submit claims for payment of their supports waiver service provider and vendor to the FMA for processing; claims must be filed per the billing instructions provided by the FMA;

(4) the eligible recipient and their supports waiver service provider and vendor must follow all FMA billing instructions; and

(5) reimbursement of a supports waiver service provider and vendor is made at a predetermined reimbursement rate by the eligible recipient with the supports waiver service provider or vendor, approved by the TPA contractor, and documented in the ISP and in the supports waiver provider or vendor agreement; at no time can the total expenditure for services exceed the eligible recipient's AAB;

(6) the FMA must submit claims that have been paid by the FMA on behalf of the eligible recipient to the MAD fiscal contractor for processing; and

(7) reimbursement may not be made directly to the eligible recipient, either to reimburse them for expenses incurred or to enable the eligible recipient to pay a service provider directly.
[8.314.7.19 NMAC - N, 4/1/2021]

8.314.7.20 RIGHT TO AN HCA ADMINISTRATIVE HEARING:

A. The health care authority/medical assistance division (HCA/MAD) must grant an opportunity for an administrative hearing as described in this section in the following circumstances and pursuant to 42 CFR Section 431.220(a)(1), Section 27-3-3 NMSA 1978 and 8.352.2 NMAC *Recipient Hearings*:

(1) when a supports waiver applicant has been determined not to meet the LOC requirement for waiver services;

(2) when a supports waiver applicant has not been given the choice of HCBS as alternative to institutional care;

(3) when a supports waiver applicant is denied the services of their choice or the provider of their choice;

(4) when a supports waiver recipient's services are denied, suspended, reduced or terminated;

(5) when a supports waiver recipient has been involuntarily terminated from the program; or

(6) when a supports waiver recipient's request for a budget adjustment has been denied.

B. DOH and its counsel, if necessary, shall participate in any fair hearing involving an eligible recipient. HCA/MAD, and its counsel, if necessary, may participate in fair hearings.

[8.314.7.20 NMAC - N, 4/1/2021]

8.314.7.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to eligible recipients who request an HCA administrative hearing within the timeframe defined in 8.352.2 NMAC. The notice will include information on the right to continued benefits and on the eligible recipient's responsibility for repayment if the hearing decision is not in the eligible recipient's favor. See 8.352.2 New Mexico administrative code (NMAC) for a complete description of the continuation of benefits process of an HCA administrative hearing for an eligible recipient.

B. The continuation of benefit is only available to an eligible recipient that is currently receiving the appealed benefit. The eligible recipient's current AAB and ISP at the time of the request is termed a 'continuation' of benefits. The continuation budget may not be revised until the conclusion of the fair hearing process.

[8.314.7.21 NMAC - N, 4/1/2021]

8.314.7.22 GRIEVANCE/COMPLAINT SYSTEM: An eligible recipient has the opportunity to register grievances or complaints concerning the provision of services under the supports waiver program. Eligible recipients may register complaints with either HCA/MAD or DDSD via e-mail, mail or phone. Complaints will be referred to the appropriate department for resolution. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing.

[8.314.7.21 NMAC - N, 4/1/2021]

HISTORY OF 8.314.7 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 320 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES
PART 2 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

8.320.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.320.2.1 NMAC - Rp, 8.320.2.1 NMAC, 1/1/2014; A, 7/1/2024]

8.320.2.2 SCOPE: The rule applies to the general public.
[8.320.2.2 NMAC - Rp, 8.320.2.2 NMAC, 1/1/2014]

8.320.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.320.2.3 NMAC - Rp, 8.320.2.3 NMAC, 1/1/201; A, 7/1/20244]

8.320.2.4 DURATION: Permanent.
[8.320.2.4 NMAC - Rp, 8.320.2.4 NMAC, 1/1/2014]

8.320.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.320.2.5 NMAC - Rp, 8.320.2.5 NMAC, 1/1/2014]

8.320.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.320.2.6 NMAC - Rp, 8.320.2.6 NMAC, 1/1/2014]

8.320.2.7 DEFINITIONS: Electronic Visit Verification (EVV): A telephone and computer-based system that electronically verifies the occurrence of HCA selected services visits and documents the precise time the service begins and ends.
[8.320.2.7 NMAC – Rp, 8.320.7 NMAC, 1/1/2014; A, 2/1/2020]

8.320.2.8 [RESERVED]
[8.320.2.8 NMAC - Rp, 8.320.2.8 NMAC, 1/1/2014; A, 2/1/2020]

8.320.2.9 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES: The medical assistance division (MAD) pays for medically necessary health services including preventive, treatment and ameliorative services for a medical assistance program (MAP) eligible recipient under 21 years of age through the early and periodic screening, diagnostic and treatment (ESPDT) services program. See 42 CFR 441.50 Subpart B.

A. EPSDT description:

(1) early: assessing health care early in life so that potential disease and disabilities can be prevented or detected in their preliminary stages, when they are most effectively treated;

(2) periodic: assessing a child's health at regular recommended intervals in the child's life to assure continued healthy development;

(3) screening: the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention;

(4) diagnostic: the determination of the nature or cause of conditions identified by the screening; and

(5) treatment: the provision of services needed to control, correct or lessen health problems.

B. Services provided under EPSDT are accessed following an initial health screening service called the tot to teen healthcheck or health check referral or through other diagnostic evaluations or assessments.
[8.320.2.9 NMAC - Rp, 8.320.2.9 NMAC, 1/1/2014]

8.320.2.10 GENERAL EPSDT SCREENINGS AND REFERRALS: EPSDT includes a screening component called the "tot to teen healthcheck". EPSDT also includes diagnostic, treatment, and other necessary health care measures needed to correct or ameliorate physical and behavioral health disorders or conditions discovered during the tot to teen healthcheck or through other diagnostic evaluations or assessments.
[8.320.2.10 NMAC - Rp, 8.320.2.10 NMAC, 1/1/2014]

8.320.2.11 INFORMATION GIVEN TO MAP ELIGIBLE RECIPIENTS:

A. A MAP eligible recipient under 21 years of age, or their family, is provided with the following information:

(1) benefits of preventive health care;
(2) services available under EPSDT and where and how to access those services;
(3) services provided under EPSDT are furnished at no cost to a MAP eligible recipient;
(4) transportation and scheduling assistance is available upon request; and
(5) the right to request a HCA administrative hearing.

B. Within 30 calendar days of the initial medical assistance application, and annually at each eligibility redetermination period thereafter, a MAP eligible recipient is furnished with information about the tot to teen healthcheck screen and EPSDT services.
[8.320.2.11 NMAC - Rp, 8.320.2.11 NMAC, 1/1/2014]

8.320.2.12 EPSDT ELIGIBLE PROVIDERS: Upon MAD's approval of a PPA, a licensed practitioner, agency or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor. MAD makes available on the HCA/MAD websites, on other program-specific or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including MAD New Mexico administrative code (NMAC) rules, billing instructions, utilization review (UR) instructions and other pertinent materials. Once enrolled, a provider receives instructions on how to access these documents. MAD makes available on the MAD website, on other program specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, UR instructions, and other pertinent material. To be eligible for reimbursement, a provider is bound by the provisions of the MAD PPA.
[8.320.2.12 NMAC - Rp, 8.320.3.10 NMAC, 8.320.4.10 NMAC & 8.320.5.10 NMAC, 1/1/2014]

8.320.2.13 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement (PPA). A provider must adhere to MAD program rules as specified in NMAC rules and program policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determine if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to a MAP eligible recipient.

C. Services furnished to a MAP eligible recipient must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority.
[8.320.2.13 NMAC - Rp, 8.320.3.11 NMAC, 8.320.4.11 NMAC & 8.320.5.11 NMAC, 1/1/2014]

8.320.2.14 GENERAL PROVIDER INSTRUCTION:

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a PPA or an electronic health record (EHR) incentive payment agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing MAD covered services to MAP eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. When approved, a provider receives instruction on how to access these

documents, it is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.

B. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency or each individual provider. Services must be in compliance with the statutes, rules and regulations of their practitioner's applicable practice board and act. Providers must be eligible for reimbursement as described in 8.310.3 NMAC.

C. A specific EPSDT service may have additional service restrictions listed in the service's non-covered section. Generally the following are considered to be noncovered by MAD:

(1) services furnished to an individual who is not eligible for MAD EPSDT services;

(2) services furnished without the prior authorization of the MAP eligible recipient's primary care provider (PCP) or HCA or its designee;

(3) services provided by a practitioner who is not in compliance with the statutes, regulations, rules or who renders services outside of the scope of practice as defined by their practice board;

(4) services that are not considered medically necessary by MAD or its designee for the condition of the MAP eligible recipient;

(5) services that are primarily educational or vocational in nature; and

(6) services related to activities for the general good and welfare of a MAP eligible recipient, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for MAD reimbursement purposes.

D. Certain EPSDT procedures or services identified in the UR instructions may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. All EPSDT services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for authorization of services. A specific EPSDT service may have additional prior authorization requirements listed in the service's prior authorization section. The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance. A provider who disagrees with the denial of a prior authorization request or other review decision can request a reconsideration.

E. All EPSDT services are reimbursed as follows, except when otherwise instructed. MAD does not pay a professional component amount to a physical, occupational or speech and language pathologist (SLP) if the therapy is performed in a hospital setting. MAD reimburses the institutional provider for all components of the service.

(1) Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement is made to a provider for covered services at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure for the provider:

(i) the provider's billed charge must be its usual and customary charge for services;

(ii) "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(2) Services not paid according to a fee schedule are reimbursed using the methodology and rate in effect at the time of service.

(3) Reimbursement to the local education agency (LEA), regional educational cooperative (REC), and another state-funded educational agency (SFEA) is not contingent upon billing a third party payer first when the MAP eligible recipient has other insurance. MAD is generally the payer of last resort. However, if medical services are included in the MAP eligible recipient's individual education plan (IEP), and an exception is created under 42 USE 1396b(c), 20 USC 1412(a)(12) and 34 CFR 300.142. and the services are covered by MAD, then MAD is permitted to pay for such services.

[8.320.2.14 NMAC - N, 1/1/2014]

8.320.2.15 TOT TO TEEN HEALTHCHECK: MAD developed the tot to teen healthcheck, the screening segment of EPSDT services. The tot to teen healthcheck includes periodic screening and regularly scheduled assessments of the MAP eligible recipient's general physical growth and development as well as behavioral health and social emotional development.

A. Primary care providers (PCP), dentists, psychologists, IHS public health clinics, federally qualified health center (FQHC), rural health clinic (RHC), community mental health centers (CMHC), hospitals, school-based clinics, independent certified or licensed nurse practitioners and other health care providers may perform tot to teen healthcheck screens or partial health screenings. A provider must meet the participation requirements specified in applicable sections of NMAC rules. Tot to teen healthcheck screens must be furnished within the scope of the provider's practice, as defined by law.

B. Screening services are furnished to a MAP eligible recipient under 21 years of age. Referrals or treatment for conditions detected during a complete or a partial screen which require further treatment are then covered as part of MAD's EPSDT services. A tot to teen healthcheck can be performed during an office visit for an acute illness as long as the illness does not affect the results or the screening process.

(1) Screening schedule for medical components:

(a) The MAD tot to teen healthcheck periodicity schedule allows for a total of 25 screens. Screenings are encouraged at the following intervals:

(i) under age one: six screenings (birth, one, two, four, six and nine months)

(ii) ages one-two: four screenings (12, 15, 18 and 24 months)

(iii) ages three-five: three screenings (three, four and five years)

(iv) ages six-nine: two screenings (six and eight years)

(v) ages 10-14: four screenings (10, 12, 13 and 14 years)

(vi) ages 15-18: four screenings (15, 16, 17 and 18 years)

(vii) ages 19-20: two screenings (19 and 20 years).

(b) Screenings may be performed at intervals other than as described on the periodicity schedule or in addition to those on the periodicity schedule if a MAP eligible recipient receives care at a time not listed on the periodicity schedule or if any components of the screen were not completed at the scheduled ages. Additional screenings **can help bring the MAP eligible recipient up to date with the periodicity schedule.**

(c) The established schedule must be followed unless the MAP eligible recipient's medical condition is such that a brief deviation is warranted.

(2) Complete medical screens include the following components:

(a) a comprehensive health and developmental history, including an assessment of both physical and behavioral health or social emotional development;

(b) a comprehensive unclothed physical exam;

(c) appropriate immunizations, according to age and health history, unless medically contraindicated at the time;

(d) laboratory tests, including an appropriate blood lead level assessment;

(e) health education, including the MAD anticipatory guidance; and

(f) vision and hearing screenings at the ages indicated in the MAD EPSDT preventative health guidelines.

(3) MAD pays for partial medical screens to a MAP eligible recipient. Partial medical screens are defined as screens where all the required components of a complete medical screen are not completed for medical reasons.

(4) MAD covers additional medical screens as listed below.

(a) Behavioral health screenings are performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of a behavioral health disorders or conditions.

(b) Dental examinations are performed at intervals which meet reasonable dental standards. Usually these examinations are furnished every six months. However, examinations can be furnished at other intervals as medically necessary.

(c) Hearing testing is performed at intervals which meet reasonable standards or at other intervals as medically necessary for the diagnosis or treatment of defects in hearing. A hearing test using an audiogram should be given to a MAP eligible recipient at five years of age or prior to them to entering school. Annual examinations should be furnished if abnormalities are identified.

(d) Interperiodic screens can be performed at intervals beyond those specified in the periodicity schedule. Reimbursement for the performance of interperiodic screens is made only to a MAD provider. Interperiodic screens are screening encounters with health care, developmental, or educational professionals to determine the existence of suspected physical or behavioral health disorders or conditions.

(e) Vision examinations are performed at intervals which meet reasonable vision standards or at other intervals as medically necessary. A vision examination should be furnished before the MAP eligible recipient reaches three years of age and again prior to five years of age or prior to entering school. If no abnormalities are found, screenings should be furnished every two years with a complete examination furnished if indicated.

(f) Other necessary health care or diagnostic services are performed when medically necessary.

C. MAD covers services considered medically necessary for the treatment or amelioration of conditions identified as a result of a complete tot to teen healthcheck screen, partial medical screen, or interperiodic screen. Diagnostic or evaluation services furnished during the screening cannot be duplicated as part of the follow-up treatment. If appropriate, treatment is furnished by the screening provider at the time of the tot to teen healthcheck.

(1) A MAP eligible recipient can be referred for treatment as a result of a tot to teen healthcheck, regardless of whether the provider making the referral is a participating MAD provider. If it is inappropriate for a screening provider to furnish treatment needed by the MAP eligible recipient, referrals must be made only to a qualified MAD provider.

(2) A MAP eligible recipient may be identified through a tot to teen healthcheck, self referral, or referral from an agency (such as a public school, child care provider, Part B or Part C provider) when they are experiencing behavioral health concerns. For a MAP eligible recipient requiring extensive or long term treatment, they must be referred to a MAD behavioral health professional for further evaluation, and if medically necessary, treatment.

(a) The receiving provider of a MAP eligible recipient must develop an individualized treatment plan.

(b) The plan must consider the total behavioral health needs of the MAP eligible recipient, including any medical conditions that may impact their behavioral health services.

(c) The plan must be developed in cooperation with the MAP eligible recipient, their parents, or guardians, and other health care professionals, as appropriate. In the case of a MAP eligible recipient under 21 years of age who is placed in the custody of the children, youth and families department (CYFD), its assigned social worker, and those appropriate from CYFD's juvenile justice system (JJS) are to be included in the development of the plan.

(d) See to 8.321.2 NMAC for additional information regarding specialized behavioral health services for an ESPDT MAP eligible recipient.

(3) A MAP eligible recipient, when allowed under state law, has the right to refuse proposed medical and behavioral health treatment. They have the freedom to select among enrolled MAD providers. Information in this section does not restrict or limit a MAP eligible recipient's rights or choice.
[8.320.2.15 NMAC - Rp, 8.320.3 NMAC, 1/1/2014]

8.320.2.16 EPSDT SPECIAL REHABILITATION (FAMILY INFANT TODDLER EARLY INTERVENTION) SERVICES: MAD special rehabilitation services are furnished through the New Mexico department of health (DOH) family infant toddler (FIT) program. FIT provides early intervention services for a MAP eligible that has or is at risk of having a developmental delay from birth to their third birth year. Developmental delay or at risk of is defined by DOH. A MAP eligible recipient with a developmental delay or who is at risk of having a developmental delay is not considered to have a diagnosis of an intellectual or developmental disability. FIT services include evaluation, diagnostics and treatment necessary to correct or treat any defects or conditions or to teach compensatory skills for deficits that directly result from a medical or behavioral health condition. The appropriate information from evaluation and diagnostics is interpreted and integrated in the individual family service plan (IFSP). If the need for special rehabilitation is identified outside of the tot to teen healthcheck process, the MAP eligible recipient's PCP must be notified of the results and be included in the treatment plan development, if the PCP so elects.

A. MAD EPSDT special rehabilitation eligible providers: An enrolled MAD agency certified by DOH as a special rehabilitation services provider is eligible to be reimbursed for furnishing special rehabilitation services to a MAP eligible recipient. Individual providers rendering special rehabilitation services that are

employed by or contracted by a MAD special rehabilitation provider agency must meet applicable DOH standards. A provider shall:

(1) render special rehabilitation services under the direction of a professional acting within their scope of practice as defined by state law;

(2) render special rehabilitation services in the most appropriate least restrictive environment;

(3) assure that claiming for special rehabilitation services does not duplicate claiming for EPSDT administrative outreach services or services funded under the state general fund DOH contract.

B. EPSDT special rehabilitation MAP eligible recipients: An individual who has been determined through a multidisciplinary developmental evaluation to have, or be at risk for, a developmental delay and to be in need of special rehabilitative services as defined by DOH is eligible to receive special rehabilitation services. Any individual that has been diagnosed with an intellectual or developmental disability is not eligible for FIT services.

C. EPSDT special rehabilitation treatment plan for a MAP eligible recipient: The need for special rehabilitation services must be documented in the MAP eligible recipient's treatment plan or in their IFSP. The treatment plan must be developed in accordance with applicable DOH policies and procedures and federal regulations governing Part C of the Individuals with Disabilities Education Act. The treatment plan or IFSP must be developed within 45 calendar days of the initiation of services and reviewed every six months or more often as indicated. The following must be contained in the treatment plan or IFSP documents and must be available for review in the MAP eligible recipient's agency file:

(1) a statement of the MAP eligible recipient's present levels of physical development including vision, hearing, and health status;

(2) an assessment of their communications development;

(3) an assessment of their behavioral health status, to include their social or emotional development;

(4) an assessment of their cognitive development;

(5) an assessment of their adaptive development;

(6) their family history and other relevant family information;

(7) a description of their intermediate and long-range goals, with a projected timetable for their attainment and dates, and the duration and scope of services;

(8) the procedures and time lines to determine the progress made toward achieving the outcomes and whether modifications to or revisions of the outcomes or services are needed; and

(9) statement of the specific special rehabilitation services needed to meet the MAP eligible recipient's unique needs and also achieve the outcomes specified, including the frequency, intensity and method of delivering each service, the environment in which each service will be provided, and the location of each service.

D. EPSDT special rehabilitation covered services:

(1) MAD only covers special rehabilitation services necessary to enhance development in one or more of the following developmental domains:

(a) physical and motor;

(b) communication;

(c) adaptive;

(d) cognitive;

(e) behavioral health to include social or emotional; or

(f) sensory.

(2) Special rehabilitation services generally involve the MAP eligible recipient's family and are designed to support and enhance the MAP eligible recipient's developmental services and are provided through FIT. The following are a list of covered services:

(a) Developmental evaluation and rehabilitation services are the assessments performed to determine if motor, speech, language and psychological problems exist with the MAP eligible recipient or to detect the presence of their developmental lags. Services include diagnostic, evaluative and consultative services for the purposes of identifying or determining the nature and extent of, and rehabilitating a MAP eligible recipient's medical or other health-related condition. Services also include consultation with the family and other professional staff. These services are provided as a result of a referral from the MAP eligible recipient's PCP.

(b) Nursing services are performed by a MAD enrolled certified nurse practitioner (CNP), registered nurse (RN) or licensed practical nurse (LPN) within the scope of their practice relevant to the medical and rehabilitative needs of the MAP eligible recipient. These services are provided as the result of a referral from the MAP eligible recipient's PCP. Services include the administration and monitoring of medication,

catheterization, tube feeding, suctioning, and the screening and referral for other health needs. Nursing services also include explanations to the MAP eligible recipient's family or other professional staff concerning the treatments, therapies, and physical or social emotional health conditions.

(c) Physical therapy services are provided by or under the direction of a qualified MAD enrolled physical therapist (PT) as a result of a referral from the MAP eligible recipient's PCP. Physical therapy services are the evaluations required to determine the MAP eligible recipient's need for physical therapy and the provision of therapies that are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age appropriate functional performance. Services also include consultation with the family and other professional staff.

(d) Occupational therapy services are provided by or under the direction of a qualified MAD enrolled occupational therapist (OT) as the result of a referral from the MAP eligible recipient's PCP. Occupational therapy services include the evaluation of the MAP eligible recipient to determine if they are experiencing problems that interfere with their functional performance and the provision of therapies that are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age appropriate functional performance. Services also include consultation with the MAP eligible recipient's family and other professional staff.

(e) Behavioral health services are diagnostic or active treatments with the intent to reasonably improve the MAP eligible recipient's condition; see 8.321.2 NMAC for a detailed description of behavioral health services.

(f) Speech, language and hearing services provided by or under the direction of a MAD enrolled SLP or audiologist, as the result of a referral by the MAP eligible recipient's PCP. Speech, language and hearing services are the evaluations required to determine the MAP eligible recipient's need for these services and recommendations for a course of treatment. Treatment is provided to a MAP eligible recipient with a diagnosed speech, language or hearing disorder which adversely affects their functioning. Services also include consultations with the MAP eligible recipient's family and other professional staff.

E. EPSDT special rehabilitation noncovered services: Special rehabilitation services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities.

F. EPSDT special rehabilitation prior approval and utilization: All MAD EPSDT services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. Specifically for special rehabilitation services, a maximum of 14 hours per month of services to a MAP eligible recipient can be furnished by a provider before prior approval is required from DOH.

[8.320.2.16 NMAC - Rp, 8.320.4 NMAC, 1/1/2014]

8.320.2.17 EPSDT CASE MANAGEMENT SERVICES: MAD pays for case management services furnished to a medically at risk MAP eligible recipient under 21 years of age as an EPSDT service. The need for case management services must be identified in the tot to teen healthcheck screen or through other diagnostic evaluations or assessments.

A. EPSDT case management eligible providers: A qualified MAD enrolled case management agency is eligible to be reimbursed for furnishing services to a MAP eligible recipient. An agency must demonstrate direct experience in successfully serving medically at risk individuals under the age of 21 years and demonstrate knowledge of available community services and methods for gaining access to those services.

(1) The following agencies can furnish case management services:

(a) a governmental agency;

(b) a native Indian tribal government;

(c) the IHS;

(d) a FQHC; and

(e) a community case management agency.

(2) Case manager qualifications: A case manager employed by a MAD enrolled case management agency must possess the education, skills, abilities, and experience to perform case management services. Case managers must have at least one year of experience serving medically at risk individuals under the age of 21 years. Case managers must have the necessary skills to meet the needs of a particular MAP eligible recipient. In some instances, it is important that the case manager have language skills, cultural sensitivity and acquired knowledge unique to a geographic area. In addition, a case manager must meet at least one of the following requirements:

(a) hold a bachelor's degree in social work, counseling, psychology, sociology, education, special education, cultural anthropology or a related health or social service field from an accredited institution; a case manager with a bachelor's degree in another field can substitute two years of direct experience in serving the medically at risk population for the required field of study; or

(b) be licensed as a RN or LPN;

(c) case management services for medically fragile MAP eligible recipients must be provided by a licensed RN; and

(d) if there are no suitable case managers with the previously described qualifications, an agency can employ a case manager with the following education and experience rendering services under the direct supervision of an experienced case manager who meets the qualifications specified above:

(i) hold an associate's degree and has a minimum of three years of experience in community health or social services; or

(ii) hold a high school diploma or a graduate equivalence diploma (GED) and has a minimum of four years of experience in community health or social services.

(3) Agency restrictions: MAD restricts the type of agency that can provide case management services to a MAP eligible recipient with developmental disabilities. See 42 U.S.C. Section 1396n(g)(1)(2). A case management provider for a MAP eligible recipient with developmental disability or severe emotional disturbance must be certified by DOH or CYFD.

(4) MAP eligible recipients: When a MAD enrolled recipient is determined to be medically at risk, they are eligible for case management services. "Medically at risk" is defined as an individual who has a diagnosed physical or social emotional condition which has a high probability of impairing their cognitive, emotional, neurological, social or physical development.

B. EPSDT case management treatment plan (CMTP) or individualized service plan (ISP): The CMTP or ISP is developed by the case manager in cooperation with the MAP eligible recipient, their family or legal guardian, their PCP, as appropriate, and others involved with the MAP eligible recipient's care. The CMTP is developed within 30 calendar days of the initiation of services. The MAP eligible recipient is reassessed and the CMTP is updated annually, or more often as indicated. For a MAP eligible recipient who is medically fragile, the ISP is written and approved within 60 calendar days of the initiation of services which are to start immediately. The ISP is reviewed regularly during the monthly visits; however, the MAP eligible recipient is reassessed annually with a new ISP developed with the MAP eligible recipient, their family and the interdisciplinary team. A social worker may be involved in the development of the treatment plan in the case of a MAP eligible recipient who is in the custody of CYFD or another state agency.

(1) The following, as appropriate, must be contained in the CMTP and ISP or documents used in the development of each. The CMTP, the ISP, and all supporting documentation must be available for review in the MAP eligible recipient's file:

(a) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient;

(b) description of the functional level of the MAP eligible recipient, including the following:

(i) social emotional or behavioral health status assessment;

(ii) intellectual function assessment;

(iii) psychological assessment;

(iv) educational assessment;

(v) vocational assessment;

(vi) social assessment;

(vii) medical assessment; and

(viii) physical assessment;

(c) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(d) description of the intermediate and long-range goals, with the projected timetable for their attainment and duration and scope of services; and

(e) statement and rationale of the CMTP or ISP for achieving these intermediate and long-range goals, including provisions of review and modification of the plan and plans for discontinuation of services, criteria for discontinuation of services and projected date service will be discontinued for the MAP eligible recipient.

(2) Assessments must be performed face-to-face with the MAP eligible recipient, their family or legal guardian.

(3) The agency must have a statement of the specific case management services needed to meet the MAP eligible recipient's unique needs and to achieve the outcomes specified in the CMTP or ISP, including the frequency, intensity and method of delivering each service, the environment in which each service will be provided, and the location of each service.

C. EPSDT case management covered services:

(1) MAD covers the following case management services:

(a) face-to-face assessment of the MAP eligible recipient's medical, behavioral health, social needs and functional limitations; the MAP eligible recipient is reassessed and the CMTP is updated annually, or more often as indicated;

(b) the development and implementation of plans of care designed to help the MAP eligible recipient retain or achieve the maximum degree of independence; certain EPSDT enhanced services can be furnished only if included in the CMTP or ISP, including private duty nursing;

(c) the mobilization of the use of natural helping networks such as family members, church members, community organizations, support groups and friends; and

(d) the coordination and monitoring of the delivery of services, the evaluation of the effectiveness and quality of the services, and the revision of the MAP eligible recipient's CMTP or ISP, when appropriate.

(2) When a MAP eligible recipient is in an out-of-home placement, MAD covers comprehensive coordinated support services (CCSS) detailed in 8.321.2 NMAC during the last 30 calendar days of their placement.

D. EPSDT case management noncovered services: Case management services are subject to the limitations and coverage restrictions which exist for other MAD services. Case management services may not be billed in conjunction with:

(1) services to an individual who is not eligible or who does not meet the MAD definition of medically at risk;

(2) services furnished by other practitioners such as: therapists, transportation providers, homemakers or personal care service providers;

(3) formal educational or vocation services related to traditional academic subjects or vocational training;

(4) client outreach activities in which a provider attempts to contact potential recipients;

(5) administrative activities, such as MAD eligibility determinations and agency intake processing;

(6) institutional discharge planning which is a required condition for payment of hospital, nursing home, treatment foster care or other residential treatment center services; discharge planning must not be billed separately as a targeted case management service;

(7) services which are not documented by the case manager in the MAP eligible recipient's agency file; or

(8) services to a recipient who receives case management services through a home and community-based services waiver program.

[8.320.2.17 NMAC - Rp, 8.320.5 NMAC, 1/1/2014]

8.320.2.18 EPSDT PERSONAL CARE SERVICES: MAD pays for medically necessary personal care services (PCS) furnished to a MAP eligible recipient under 21 years of age as part of the EPSDT program when the services are part of their ISP for the treatment of correction, amelioration, or prevention of deterioration of a MAD identified medical or behavioral health condition, see 42 CFR Section 440.167. PCS provides a range of services to a MAP eligible recipient who is unable to perform some or all activities of daily living (ADLs) or instrumental activities of daily living (IADLs) because of a disability or a functional limitation. A prescribed course of regular PCS services and daily living assistance supports the MAP eligible recipient to live in their home rather than an institution and allows them to achieve the highest possible level of independence. These services include, but are not limited to, activities such as bathing, dressing, grooming, eating, toileting, shopping, transporting, caring for assistance animals, cognitive assistance, and communicating. A MAP eligible recipient may be physically capable of performing ADLs or IADLs but may have limitations in performing these activities because of a cognitive impairment. PCS services may be required because a cognitive impairment prevents a MAP eligible recipient from

knowing when or how to carry out the task. In such cases, PCS services may include cuing along with supervision to ensure that the MAP eligible recipient performs the task properly.

A. EPSDT PCS eligible providers:

(1) agencies that meet the following conditions are eligible to enroll as providers and be reimbursed for providing EPSDT PCS services:

(a) a licensed nursing or home health agency that is a public agency, a private for-profit agency, or private non-profit agency; and

(b) the PCS attendant to the MAP eligible recipient must be supervised by a MAD enrolled RN;

(2) certification for participation as a medicare home health agency is not required; a MAP eligible recipient's family member may not furnish PCS services to them; in this instance, a family member is defined as a legally responsible relative, such as parents of minor child or stepparent who is legally responsible for minor child; for a MAP eligible recipient 18 to 21 years of age, parents or other relatives may provide PCS services if they are not legally responsible for the MAP eligible recipient; the parent or another relative must be employed by a MAD approved PCS agency eligible to bill for PCS services and must meet all MAD required training and supervision standards.

B. EPSDT PCS attendant training:

(1) The PCS agency is responsible for ensuring that the PCS attendant has completed a training program and is competent to provide assigned tasks as a PCS attendant specific to the MAP eligible recipient's needs.

(2) The PCS attendant training program must consist of no less than 40 hours of training to be completed by the PCS attendant in the first year of employment. Ten hours of training must be completed prior to placing the employee in a MAP eligible recipient's home. Two of the 10 hours may include agency orientation. Eight of the 10 hours of training must be specific to the MAP eligible recipient.

(3) The training curriculum must include, at a minimum, the following areas:

(a) communication;

(b) MAP eligible recipient's rights;

(c) recording of information in MAP eligible recipient's records;

(d) nutrition and meal preparation;

(e) care of ill and disabled children and adolescents;

(f) emergency response (first aid, CPR, 911, etc.);

(g) basic infection control;

(h) housekeeping skills;

(i) home safety and fire protection; and

(j) electronic visit verification (EVV).

C. EPSDT PCS criteria: PCS services are defined as medically necessary tasks pertaining to a MAP eligible recipient's physical or cognitive functional ability. The goal of the provision of care is to avoid institutionalization and maintain the MAP eligible recipient's functional level. Services are covered under specific criteria.

(1) The MAP eligible recipient must have a need for assistance with at least two or more ADLs or both such as eating, bathing, dressing and toileting activities, appropriate to their age.

(2) PCS services must be medically necessary, prescribed by the MAP eligible recipient's PCP and included in the MAP eligible recipient's individual treatment plan (ITP).

(3) The need for PCS services is evaluated based on the availability of the MAP eligible recipient's family members or natural supports, such as other community resources or friends that can aid in providing such care.

(4) PCS services must be provided with the consent of the MAP eligible recipient's parent or guardian if the MAP eligible recipient is under the age of 18 years. If a MAP eligible recipient is emancipated or is at least 18 years old and is able to provide consent, their consent is required.

(5) PCS services are furnished in the MAP eligible recipient's place of residence and outside their home when medically necessary and when not available through other existing benefits and programs such as home health, early intervention or school programs. PCS services are services furnished to a MAP eligible recipient who is not an inpatient or a resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), or an institution for mental illness.

(6) Medically necessary PCS services to support a MAP eligible recipient attend school are furnished in partnership with the MAP eligible recipient's school as an alternative to their participation in a

homebound program. PCS services should foster the MAP eligible recipient's independence. PCS services are furnished only to a MAP eligible recipient based on MAD or its designee's UR contractor's approval. PCS services may not be furnished to a non-MAP eligible recipient in the school setting.

(7) Only a trained PCS attendant who has successfully demonstrated service competency such as bathing, dressing, eating and toileting may provide PCS services to a MAP eligible recipient. The PCS attendant must be employed by a MAD approved PCS agency and work under the direct supervision of a MAD approved RN.

(8) The supervisory RN must be employed or contracted by the PCS agency and have one year direct patient care experience. The supervisory RN is responsible for conducting and documenting visits at the MAP eligible recipient's residence for the purpose of assessing their progress and the PCS attendant's performance. The ITP should be updated as indicated and in cooperation with the MAP eligible recipient's case manager. These visits will be conducted and documented every 62 calendar days or more often if the MAP eligible recipient's condition warrants it.

D. EPSDT PCS covered services: MAD covers the following personal care services:

(1) basic personal care services consist of bathing, care of the teeth, hair and nails, assistance with dressing, and assistance with toileting activities;

(2) assistance with eating and other nutritional activities, when medically necessary, i.e., due to documented weight loss or another physical effect; and

(3) cognitive assistance such as prompting or cuing.

E. EPSDT PCS noncovered services: PCS services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities. Specifically, PCS services may not be billed in conjunction with the following services:

(1) any task that must be provided by a person with professional or technical training, such as but not limited to: insertion and irrigation of catheters, nebulizer treatments, irrigation of body cavities, performance of bowel stimulation, application of sterile dressings involving prescription medications and aseptic techniques, tube feedings, and administration of medications;

(2) services that are not in the MAP eligible recipient's approved ITP and for which prior approval has not been received;

(3) services not considered medically necessary by MAD or its designee for the condition of the MAP eligible recipient.

F. EPSDT PCS treatment plan: The MAP eligible recipient's ITP is approved by MAD or its designated UR contractor prior to the initiation of PCS services. The PCS ITP is developed as a result of a face-to-face assessment of the MAP eligible recipient and must include the following:

(1) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient for PCS services;

(2) description of the physical or cognitive functional level of the recipient as evidenced by the PCP's clinical evaluation, including social emotional or behavioral health status, intellectual functioning and the documented medical necessity for PCS services;

(3) description of intermediate and long-range service goals that includes the scope and duration of service, how goals will be attained and the projected timetable for their attainment;

(4) specification of the PCS attendant's responsibilities, including tasks to be performed by the attendant and any special instructions for the health and safety of the MAP eligible recipient;

(5) a statement of the least restrictive conditions necessary to achieve the goals identified in the plan; and

(6) the ITP must be reviewed and revised in cooperation with the MAP eligible recipient's case manager according to their clinical needs at least every six months.

G. Use of the electronic visit verification (EVV) system is required for payment of PCS services including EPSDT eligible members. The managed care organizations shall collaborate to offer a single EVV vendor for PCS and monitor compliance with the federal 21st Century Cures Act. 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.

[8.320.2.18 NMAC - Rp, 8.323.2 NMAC, 1/1/2014; A, 2/1/2020]

8.320.2.19 EPSDT PRIVATE DUTY NURSING SERVICES: MAD pays for private duty nursing (PDN) services as part of the EPSDT program, see 42 CFR Section 441.57. Services must be accessed through the tot to teen healthcheck screen. A MAP eligible recipient is under 21 years, who has been referred for PDN services shift

care (not intermittent care), must meet the established medically fragile criteria and parameters that have been approved by MAD.

A. EPSDT PDN eligible providers**:** A nurse working for a MAD approved PDN agency must have a RN or LPN on staff that meets MAD requirements. Services must be furnished under the direction of the MAP eligible recipient's PCP. Certification for participation as a medicare home health agency is not required. The following agencies are eligible to be reimbursed for providing EPSDT PDN services:

(1) a licensed nursing agency; or

(2) a FQHC.

B. EPSDT PDN coverage criteria: PDN services must be furnished by a RN or a LPN in the MAP eligible recipient's home or in their school setting if it is medically necessary for school attendance. The goal of the provision of care is to avoid institutionalization and maintain the MAP eligible recipient's function level in a home setting.

(1) EPSDT PDN services are for a MAP eligible recipient under 21 years of age who requires more individual and continuous care than can be received through the MAD home health program.

(2) EPSDT PDN services must be ordered by the MAP eligible recipient's PCP and must be included in their approved treatment plan. Services furnished must be medically necessary and be within the scope of the nursing profession. A MAP eligible recipient must have an approved ISP before nursing services can begin. Prior authorization for these services is required.

C. EPSDT PDN treatment plan: The need for skilled nursing services must be included in the MAP eligible recipient's ITP or ISP. The ISP meeting must have been held and the ISP written by the RN or case manager must be approved before nursing services can start. The plan must contain the following:

(1) statement of the nature of the specific problem and the specific needs of the MAP eligible recipient;

(2) description of the functional level of the MAP eligible recipient as documented by the PCP's clinical evaluation, including social, emotional or behavioral health status, intellectual functioning and medical necessity which identify and document the need for a PDN;

(3) specific clinical problems relating to:

(a) physical assessment needs including the identification of durable medical equipment or medical supplies needed by the MAP eligible recipient;

(b) psychosocial evaluation including level of support from family in reaching projected clinical goals; and

(c) medication history including status of compliance of the MAP eligible recipient;

(4) applicable clinical interventions related to the identified clinical problem including measurable goals;

(5) statement of the least restrictive conditions necessary to achieve the goals identified in the plan;

(6) description of intermediate and long-range goals with the projected timetable for their attainment and duration and scope of services, and strengths and priorities of the family and MAP eligible recipient;

(7) statement and rationale of the nursing care plan for achieving these intermediate and long-range goals including provisions for the review and modification of the plan;

(8) specification of nursing responsibilities, description of the proposed nursing care, orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the MAP eligible recipient; and

(9) a transition plan that identifies what the plan will be after discharge from PDN services.

D. EPSDT PDN covered services: MAD covers the following PDN services:

(1) skilled nursing services furnished to the MAP eligible recipient's at their home; and

(2) skilled nursing services which are medically necessary for attending school and furnished to the MAP eligible recipient in the school setting. These services are an alternative to their participation in a homebound program. Nursing services are furnished only to a MAP eligible recipient and not to others in the school setting.

E. EPSDT PDN noncovered services: PDN services are subject to the limitations and coverage restrictions which exist for other MAD services. See Section 14 of this rule for general non-covered MAD EPSDT services or activities.

[8.320.2.19 NMAC - Rp, 8.323.4 NMAC, 1/1/2014]

8.320.2.20 EPSDT REHABILITATION SERVICES: MAD pays for medically necessary services, including outpatient services furnished to a MAP eligible recipient under 21 years of age by or under the supervision of licensed PT; OT; and master's level SLP. A MAP eligible recipient under 21 years of age who is eligible for a home and community based waiver program receives medically necessary rehabilitation services through the EPSDT rehabilitation services, the home and community based waiver program provides rehabilitation services only for the purpose of community integration.

A. EPSDT rehabilitation eligible providers: A PT, OT and master's level SLP is eligible to be reimbursed for furnishing services to a MAP eligible recipient under 21 years of age in need of EPSDT rehabilitation services. The following providers are eligible to be reimbursed for furnishing outpatient rehabilitation services to a MAP eligible recipient:

(1) a master's level SLP licensed by the regulation and licensing department (RLD) board of speech-language pathology and audiology;

(2) a PT licensed as physical therapists by the RLD physical therapy board;

(3) an OT licensed as occupational therapists by the RLD board of examiners for occupational therapy;

(4) certified outpatient rehabilitation centers with a primary emphasis on physical therapy, occupational therapy or speech therapy, licensed by DOH;

(5) home health agencies licensed and certified by DOH; and

(6) general hospitals eligible to provide outpatient rehabilitation services licensed and certified by the DOH;

(7) a PT assistant licensed by the RLD physical therapy board and working under the supervision of a licensed PT;

(8) an OT assistant licensed by the RLD occupational therapy board and working under the supervision of a licensed OT;

(9) a SLP licensed by the RLD board of speech-language pathology and audiology; and

(10) SLP apprentices and clinical fellows licensed by the RLD board of speech-language pathology and working under the supervision of a licensed SLP.

B. EPSDT rehabilitation covered services: MAD covers speech therapy, physical therapy and occupational therapy services provided to a MAP eligible recipient under 21 years of age. MAD covers evaluations, individual therapy and group therapy in an outpatient setting. Services must be medically necessary and provided for the purpose of diagnostic study or treatment. Even though a MAP eligible recipient is receiving therapy services or can access therapy services at their school, they may require additional medically necessary services in addition to those provided at a school. Services must be designed to improve, restore or maintain the MAP eligible recipient's condition including controlling symptoms and maintaining the functional level to avoid further deterioration as indicated their ITP. The provider, following the MAP eligible recipient's PCP orders, will develop the treatment plan.

(1) Physical, occupational, and speech therapy services must be specifically related to the active written treatment plan developed by qualified a PT, OT, SLP therapist with authorization from the MAP eligible recipient's PCP.

(2) Services must be performed within the scope and practice of the RLD practice board and as defined by state statute and rule.

(3) All services provided by or under the supervision of a SLP, OT, PT must be prescribed or ordered by the MAP eligible recipient's PCP. The PCP must be a physician or doctor of osteopathy, certified nurse practitioner, or physician assistant licensed to practice in New Mexico.

C. EPSDT rehabilitation noncovered services:

(1) Services furnished by or under the supervision of a SLP, OT, PT are subject to the limitations and coverage restrictions that exist for other MAD services.

(2) MAD does not cover these specific services related to activities for the general good and welfare of a MAP eligible recipient, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for MAD reimbursement purposes.

D. Prior Authorization: All therapy services with the exception of the initial evaluation require prior authorization from MAD or its designee.

[8.320.2.20 NMAC - Rp, 8.323.5 NMAC, 1/1/2014]

HISTORY OF 8.320.2 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.1700, EPSDT Services, filed 2/13/1980.
ISD 310.1700, EPSDT Services, filed 6/25/1980.
ISD Rule 310.1700, EPSDT Services, filed 10/22/1984.
MAD Rule 310.17, EPSDT Services, filed 5/1/1992.
MAD Rule 310.17, EPSDT Services, filed 7/14/1993.
MAD Rule 310.17, EPSDT Services, filed 11/12/1993.
MAD Rule 310.17, EPSDT Services, filed 12/17/1993.
MAD Rule 310.17, EPSDT Services, filed 3/14/1994.
MAD Rule 310.17, EPSDT Services, filed 6/15/1994.
MAD Rule 310.17, EPSDT Services, filed 11/30/1994.

History of Repealed Material:
MAD Rule 310.17, EPSDT Services, filed 11/30/1994 - Repealed effective 2/1/1995.
8.320.2 NMAC, Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services, filed 2/17/2012 - Repealed effective 1/1/2014.
8.320.3 NMAC, Tot to Teen Healthcheck, filed 2/17/2012 - Repealed effective 1/1/2014.
8.320.4 NMAC, Special Rehabilitation Services, filed 11-12-03 - Repealed effective 1/1/2014.
8.320.5 NMAC, EPSDT Case Management, filed 2/17/2012 - Repealed effective 1/1/2014.
8.323.2 NMAC, EPSDT Personal Care Services, filed 9/16/2002 - Repealed effective 1/1/2014.
8.323.4 NMAC, EPSDT Private Duty Nursing Services - Repealed effective 1/1/2014.
8.323.5 NMAC, EPSDT Rehabilitation Services, filed 6/6/2002 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 320 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES
PART 6 SCHOOL-BASED SERVICES FOR MAP ELIGIBLE RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE

8.320.6.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.320.6.1 NMAC - Rp, 8.320.6.1 NMAC, 7/1/2015; A, 7/1/2024]

8.320.6.2 SCOPE: The rule applies to the general public.
[8.320.6.2 NMAC - Rp, 8.320.6.2 NMAC, 7/1/2015]

8.320.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.320.6.3 NMAC - Rp, 8.320.6.3 NMAC, 7/1/2015; A, 7/1/2024]

8.320.6.4 DURATION: Permanent.
[8.320.6.4 NMAC - Rp, 8.320.6.4 NMAC, 7/1/2015]

8.320.6.5 EFFECTIVE DATE: July 1, 2015, unless a later date is cited at the end of a section.
[8.320.6.5 NMAC - Rp, 8.320.6.5 NMAC, 7/1/2015]

8.320.6.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance division's (MAD) medical assistance programs (MAP).
[8.320.6.6 NMAC - Rp, 8.320.6.6 NMAC, 7/1/2015]

8.320.6.7 DEFINITIONS: [**RESERVED**]

8.320.6.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.320.6.8 NMAC - Rp, 8.320.6.8 NMAC, 7/1/2015; Repealed, 2/1/2020; A, 7/1/2022]

8.320.6.9 SCHOOL-BASED SERVICES FOR RECIPIENTS UNDER TWENTY-ONE YEARS OF AGE: MAD pays for medically necessary services for a MAP eligible recipient under twenty-one years of age when the services are part of the MAP eligible recipient's (eligible recipient's) individualized education program (IEP) or an individualized family service plan (IFSP), a section 504 accommodation plan pursuant to 34 CFR 104 Subpart D (504 plan), an individual health care plan (IHCP), or are otherwise medically necessary as appropriate for each covered service for treatment (correction, amelioration, or prevention of deterioration) of an identified medical condition.
[8.320.6.9 NMAC - Rp, 8.320.6.9 NMAC, 7/1/2015; A, 7/1/2022]

8.320.6.10 GENERAL PROVIDER INSTRUCTIONS: Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a 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 MAD covered services to MAP eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA/MAD or its authorized agents, including program rules, billing instructions, utilization review (UR) instructions, and other pertinent materials. When approved, a provider receives instruction on how to access these documents, it is the provider's responsibility to access these instructions, to understand the

information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. Services must be provided within the scope of the practice and licensure for each agency, each rendering provider within that agency and each individual provider. Services must be in compliance with the statutes, rules and regulations of their practitioner's applicable practice board and act. Providers must be eligible for reimbursement as described in 8.310.3 NMAC.
[8.320.6.10 NMAC - Rp, 8.320.6.10 NMAC, 7/1/2015]

8.320.6.11 ELIGIBLE PROVIDERS:

A. Upon approval of a New Mexico MAD PPA by MAD or its designee, local education agencies (LEAs), regional educational cooperatives (RECs), and other state-funded educational agencies (SFEAs) that meet specified requirements are eligible to be reimbursed for furnishing services to an eligible recipient. The LEA, REC, or other SFEA must enter into a governmental services agreement (GSA) with HCA and abide by the terms and conditions of it.

B. The following individual service providers must be employed by, or under contract to, the LEA, REC, or other SFEA when furnishing treatment and meet other specified qualification criteria:

(1) physical therapists (PT);

(2) physical therapy assistants working under the supervision of a MAD enrolled PT;

(3) occupational therapists (OT);

(4) occupational therapy assistants working under the supervision of a MAD enrolled licensed occupational therapist;

(5) speech and language pathologists (SLP) and clinical fellows;

(6) apprentices in speech-language (ASL) working under the supervision of a MAD enrolled licensed speech therapist; supervision for those providers listed in Paragraphs (1) - (6) above must adhere to the requirements of the practitioner's applicable licensing board;

(7) audiologists;

(8) licensed nutritionists or registered dieticians;

(9) case managers meeting one of the following requirements:

(a) bachelor's degree in social work, counseling, psychology, nursing or a related health or social services field from an accredited institution;

(b) one year experience serving medically-at-risk children or adolescents; or

(c) a licensed registered (RN).

(10) psychologists meeting one of the following requirements:

(a) psychologists (Ph.D., Psy.D., or Ed.D.); or

(b) master's level practitioners licensed by the New Mexico psychologist examiners board as psychologist associates or licensed by PED as school psychologists and working under the supervision of a MAD enrolled licensed psychiatrist or a licensed psychologist (Ph.D., Psy.D., or Ed.D.) or a PED level 3 independent school psychologist, as applicable;

(c) supervision of psychologist associates and school psychologists must adhere to the requirements of the practitioner's applicable licensing board.

(11) social work practitioners meeting one of the following requirements:

(a) licensed independent social worker (LISW); or

(b) licensed master social worker (LMSW) or licensed baccalaureate social worker (LBSW) and working under the supervision of a MAD enrolled licensed independent social worker (LISW) or licensed psychologist (Ph.D., Psy.D., Ed.D.) or other supervisor approved by the New Mexico board of social work examiners;

(i) services provided by licensed master social workers (LMSW) and licensed baccalaureate social workers (LBSW) must be within the scope of their practice respectively and supervised and periodically evaluated;

(ii) an eligible recipient receiving services from an LMSW or LBSW must be diagnosed by the practitioner's supervisor; the diagnosis must be documented in the MAP eligible recipient's record with the signature of the supervisor.

(12) licensed counselors or therapists meeting one of the following requirements:

(a) licensed professional clinical mental health counselor (LPCC); or

(b) licensed marriage and family therapist (LMFT); or

(c) licensed mental health counselor (LMHC) or licensed professional mental health counselor (LPC) and working under the supervision of a MAD enrolled licensed psychiatrist, a licensed psychologist (Ph.D., Psy.D., or Ed.D.), licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), or licensed independent social worker (LISW);

(i) supervision of licensed mental health counselors (LMHC) and licensed professional mental health counselors (LPC) must adhere to the requirements of the practitioner's applicable licensing board;

(ii) an eligible recipient receiving services from a LMHC or LPC must be diagnosed by the practitioner's supervisor; the diagnosis must be documented in the eligible recipient's record with the signature of the supervisor.

(d) licensed associate marriage and family therapist (LAMFT); supervision of LAMFTs must adhere to the requirements of the practitioner's applicable licensing board;

(13) licensed psychiatric clinical nurse specialist (CNS);

(14) physicians and psychiatrists licensed by the board of medical examiners; or

(15) registered nurse (RN), licensed practical nurse (LPN) or unlicensed school personnel providing delegated nursing services in accordance with the New Mexico board of nursing under the supervision of a RN. Delegated nursing services must be delivered in accordance with Subsection B of 16.12.2.12 NMAC.

C. For a LEA, REC, or other SFEA that employs a RN or a licensed practical nurse (LPN) not as a case worker, each is under the oversight of the department of health's (DOH) district health officer, as provided by state statue (Section 24-1-4 NMSA 1978). A LPN must work under the supervision of a RN who is a PED licensed school nurse.

D. As applicable, each provider must be licensed by the public education department (PED) when such licensure exists.

E. As applicable, each provider must be licensed by its specific regulation and licensing division (RLD)'s board of practice or by PED.

[8.320.6.11 NMAC - Rp, 8.320.6.11 NMAC, 7/1/2015; A, 2/1/2020; A, 7/1/2022]

8.320.6.12 PROVIDER RESPONSIBILITIES:

A. General responsibilities:

(1) A provider who furnishes services to an eligible recipient must comply with all terms and conditions of their MAD PPA and the MAD New Mexico administrative code (NMAC) rules.

(2) A provider must verify that an individual is an eligible recipient at the time services are billed.

(3) A provider must appoint a program liaison and backup alternate for each LEA, REC or other SFEA, who will be responsible for receiving and disbursing all communication, information and guidelines from HCA regarding the MAD school-based services program, including information on, but not limited to, direct services and administrative claiming.

B. Documentation requirements:

(1) A provider must maintain all records necessary to fully disclose the nature, quality, amount and medical necessity of services billed to a MAP eligible recipient who is currently receiving MAD services or has received MAD school-based services in the past that are or were part of the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan. Payment for services billed to MAD that are not substantiated in the eligible recipient's records are subject to recoupment. Documentation must be retained for at least six years from the date of payment or until ongoing audit issues are resolved, whichever is longer; see 8.302.2 NMAC.

(2) For services covered under this rule, complete copies of the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan with the individualized treatment plan (ITP) portions of the IEP, IFSP, 504 plan, IHCP or other care plan must be maintained as part of the required records. Those records must clearly indicate that the MAD school-based service is a part of the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan.

(3) Documents in the MAP eligible recipient's file must include:

(a) the IEP, IFSP, 504 plan, IHCP or other care plan with the ITP;

(b) evaluation performed by the provider or the annual and current present level of performance or other determination of medical necessity;

(c) annual PCP notification or documentation of a good faith effort for services provided through an IEP/IFSP;

(d) treatment notes that relate directly to the IEP, IFSP, 504 plan, IHCP or other care plan goals and objectives specific to each MAP eligible recipient; and

(e) billing information recorded in units of time; see 8.302.2 NMAC.

C. Record availability: The provider must upon request promptly furnish to HCA, the secretary of the federal department of health and human services, or the state medicaid fraud control unit any information required in this rule, including the eligible recipient and employee records, and any information regarding payments claimed by the provider furnishing services. Failure to provide records on request may result in a denial of claims. [8.320.6.12 NMAC - Rp, 8.320.6.12 NMAC, 7/1/2015; A, 7/1/2022]

8.320.6.13 COVERED SERVICES: MAD covers the following services when medically necessary and rendered as part of an eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan by specified providers in school settings.

A. For services in Subsections A - E of 8.320.6.13 NMAC, a provider must first develop and then update the eligible recipient's present level of performance for each of their IEP or IFSP cycles. 504 plans, IHCPs or other care plans should be reviewed annually to establish ongoing medical necessity for services. MAD requires the following elements be included in the provider's treatment notes:

(1) the specific activity provided to the MAP eligible recipient for each date of service billed;

(2) a description of the level of engagement and the ability of the eligible recipient for each date of service billed; and

(3) the outcomes of session on the impact on the eligible recipient's exceptionality for each date of service billed.

B. To be reimbursed for a MAD school-based service, all of the requirements in this subsection must be met.

(1) Services must be medically necessary and must meet the needs specified in their IEP, IFSP, 504 plan, IHCP or other care plan. The services must be necessary for the treatment of the eligible recipient's specific identified condition.

(2) The ITP portion of the IEP, IFSP, 504 plan, IHCP or other care plan must be developed in conjunction with the appropriate qualified PT, OT, SLP, audiologist, RN, or behavioral health provider listed in 8.320.6.11 NMAC.

(3) The LEA, REC or other SFEA must complete a MAD specified good faith effort to notify the eligible recipient's PCP of the services to be provided under an IEP or IFSP.

(4) Frequency and duration of services billed may not exceed those specified in the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan.

(5) Reimbursement is made directly to the LEA, REC, or other SFEA when therapy, licensed nutritionists or registered dieticians, transportation, case manager, or nurse providers furnish services under contract to the LEA, REC, or other SFEA.

C. Therapy services: MAD covers physical, occupational, audiological and speech evaluations, and therapy required for treatment of an identified medical condition that is part of an eligible recipient's ITP.

D. Nutritional assessment and counseling: MAD covers nutritional assessment and counseling when rendered by a licensed nutritionist or dietician for an eligible recipient who has been referred for a nutritional need when part of their ITP. A nutritional assessment consists of an evaluation of the nutritional needs of the eligible recipient based upon appropriate biochemical, anthropometric, physical, and dietary data, including a recommendation for appropriate nutritional intake.

E. Transportation services: MAD covers transportation services for an eligible recipient who must travel from their school to receive a covered service from a MAD provider when the service is unavailable in the school setting and when the service is medically necessary and are part of the eligible recipient's IEP or IFSP; see 8.324.7 NMAC. MAD covers transportation to and from the school on the date a medically necessary MAD school-based service is rendered in the school setting for an eligible recipient who has a disability.

(1) MAD school-based services are billed on the specific day on which transportation is rendered and are part of the ITP portion of their IEP or IFSP.

(2) The eligible recipient requires transportation in a vehicle adapted to serve their needs that are part of the ITP portion of their IEP or IFSP.

(3) Transportation occurs in a modified school bus for disabled students.

F. Case management: MAD covers school-based case management services rendered in school settings to an eligible recipient who is medically at risk when these services are part of the eligible recipient's ITP. Medically at risk refers to an eligible recipient who has a diagnosed physical condition which has high probability of impairing cognitive, emotional, neurological, social, or physical development.

(1) The service is developed in conjunction with a qualified case manager.

(2) MAD covers the following school-based case management services.

(a) The assessment of the eligible recipient's medical, social and functional abilities at least every six months, unless more frequent reassessment is indicated by the eligible recipient's condition.

(b) The development and implementation of a comprehensive case management plan of care that helps the eligible recipient retain or achieve the maximum degree of independence.

(c) The mobilization of the use of natural helping networks, such as family members, church members, community organizations, support groups, friends, and the school, if the eligible recipient is able to attend.

(d) Coordination and monitoring of the delivery of services, evaluation of the effectiveness and quality of the services, and revision of the case management plan of care as necessary.

(e) All services must be delivered to be eligible for MAD reimbursement.

(3) An eligible recipient has the freedom to choose a case management service provider. MAD will pay for only *one* case management provider to furnish services to an eligible recipient at any given time period. If an eligible recipient has a case manager or chooses to use a case manager who is not employed or under contract to the LEA, REC or other SFEA, the LEA, REC or other SFEA must coordinate with the case manager in the development of the eligible recipient's ITP.

G. Nursing: MAD covers certain nursing services required for treatment of a diagnosed medical condition that qualifies an eligible recipient for an IEP , IFSP or IHCP when provided by a licensed RN or LPN. Nursing services require professional nursing expertise and are provided by a licensed RN or a LPN and must be provided in accordance with the New Mexico Nursing Practice Act and must be a covered MAD service. Delegated nursing services which are tasks in accordance with the New Mexico board of nursing that may be delegated by the RN to unlicensed school personnel. Delegated staff may include, but is not limited to, school or contracted staff, such as health assistants, teachers, teacher assistants, therapists, school administrators, administrative staff, cafeteria staff, or personal care aides.

(1) The IHCP should be written by the RN in accordance with the NM DOH school health manual.

(2) Delegated nursing services must be delivered in accordance with Subsection B of 16.12.2.12 NMAC.

H. Behavioral health services: MAD covers counseling, evaluation and therapy required for treatment of an identified behavioral health condition that is part of an eligible recipient's ITP.

I. Telemedicine services: MAD covers school-based services provided via telemedicine; see 8.310.2 NMAC.

J. Administrative activities: MAD covers the cost of certain administrative activities that directly support efforts to provide health-related services to a MAP eligible recipient with special education or health care needs. These administrative activities include, but are not limited to, providing information about MAD services and how to access them; facilitating the eligibility determination process; assisting in obtaining transportation and translation services when necessary to receive health care services; making referrals for MAD reimbursable services; and coordinating and monitoring MAD covered medical services.

(1) Payment for an allowable administrative activity is contingent upon the following:

(a) the LEA, REC or other SFEA must complete a MAD PPA to become an approved school-based health services provider;

(b) the LEA, REC or other SFEA must enter into a GSA with HCA and agree to abide by the terms and conditions of the GSA;

(c) the LEA, REC or other SFEA must submit claims for allowable administrative activities in accordance with federal and state regulations, rules and guidelines.

(2) A provider or contractor coordination with the school or contractor or in consultation with principals, school counselors, or teachers are not billable as a service by the provider. The provider must consult with the school to determine if the school will include such activities in its contract with the provider or contractor. The school may not bill MAD separately for these services but can include the costs as administrative costs.

(3) Administrative claiming is subject to compliance reviews and audits conducted by HCA, the state medicaid fraud control unit and the Centers for Medicare and Medicaid Services (CMS). By signing the MAD PPA, the LEA, REC or other SFEA agrees to cooperate fully with HCA, the state medicaid fraud control unit and CMS in the performance of all reviews and audits and further agrees to comply with all review and audit requirements.
[8.320.6.13 NMAC - Rp, 8.320.6.13 NMAC, 7/1/2015; A, 2/1/2020; A, 7/1/2022]

8.320.6.14 INDIVIDUALIZED TREATMENT PLAN:

A. The ITP must specify:

(1) the eligible recipient's objectives and goals; and

(2) the duration, the frequency of the service for the eligible recipient.

B. The plan is developed by the LEA, REC or other SFEA in conjunction with the eligible recipient, their family, and applicable service providers.

C. The ITP is a plan of care agreed upon by the eligible recipient, their parents or legal guardians, the evaluating therapists, the IEP or IFSP committee, and the eligible recipient's teacher, all of whom are included in the IEP or IFSP. The ITP utilizes the eligible recipient's health history, medical and educational evaluations and recommendations by the PCP and other medical providers, as applicable. If medical needs are identified in the IEP or IFSP, the medical portion of the IEP or IFSP is the eligible recipient's ITP. The ITP must be incorporated into the IEP or IFSP.

D. For purposes of non-IEP/IFSP school-based services, the ITP may also be listed in a section 504 accommodation plan pursuant to 34 CFR 104 Subpart D, an individual health care plan, or other plan of care services that are otherwise determined to be medically necessary as appropriate for each covered service.
[8.320.6.14 NMAC - Rp, 8.320.6.14 NMAC, 7/1/2015; A, 7/1/2022]

8.320.6.15 NON-COVERED SERVICES: MAD school-based services billed in school settings are subject to the limitations and coverage restrictions that exist for other MAD services; see 8.301.3 NMAC. MAD does not cover the following services.

A. Services classified as educational.

B. Services to non-MAP eligible individuals.

C. Services billed by a practitioner outside their area of expertise.

D. Vocational training that is related solely to specific employment opportunities, work skills or work settings.

E. Services that duplicate services billed outside the school setting unless determined to be medically necessary and MAD or its designee gave prior authorization for the service.

F. Services not identified in the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan.

G. Transportation services listed below:

(1) transportation that a MAP eligible recipient would otherwise receive in the course of attending school;

(2) transportation for the eligible recipient with special education needs under the Individuals with Disabilities Education Act (IDEA) who rides the regular school bus to and from school with non-disabled children; and

(3) transportation of a minor aged child, such as a sibling of the eligible recipient who is simply accompanying the eligible recipient to a MAD service.
[8.320.6.15 NMAC - Rp, 8.320.6.16 NMAC, 7/1/2015; A, 7/1/2022]

8.320.6.16 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: Certain procedures or services identified in the UR instructions may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. All services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for authorization of services. A specific service may have additional prior authorization requirements listed in the service's prior authorization section. The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the eligible recipient has other health insurance. A provider who disagrees with the denial of a prior authorization request or other review decision can request a reconsideration.

[8.320.6.16 NMAC - Rp, 8.320.6.17 NMAC, 7/1/2015]

8.320.6.17 REIMBURSEMENT: Reimbursement to the LEA, REC, or SFEA is not contingent upon billing a third party payer first when the eligible recipient has other insurance. MAD is generally the payer of last resort. However, if medical services are included in the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan, and an exception is created under 42 USE 1396b(c), 20 USC 1412(a)(12) and 34 CFR 300.142., and the services are otherwise covered by MAD, then MAD is authorized to pay for such services. The LEA, REC, or other SFEA must submit claims for reimbursement on the 837P electronic format or its successor unless it received written permission from MAD to bill on paper.

A. Interim payment to the LEA, REC or other SFEA for covered services are made at the MAD fee schedule for the specific service.

B. The LEA, REC or other SFEA will complete an annual cost report utilized to reconcile interim payments with actual costs in accordance with CMS approved methodology. The LEA, REC or other SFEA must participate in the CMS approved quarterly random moment time study (RMTS).

C. A MAD school-based service that is in the eligible recipient's IEP, IFSP, 504 plan, IHCP or other care plan must only be billed by the school. When the school utilizes a contractor to render the service, the school must submit the claim, not the contractor. It is the responsibility of the school to reimburse the contractor.
[8.320.6.17 NMAC - Rp, 8.320.6.18 NMAC, 7/1/2015; A, 7/1/2022]

HISTORY OF 8.320.6 NMAC:
Pre NMAC History: The material in this part was derived from that previously filed with the State Records Center: MAD-747, School Based Services for Recipients Under Twenty-one Years of Age, filed 12/16/1994.

History of Repealed Material:
8.320.6 NMAC, School Based Services for Recipients Under Twenty-One Years of Age, filed 10/16/2002 - Repealed 1-1-2014.
8.320.6 NMAC, School Based Services for Recipients Under Twenty-One Years of Age, filed 12/17/2013 - Repealed 7/1/2015.

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 4 PHARMACY SERVICES, PRESCRIBING, AND PRACTITIONER ADMINISTERED DRUG ITEMS

8.324.4.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.324.4.1 NMAC - Rp, 8.324.4.1 NMAC, 1/1/2014; A, 7/1/2024]

8.324.4.2 SCOPE: The rule applies to the general public.
[8.324.4.2 NMAC - Rp, 8.324.4.2 NMAC, 1/1/2014]

8.324.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.324.4.3 NMAC - Rp, 8.324.4.3 NMAC, 1/1/2014; A, 7/1/2024]

8.324.4.4 DURATION: Permanent.
[8.324.4.4 NMAC - Rp, 8.324.4.4 NMAC, 1/1/2014]

8.324.4.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.324.4.5 NMAC - Rp, 8.324.4.5 NMAC, 1/1/2014]

8.324.4.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.324.4.6 NMAC - Rp, 8.324.4.6 NMAC, 1/1/2014]

8.324.4.7 DEFINITIONS: [**RESERVED**]

8.324.4.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.324.4.8 NMAC - Rp, 8.324.4.8 NMAC, 1/1/2014]

8.324.4.9 PHARMACY SERVICES: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to MAP eligible recipients, including covered pharmacy services and practitioner administered drugs [42 CFR Section 440.120(a)]. Pharmacy claims must be submitted to the appropriate pharmacy claims processor as designated by MAD.
[8.324.4.9 NMAC - Rp, 8.324.4.9 NMAC, 1/1/2014]

8.324.4.10 ELIGIBLE PROVIDERS:

A. Health care to New Mexico MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to MAP eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement (PPA), an agreement with a HCA contracted managed care organization (MCO) and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims

processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. Eligible providers include:

(1) pharmacies licensed by the New Mexico pharmacy board;

(2) clinics licensed for outpatient dispensing by the New Mexico pharmacy board;

(3) institutional pharmacies licensed for outpatient dispensing by the New Mexico pharmacy board;

(4) family planning clinics and rural health clinics licensed for outpatient dispensing by the New Mexico pharmacy board;

(5) prescribing practitioners practicing in communities more than 15 miles from a licensed pharmacy;

(6) Indian health service (IHS), Indian Self-Determination and Education Assistance Act ("tribal 638") and IHS contract pharmacies and drug rooms operated consistent with IHS standards of practice for pharmaceutical care; and

(7) mail order pharmacies licensed to dispense in New Mexico.

B. When services are billed to and paid by a MAD coordinated services contractor, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

C. Properly licensed practitioners and facilities may also be enrolled for the purpose of being reimbursed for practitioner administered drug items that cannot be self-administered by the medical assistance program (MAP) eligible recipient.

[8.324.4.10 NMAC - Rp, 8.324.4.10 NMAC, 1/1/2014]

8.324.4.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to an MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement. A provider must adhere to MAD program rules as specified in the New Mexico administrative code (NMAC) and program policies that include but are not limited to supplements, billing instructions, and utilization review directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if an MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an MAP eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority; see 8.310.3 NMAC.

D. Retention and storage of the original prescription, electronic prescription, and records of phone or fax orders must meet all pharmacy board requirements and must be retained for six years. If the prescriber certifies that a specific brand is medically necessary, by handwriting "brand medically necessary" or "brand necessary" on the face of the prescription, the allowed ingredient cost is the estimated acquisition cost (EAC) of the brand drug. The documentation of the provider's handwritten certification must be maintained by the pharmacy provider and furnished upon request. Checked boxes, rubber stamps and requests by telephone do not constitute appropriate documentation, pursuant to 42 CFR 447.512. "Brand necessary" prescriptions may be subject to prior authorization. Any claim for which "brand necessary" is claimed must be supported with documentation in the prescriber's medical records. Electronic alternatives approved by the secretary of the federal department of health and human services are acceptable.

E. A pharmacy provider must discuss any matters with the MAP eligible recipient or their personal representative that in the provider's professional judgment are significant. See 42 USC 1396r-8(g)(2)(A)(ii)(I) of the Social Security Act. Pharmacy counseling services are subject to the standards for counseling established under the state Pharmacy Practice Act. Counseling must be furnished unless declined by the MAP eligible recipient or their authorized representative.

F. A pharmacy must follow all federal and state laws, regulations and rules regarding management of pain with controlled substances, use of the drug monitoring program database, limiting dispensing of controlled substances, and reporting dispensing of controlled substances to state monitoring programs.

[8.324.4.11 NMAC - Rp, 8.324.4.11 NMAC, 1/1/2014]

8.324.4.12 COVERED SERVICES: MAD covers medically necessary prescription drugs and some over-the-counter drugs, subject to the limitations and restrictions delineated in this section of this rule. Claims for injectable drugs, intravenous (IV) admixtures, IV nutritional products and other expensive medications may be reviewed for medical necessity before or after reimbursement. Providers must consult MAD, or its designated contractor, before supplying items not specifically listed in this policy or billing instructions. Drug restrictions include dosage, day supply, and refill frequency limits necessary to ensure appropriate utilization or to prevent fraud and abuse. In establishing such limits, professional standards are considered.

A. For a MAP eligible recipient 21 years of age and older not in an institution, coverage of over-the-counter items is limited to insulin**,** diabetic test strips, prenatal vitamins, electrolyte replacement system, ophthalmic lubricants, pediculosides and scabicides, sodium chloride for inhalations, topical and vaginal antifungals and topical anti-inflammatories. MAD, or its designee, may expand the list of covered over-the-counter 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 incorporated as part of the generic-first coverage provisions. Otherwise, the MAP eligible recipient 21 years and older, or their authorized representative is responsible for purchasing or otherwise obtaining an over-the-counter item. Prior authorization for coverage of other over the counter products may be requested when a specific regimen of over the counter drugs is required to treat chronic disease conditions.

B. When drugs are provided through a preferred drug list, drugs are subject to generic-first coverage provisions. The MAP eligible recipient must first use one or more generic items available on the preferred drug list to treat a condition before MAD covers a brand name drug for the condition. MAD publishes a list of the therapeutic categories of drug items that are exempt from the generic-first coverage provisions. Brand name drug items may be covered upon approval by MAD, or its designee, including HCA contracted managed care organization (MCO), based upon medical justification by the prescriber. Generic-first provisions do not apply to injectable drug items.

[8.324.4.12 NMAC - Rp, 8.324.4.12 NMAC, 1/1/2014]

8.324.4.13 COVERAGE REQUIREMENTS:

A. Legal requirements: All drug items must be assigned a national drug code by the respective manufacturer, repackager or labeler. A prescription must meet all federal and state laws, regulations and rules. A pharmacy provider and a prescriber must fulfill all the requirements of federal and state laws relating to their practice and ethics.

B. Rebate requirements: MAD pays only for the drugs of pharmaceutical manufacturers that have entered into and have in effect a rebate agreement with the federal department of health and human services. This limitation does not apply to dispensing a single-source or innovator multiple-source drug if MAD has determined that the availability of the drug is essential to the health of a MAP eligible recipient.

C. Prescribing: A prescriber must be enrolled as a MAD provider in order to prescribe drug items for a MAP eligible recipient. A provider who has been terminated or suspended by MAD or is not enrolled as a provider must notify their MAP eligible recipients that the provider cannot prescribe drug items for them.

[8.324.4.13 NMAC - Rp, 8.324.4.13 NMAC, 1/1/2014]

8.324.4.14 NONCOVERED SERVICES OR SERVICE RESTRICTIONS: Pharmacy services are subject to the limitations and coverage restrictions that exist for other MAD services.

A. MAD does not cover the following specific pharmacy items:

(1) medication supplied by state mental hospitals to a MAP eligible recipient on convalescent leave from the center;

(2) methadone for use in drug treatment programs except as part of a MAD approved medication assisted treatment program (MAT);

(3) personal care items such as non-prescription shampoos, soaps;

(4) cosmetic items, such as retin-A for aging skin, rogaine for hair loss;

(5) drug items that are not eligible for federal financial participation (FFP), including drugs not approved as effective by the federal food and drug administration (FDA), known as DESI (drug efficacy study implementation) drugs;

(6) fertility drugs;

(7) antitubercular drug items available from the New Mexico department of health (DOH) or the United States public health service;

(8) weight loss/weight control drugs;

(9) barbiturate hypnotic drugs whose primary action is to induce sleep unless the MAP eligible recipient resides in a nursing home;

(10) drug items used to treat sexual dysfunction;

(11) compounded drug items which lack an ingredient approved by the federal food and drug administration (FDA) for the indication for which the drug is intended;

(12) compounded drug items for which the therapeutic ingredient does not have an assigned national drug code and is not approved by the FDA for human use; and

(13) cough and cold preparations for a MAP eligible recipient under the age of four.

B. MAD covers non-prescription drug items without prior authorization when prescribed by a licensed practitioner authorized to prescribe for a MAP eligible recipient who resides in a nursing facility (NF) or an intermediate care facility for individuals with intellectual disabilities (ICF-IID), when such items are not routinely included in the facility's reimbursable cost and a specific prescription for the item is dispensed based on a practitioner's order. The following cannot be charged to the MAP eligible recipient or billed to MAD, or a HCA contracted managed care organization, by a provider:

(1) diabetic testing supplies and equipment;

(2) aspirin and acetaminophen;

(3) routine ointments, lotions and creams, and rubbing alcohol; and

(4) other non-prescription items stocked at nursing stations and distributed for use individually in small quantities.

C. MAD does not cover drug items for a MAP eligible recipient who is eligible for medicare Part D when the drug item or class of drug meets the federal definition of a medicare Part D covered drug. MAD does not cover any copayment due from the MAP eligible recipient towards a claim paid by medicare Part D nor any medicare Part D covered drug or class of drug where the MAP eligible recipient has a gap in medicare Part D coverage due to a medicare coverage limit. Items or drug classes specifically excluded by medicare Part D are covered, non-covered or limited to the same extent that MAD covers the excluded drug items for a MAP eligible recipient who is not dually-eligible.

[8.324.4.14 NMAC - Rp, 8.324.4.14 NMAC, 1/1/2014]

8.324.4.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and, before payment is made or after payment is made; see 8.302.5 NMAC. Once enrolled, providers receive directions on how to access instructions and documentation forms necessary for prior authorization and claims processing. Review or prior authorization may be required for items for which a less expensive or therapeutically preferred alternative should be used first. In addition to the generic-first coverage provisions, applicable therapeutic "step" requirements will be based on published clinical practice guidelines, professional standards of health care and economic considerations.

A. Prior authorization: MAD or its designee reviews all requests for prior authorizations. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that an individual is eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request reconsideration; see 8.350.2 NMAC.

D. Drug utilization review: The MAD drug utilization review (DUR) program is designed to assess the proper utilization, quality, therapy, medical appropriateness and costs of prescribed medication through evaluation of claims data, as required by 42 CFR 456.700-716. The DUR program is done on a retrospective, prospective and concurrent basis. This program shall include, but is not limited to, data gathering and analysis and a mix of educational interventions related to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage or duration of treatment and clinical abuse or misuse. Information collected in the DUR program that identifies individuals is confidential and may not be disclosed by the MAD DUR board to any persons other than those identified as the MAP eligible recipient's service providers or governmental entities legally authorized to receive such information.

(1) Prospective drug use review: Prospective DUR (ProDUR) is the screening for potential drug therapy problems (such as, over-utilization, under-utilization, incorrect drug dosage, therapeutic duplication, drug-disease contraindication, adverse interaction, incorrect duration of drug therapy, drug-allergy interactions**,** clinical abuse or misuse) before each prescription is dispensed. The dispensing pharmacist is required to perform

prospective drug use review prior to dispensing. Only a licensed pharmacist or intern may perform ProDUR activities. The pharmacist may be required to insert appropriate DUR override codes when the ProDUR system detects drug therapy issues. In retrospective review of paid claims, payment may be recouped for claims in which the pharmacist has not followed accepted standards of professional practice.

(2) Counseling: Pursuant to 42 CFR 456.705, each dispensing pharmacist must offer to counsel each MAP eligible recipient or their authorized representative receiving services who presents a new prescription, unless the MAP eligible recipient or their authorized representative refuses such counsel. Pharmacists must document these refusals. If no documentation of refusal of counseling is available or readily retrievable, it will be assumed that appropriate counseling and prospective drug use review has taken place. A reasonable effort must be made to record and maintain the pharmacist's comments relevant to said counseling and prospective drug review, particularly when ProDUR overrides are performed. Counseling must be done in person, whenever practicable. If it is not practicable to counsel in person, providers whose primary patient population does not have access to a local measured telephone service must provide a MAP eligible recipient access to a toll-free number.
[8.324.4.15 NMAC - Rp, 8.324.4.15 NMAC, 1/1/2014]

8.324.4.16 REIMBURSEMENT: Pharmacy providers must submit claims for reimbursement on the separate pharmacy claim form or its successor, see 8.302.2 NMAC and Section 17 of this rule.

A. General reimbursement methodology: The estimated ingredient cost will not exceed the lowest of the estimated acquisition cost (EAC), the maximum allowable cost (MAC), the actual acquisition cost of a 340B drug, or the federal upper limit (FUL).

(1) Estimated acquisition cost (EAC). MAD determines EAC as follows:

(a) MAD establishes EAC, defined as MAD's approximation of the net or actual acquisition costs of such drugs;

(b) the factors MAD considers in setting rates for drugs under this subparagraph include:

(i) product cost, which may vary among purchasing contracts;
(ii) clinical concerns;
(iii) MAD's budget limits;
(iv) the actual package size dispensed; and
(v) payments by other payers in New Mexico and other state MAD and medicare pricing policies;

(c) MAD uses the EAC as its reimbursement for a drug when the EAC, plus a dispensing fee established by MAD, is the lowest of the rates calculated under the methods listed in general reimbursement methodology;

(d) EAC is calculated using the current published average wholesale price (AWP) of a drug less a percentage established by MAD, the average manufacturer price (AMP) plus a percentage established by MAD, or the wholesale acquisition cost (WAC) plus a percentage established by HCA, and other pricing limits determined by other pricing information sources selected by MAD; and

(e) MAD uses the ingredient cost indicated in the ingredient cost field on the billing transaction as the EAC when that indicated ingredient cost is lower than the MAD EAC.

(2) Maximum allowable cost (MAC) MAC methodology. MAD establishes a MAC applicable for certain multiple-source drugs with FDA rated therapeutic equivalents and for certain over-the-counter drugs and non-drug items on the following basis:

(a) at least one A-rated generic (as listed in the FDA orange book) is readily available to New Mexico pharmacies;

(b) the MAC for the brand name drug products and for all A-rated therapeutic equivalents shall be determined by arraying costs for the A-rated therapeutic equivalent drugs regardless of manufacturer, and selecting a reasonable price from the arrayed list in a manner consistent with the state plan or any waiver approved by CMS subjecting that price to cost factors and tests for reasonableness;

(c) hen a state MAC price has not been calculated by MAD, a baseline price calculated by a national supplier of drug pricing information is used as the state MAC;

(d) MAC will not be applied if a specific brand has been determined to be medically necessary, in which event the reimbursement rate will be the lower of the EAC of the product dispensed plus the dispensing fee or the provider's billed usual and customary charge; and

(e) for over-the-counter drugs and non-drug items, MAC may be established using the pricing sources in Subsection B of this section.

(3) Federal upper limit (FUL) methodology:

(a) MAD adopts the FUL that is set by CMS or recommended by the federal department of justice.

(b) MAD's maximum payment for multiple-source drugs for which CMS has set FULs will not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by MAD under the dispensing fee determination.

(c) MAD will not use the individual drug FUL as MAD's reimbursement rate when the prescribing practitioner has certified that a specific brand is medically necessary, in which event the reimbursement rate will be the lower of the EAC of the product dispensed plus the dispensing fee or the provider's usual and customary billed charge.

(4) 340B drug discount actual acquisition cost:

(a) The actual ingredient cost for drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to a MAP eligible recipient must placed in the ingredient cost field and indicated on the billing transaction as a 340B drug item.

(b) Drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to a MAP eligible recipient must be billed at the actual acquisition cost of the provider and indicated on the billing transaction as a 340B drug item. If a MAP eligible recipient with a prescription written at a 340B entity requests the item to be dispensed by a 340B pharmacy under contract to the 340B entity then the pharmacist must dispense 340B purchased items when filling the prescription.

(5) Usual and customary charge:

(a) The provider's billed charge must be its usual and customary charge for services. Over-the-counter items must be billed with the over-the-counter price as the usual and customary charge, unless it is labeled and dispensed as a prescription.

(b) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

(c) Usual and customary charges must reflect discounts given to a MAP recipient for certain reasons, such as age or NF resident, when a MAP eligible recipient meets the standards for the discount. MAD must be given the advantage of discounts received by the general public, including promotions or items sold at cost to the general public, if these are the prices usually and customarily charged to non-MAP recipient.

(d) Providers cannot add additional costs for their time, paperwork, or anticipated turnaround time for payment.

(6) Medicare reimbursement: Reimbursement may be limited to medicare reimbursement limits where the total of the medicare-allowed amounts plus, if applicable, a dispensing fee, is the lowest of EAC, MAC, FUL, usual and customary charge or 340B drug discount amount as defined in this Section Subsection A of this rule.

(7) Practitioner administered drug items are reimbursed according to the MAD fee schedule.

B. Pricing information to set EAC and MAC: MAD selects the sources for pricing information used to set EAC and MAC. These sources may include pharmaceutical wholesalers, manufacturers, federal agencies, drug data information clearinghouses and pharmacy invoices.

C. Assistance in establishing EAC and MAC: MAD may solicit assistance from pharmacy providers, pharmacy benefit managers (PBMs), other government agencies, actuaries, or other consultants when establishing EAC or MAC.

D. Pharmacy price reductions: If the pharmacy provider offers a discount, rebate, promotion or other incentive that results in a reduction of the price of a prescription to the individual non- MAP recipient, the provider must similarly reduce its charge to MAD for the prescription.

E. **No claims for free products:** If a pharmacy gives a product free to the general public, the pharmacy must not submit a claim to MAD when giving the free product to a MAP eligible recipient.

F. Solutions: Solutions, such as saline for nebulizers, intravenous (IV) solutions without additives, electrolyte and irrigation solutions, and diluents are considered medical supply items for reimbursement purposes; see 8.310.2 NMAC.

G. Non-drug items: Urine test reagents, electrolyte replacement and nutritional products, equipment and medical supplies, including syringes and alcohol swabs, are subject to restrictions for medical supplies, see 8.310.2 NMAC.

[8.324.4.16 NMAC - Rp, 8.324.4.16 NMAC, 1/1/2014]

8.324.4.17 POINT OF SALE: The point-of-sale system provides relevant drug utilization information that the pharmacist must consider before dispensing a drug. If utilization information indicates that a MAP eligible recipient has an adequate supply of the drug item or that the quantity being dispensed is excessive, the claim will initially be denied. The pharmacist is responsible for resolving the issue and obtaining an authorization to dispense the drug, if necessary.

A. General requirements: All MAD in-state and border area pharmacy providers are required to submit claims through the point-of-sale system.

B. Exceptions to general requirements: The following are exceptions to this general requirement:

(1) the provider is out-of-state and is not a border area provider;

(2) the provider is a family planning clinic dispensing prescriptions;

(3) the provider submitted on average less than 50 claims per month to MAD for the preceding six-month period;

(4) the claim requires an attachment or explanation; or

(5) a required data element on the claim cannot be entered in the current standard point-of-sale format.

[8.324.4.17 NMAC - Rp, 8.324.4.17 NMAC, 1/1/2014]

8.324.4.18 PRESCRIPTIONS AND REFILLS:

A. Dispensing frequencies: MAD limits the frequency for which it reimburses the same pharmacy for dispensing the same drug to the same MAP eligible recipient.

(1) The limitation is established individually for each drug.

(2) Maintenance drugs are subject to a maximum of three times in 90 days with a 14-calendar day grace period to allow for necessary early refills.

(3) Certain drugs are given more flexibility due to their specific dosage forms, packaging or clinical concerns.

(4) The excessive dispensing limitation applies regardless of whether the claim is for a new prescription or refill.

(5) Schedule II controlled substances are limited to a maximum 34-day supply. Initial use of controlled substances may also be further limited by state law.

B. Refill requirements: Refills must be consistent with the dosage schedule prescribed and with all applicable federal and state laws, regulations and rules. Consistent use of early refills will result in a calculation that the MAP eligible recipient has sufficient stock of the drug item on hand and allowed refill dates will be adjusted accordingly.

C. Quantities dispensed: Maintenance drugs are those on the MAD-approved maintenance drug list.

(1) For a MAP eligible recipient with likely continuous eligibility due to age, disability or category of eligibility, prescriptions for maintenance drugs may be dispensed in amounts up to a 90-day supply.

(2) Prescriptions for non-maintenance drugs are limited to 34-day supplies.

(3) Oral contraceptives may be dispensed for up to a one-year supply if the appropriate contraceptive for the MAP eligible recipient has been established.

(4) Controlled substances may not be refilled until 75 percent of the drug has been used based on the days supply of the previous prescription unless the prescriber has been notified and given approval. A pharmacy with access to dispensing information through a chain store or linked database, or that is notified of early refills or other dispensing of drugs through a point-of-sale system, is responsible for assuring the refill meets the criteria by verifying the dispensing history available, including the drug monitoring program database. Dispensed drug items which do not meet these criteria are subject to recoupment.

(5) Pharmacy providers shall not reduce prescriptions for maintenance drugs that are written for quantities larger than a 34-day supply and may dispense up to a 90-day supply. MAD considers prescription splitting to be fraudulent. Pharmacies that do not have the entire prescribed amount on hand may dispense a partial fill.

(6) Coverage may be limited by the end date of the MAP eligible recipient's span of eligibility at the time of dispensing.

(7) Pharmacists are encouraged to consult with prescribers to achieve optimal drug therapy outcomes, consistent with NMSA 1978, Section 61-11-2(V).

(8) Controlled substances may have specific controls on the quantities dispensed.

D. Unit dose packaging: MAD does not pay additional for unit dose packaging.

E. Prevention of abuse: Drug items are to be dispensed for legitimate medical needs only. If the pharmacist suspects the MAP eligible recipient of over-utilizing or abusing drug services, the pharmacist must contact the provider and MAD so that the MAP eligible recipient's use of medications can be reviewed. Excessively high doses and overlapping use of multiple drug items with the same therapeutic uses that are potentially abusive or otherwise dangerous may result in subjecting the prescriptions to the prior authorization process or recoupment from the pharmacy if the prescriber is not contacted and the contact documented.

F. Mail service pharmacy: MAD may provide a mail service pharmacy for a MAP eligible recipient use.

(1) The mail service pharmacy is available as an option to all MAP eligible recipients.

(2) Retail pharmacies may mail, ship or deliver prescriptions to all MAP eligible recipients consistent with applicable state and federal statutes, rules and regulations.

[8.324.4.18 NMAC - Rp, 8.324.4.18 NMAC, 1/1/2014]

HISTORY OF 8.324.4 NMAC:

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

ISD 310.0700, Pharmacy Services, filed 2/29/1980.
ISD 310.0700, Drug Services, filed 2/10/1981.
ISD 310.0700, Drug Services, filed 7/8/1982.
ISD Rule 310.0700, Drug Services, filed 3/1/1983.
ISD Rule 310.0700, Drug Services, filed 2/15/1989.
ISD Rule 310.0700, Drug Services, filed 7/9/1984.
MAD Rule 310.07, Drug Services, filed 3/31/1989.
MAD Rule 310.07, Drug Services, filed 1/3/1992.
MAD Rule 310.07, Drug Services, filed 4/20/1992.
MAD Rule 310.07, Drug Services, filed 12-8-94.

History of Repealed Material:

MAD Rule 310.07, Drug Services, filed 12/8/1994 - Repealed effective 2/1/1995.
8 NMAC 4.MAD.753, Pharmacy Services, filed 1/18/1995 - Repealed effective 8/13/2004.
8.324.4 NMAC, Pharmacy Services, filed 8/2/2004 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 5 VISION APPLIANCES, HEARING APPLIANCES, DURABLE MEDICAL EQUIPMENT, OXYGEN, MEDICAL SUPPLIES, PROSTHETICS AND ORTHOTICS

8.324.5.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.324.5.1 NMAC - Rp, 8.324.5.1 NMAC, 1/1/2014; A, 7/1/2024]

8.324.5.2 SCOPE: The rule applies to the general public.
[8.324.5.2 NMAC - Rp, 8.324.5.2 NMAC, 1/1/2014]

8.324.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.324.5.3 NMAC - Rp, 8.324.5.3 NMAC, 1/1/2014; A, 7/1/2024]

8.324.5.4 DURATION: Permanent.
[8.324.5.4 NMAC - Rp, 8.324.5.4 NMAC, 1/1/2014]

8.324.5.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.324.5.5 NMAC - Rp, 8.324.5.5 NMAC, 1/1/2014]

8.324.5.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.324.5.6 NMAC - Rp, 8.324.5.6 NMAC, 1/1/2014]

8.324.5.7 DEFINITIONS: [**RESERVED**]

8.324.5.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.324.5.8 NMAC - Rp, 8.324.5.8 NMAC, 1/1/2014]

8.324.5.9 VISION APPLIANCES, HEARING APPLIANCES, DURABLE MEDICAL EQUIPMENT, OXYGEN, MEDICAL SUPPLIES, PROSTHETICS AND ORTHOTICS: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to a medical assistance program (MAP) eligible recipient, including covered vision appliances, hearing aids and related services [42 CFR Section 440.60(a) and Section 440.110(c)], durable medical equipment and medical supplies, [42 CFR Section 440.70 (c)] and covered prosthetic and orthotic services [42 CFR Section 440.120(c)].
[8.324.5.9 NMAC - Rp, 8.324.5.9 NMAC, 1/1/2014]

8.324.5.10 ELIGIBLE PROVIDERS: Health care to a MAP eligible recipient is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA), a licensed practitioner of a facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instruction, utilization review (UR) instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided, to comply with the requirements and to update their knowledge as new material is provided by MAD. The provider must contact HCA or its authorized agents to request hard copies of any MAD New Mexico administrative code (NMAC) program rules, MAD billing and UR instructions and other pertinent material, and to obtain answers to questions related to the material or not covered by

the material. To be eligible for reimbursement, a provider must adhere to the provisions of their MAD PPA and all applicable statutes, regulations, rules and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. A provider must supply necessary information in order for payment to be made. Upon approval of their MAD PPA, the following practitioners and facilities may be enrolled as MAD providers:

A. Vision appliance provider:

(1) an ophthalmologist licensed to practice medicine in New Mexico, who limits their practice to ophthalmology (ophthalmologist) and the groups, corporations, and professional associations they form;

(2) an optometrist licensed to practice optometry in New Mexico and the groups, corporations, and professional associations they form;

(3) an optician qualified to provide eyeglasses, contact lenses, supplies, and other vision-related materials; or

(4) Indian health service (IHS) or a tribal facility operating under Public Law 93-638.

B. Hearing appliances providers:

(1) an individual licensed to practice medicine or osteopathy; or

(2) a hearing aid dealer registered and licensed by the New Mexico regulations and licensing division (RLD) practice boards for speech language pathology, audiology, and hearing aid dispensing.

C. Durable medical equipment (DME), oxygen and medical supplies provider: A DME, oxygen and medical supplies provider must hold a current PPA with MAD.

D. Prosthetics and orthotics provider: A prosthetics or orthotics provider must hold a current PPA with MAD.

[8.324.5.10 NMAC - Rp, 8.324.5.10 NMAC, 1/1/2014]

8.324.5.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of their PPA. A provider must adhere to the NMAC program rules and program policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service, as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to the MAP eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority; see 8.302.2 NMAC.

D. Vision appliances providers: A provider must ensure that a prescription for eyeglasses or contact lenses is accurate to the extent that the prescription corrects the MAP eligible recipient's vision to the degree of acuity indicated on their vision examination record. An eyeglass and contact lens supplier is responsible for verifying that the correct prescription is provided.

(1) If a prescription is inaccurate and the MAP eligible recipient is unable to use their eyeglasses or contact lenses, payment for both the eye examination and the eyeglasses or contact lenses is subject to recoupment.

(2) If the eyeglasses or contact lenses are not ground to the correct prescription, payment for the eyeglasses or contact lenses is subject to recoupment.

[8.324.5.11 NMAC - Rp, 8.324.5.11 NMAC, 1/1/2014]

8.324.5.12 COVERED SERVICES:

A. Vision appliances: MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases. MAD pays a provider for the correction of refractive errors that are required by the condition of the MAP eligible recipient. All services must be furnished within the limits of MAD benefits, 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 their New Mexico regulation and licensing division's (RLD) practice board.

(1) Exam: MAD covers routine eye exams. Coverage for a MAP eligible recipient over 22 years of age is limited to one routine eye exam in a 36-month period. Exam coverage for a MAP eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period. If a MAP eligible recipient has transitioned from the early, periodic screening, diagnosis and treatment (EPSDT) program at age 21, the date of service for their last exam starts the 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma will be covered for required follow-up and treatment. The medical condition must be clearly documented on their visual examination record and indicated by diagnosis on the claim form.

(2) Corrective lenses: MAD covers one set of corrective lenses for a MAP eligible recipient 21 years of age and older not more frequently than once in a 36-month period. For a MAP eligible recipient under 21 years of age, one set of corrective lenses is covered no more frequently than once every 12 months. If a MAP eligible recipient has transitioned from the EPSDT program at age 21, the date of service for their last corrective lenses starts the 36-month period. For either age group, MAD covers corrective lenses more frequently when an ophthalmologist or optometrist recommends a change in prescription due to a medical condition, including but not limited to cataracts, diabetes, hypertension, glaucoma or treatment with certain systemic medications affecting vision. The vision prescription must be appropriately recorded on the MAP eligible recipient's visual examination record and indicated by a diagnosis on the claim.

(a) For the purchase of eyeglasses, the diopter correction must meet or exceed one of the following diopter correction criteria:

(i) -1.00 myopia (nearsightedness);

(ii) + 1.00 for hyperopia (farsightedness);

(iii) 0.75 astigmatism (distorted vision), the combined refractive error of sphere and cylinder to equal 0.75 will be accepted;

(iv) ±1.00 for presbyopia (farsightedness of aging); or

(v) diplopia (double vision) - prism lenses.

(b) When a MAP eligible recipient's existing prescription is updated and the frequency of replacement lenses meets the requirements in Paragraph (2) above, the lenses may be replaced when there is a minimum 0.75 diopter change in the prescription. The combined refractive error of sphere and cylinder to equal 0.75 will be accepted. An exception is considered for the following:

(i) a MAP eligible recipient over 21 years of age with cataracts;

(ii) an ophthalmologist or optometrist recommends a change due to a medical condition; or

(iii) a MAP eligible recipient is under 21 years of age.

(3) Bifocal lenses: MAD covers bifocal lenses with a correction of 0.25 or more for distance vision and 1 diopter or more for added power (bifocal lens correction).

(4) Tinted lenses: MAD covers tinted lenses with filtered or photochromic lenses if the examiner documents one or more of the following disease entities, injuries, syndromes or anomalies in the comments section of the visual examination record, and the prescription meets the dioptic correction purchase criteria:

(a) aniridia;

(b) albinism, ocular;

(c) traumatic defect in iris;

(d) iris coloboma, congenital;

(e) chronic keratitis;

(f) sjogren's syndrome;

(g) aphakia, U.V. filter only if intraocular lens is not U.V. filtered;

(h) rod monochromaly;

(i) pseudophakia; or

(j) other diagnoses confirmed by ophthalmologist or optometrist that is documented in the MAP eligible recipient's visual examination form.

(5) Polycarbonate lenses: MAD covers polycarbonate lenses for:

(a) a MAP eligible recipient for medical conditions which require prescriptions for high power lenses;

(b) a MAP eligible recipient with monocular vision;

(c) a MAP eligible recipient who works in a high-activity physical job;

(d) a MAP eligible recipient under 21 years of age; or

(e) a MAP eligible recipient 21 years and older that has a developmental or intellectual disability.

(6) Balance lenses: MAD covers balance lenses for a MAP eligible recipient under 21 years of age without a prior authorization in the following situations:

(a) lenses used to balance an aphakic eyeglass lens; or

(b) a MAP eligible recipient under 21years of age is blind in one eye and the visual acuity in the eye requiring correction meets the diopter correction purchase criteria.

(7) Frames: MAD covers frames for corrective lenses. Coverage for a MAP eligible recipient 21 years of age and older is limited to one frame in a 36-month period. If a MAP eligible recipient has transitioned from the EPSDT program at age 21, the date of service of their last frames starts the 36-month period. Coverage for a MAP eligible recipient under 21 years of age is limited to one frame in a 12-month period unless:

(a) an ophthalmologist or optometrist has documented a medical condition that requires replacement; or

(b) other situations that will be reviewed on a case-by-case basis.

(8) Contact lenses: MAD covers contact lenses, either the original prescription or replacement, only with a prior authorization. Coverage for an eligible adult recipient 21 years of age and older is limited to one pair of contact lenses in a 24-month period, unless an ophthalmologist or an optometrist recommends a change in prescription due to a medical condition affecting vision. If a MAP eligible recipient is transition from the EPSDT program at age 21, the date of service for their last contact lenses starts as the 24-month period. A request for prior authorization will be evaluated on dioptic criteria or visual acuity, the MAP eligible recipient's social or occupational need for contact lenses, and special medical needs. The criteria for authorization of contact lenses are as follows:

(a) the MAP eligible recipient must have a diagnosis of keratoconus or diopter correction of +/- -6.00 or higher in any meridian or at least 3.00 diopters of anisometropia; or

(b) monocular aphakics may be provided with one contact lens and a pair of bifocal glasses.

(9) Replacement: Eyeglasses or contact lenses that are lost, broken or have deteriorated to the point that, in the examiner's opinion, they have become unusable to the MAP eligible recipient, may be replaced. Two items must be documented in the provider's request for the replacement in addition to being found in the MAP eligible recipient's visual examination record: The MAP eligible recipient's eyeglasses or contact lens (or lenses) must meet the diopter correction purchase criterion; and an explanation of the loss, deterioration or breakage is provided. The following are the criteria that an MAP eligible recipient must be meet for the replacement of their eyeglasses or contact lenses:

(a) the MAP eligible recipient is under 21 years of age; or

(b) the MAP eligible recipient is 21 years of age and older and has a developmental or intellectual disability.

(10) Prisms: Prisms are covered if medically indicated to prevent diplopia (double vision). Documentation is required on the MAP eligible recipient's visual examination record.

(11) Lens tempering: MAD covers lens tempering only on new glass lenses.

(12) Lens edging: MAD covers lens edging and lens insertion.

(13) Minor repairs: MAD covers minor repairs to eyeglasses.

(14) Dispensing fee: MAD pays a dispensing fee to an ophthalmologist, optometrist, or optician for dispensing a combination of lenses and new frames at the same time. This fee is not paid when contact lenses are dispensed. The prescription and fitting of contact lenses is paid to dispensing ophthalmologists and optometrists. Independent technicians are not approved by MAD to prescribe and fit contact lenses.

(15) Eye prosthesis: MAD covers eye prostheses (artificial eyes); see Subsection D below.

B. Hearing appliances:

(1) Within specified limitations, MAD covers the following services when furnished by primary care provider (PCP), licensed audiologists or by licensed hearing aid dealers:

(a) hearing aid purchase, rental repairs, hearing aid repair and handling, replacements, and the loan of equipment while repairs or replacements are made:

(i) binaural hearing aid fitting will be covered for a MAP eligible recipient with bilateral hearing loss who is attending an educational institution, seeking employment, is employed, or for a MAP eligible recipient with a current history of binaural fitting; or

(ii) binaural hearing aid fitting will be considered on a case-by-case basis for a MAP eligible recipient determined to be legally blind;

(b) hearing aid accessories and supplies, including the batteries required after the initial supply furnished at the time the hearing aid is dispensed; and

(c) hearing aid insurance against loss and breakage for up to four years for all purchased hearing aids; hearing aid insurance is required when the aid is dispensed; four years of hearing aid insurance is required for:

(i) a MAP eligible recipient under 21 years of age;

(ii) a MAP eligible recipient residing in a nursing facility (NF); or (iii) a MAP eligible recipient who has a developmental or intellectual disability;

(d) replacement of hearing aids is limited to the provisions of the MAP eligible recipient's hearing aid insurance; the provider is responsible for obtaining insurance for every hearing aid purchased for a MAP eligible recipient.

C. **DME, oxygen and medical supplies:** MAD covers DME that meets the MAD definition of DME, the medical necessity criteria, and MAD prior authorization requirements. MAD covers the repair, maintenance, delivery of durable medical equipment, and the disposable and non-reusable items essential for the use of the equipment, subject to the limitations specified in this rule. All items purchased or rented must be ordered by a provider who has an approved MAD PPA. Coverage for DME is limited for a MAP eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, NF, intermediate care facility for individuals with intellectual disabilities (ICF-IID), and a rehabilitation facility. A MAP eligible recipient who is receiving services from a home and community-based waiver is not considered an institutionalized eligible recipient. MAD does not cover duplicates of items, for example, a MAP eligible recipient is limited to one wheelchair, one hospital bed, one oxygen delivery system, or one of any particular type of equipment. A back-up ventilator is covered.

(1) DME is defined by MAD as: (a) equipment that can withstand repeated use; (b) primarily and customarily used to serve a medical purpose; (c) not useful to an eligible recipient in the absence of an illness or injury; and (d) appropriate for use at home.

(2) Equipment used in a MAP eligible recipient's residence must be used exclusively by the MAP eligible recipient for whom it was approved.

(3) To meet the medical necessity criterion, DME must be necessary for the MAP eligible recipient's treatment of an illness, injury, or to improve the functioning of a specific body part.

(4) Replacement of equipment is limited to the same extent as it is limited by medicare regulation. When medicare does not specify a limitation, equipment is limited to one item every three years unless there are changes in the MAP eligible recipient's medical necessity or as otherwise indicated in this rule.

(5) Medical supplies: MAD covers medical supplies that are necessary for an ongoing course of treatment within the limits specified in this section. As distinguished from DME, medical supplies are disposable and non-reusable items.

(a) A provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or their authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have in excess of a 15-calendar day supply of the item before releasing the next supply order. A provider must keep documentation in its files available for auditing that shows compliance with this requirement.

(b) MAD coverage for DME and medical supplies is limited for a MAP eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, NF, ICF-IID, and a rehabilitation facility.

(6) Covered services and items: MAD covers the following items without prior authorization for both an institutionalized and non-institutionalized MAP eligible recipient:

(a) trusses and anatomical supports that do not need to be made to measure;

(b) family planning devices;

(c) repairs to DME and replacement parts if a MAP eligible recipient owns the equipment for which the repair is necessary and the equipment being repaired is a covered MAD benefit; some replacement items used in repairs may require prior authorization; see Section 13 of this rule;

(d) repairs to augmentative and alternative communication devices require prior authorization;

(e) monthly rental includes monthly service and repairs; and

(f) replacement batteries and battery packs for augmentative and alternative communication devices owned by the MAP eligible recipient.

(7) Covered services for a non-institutionalized MAP eligible recipient: MAD covers certain medical supplies, nutritional products and DME provided to a non-institutionalized MAP eligible recipient without prior authorization. Monthly allowed quantities of items are limited to the same extent as limited by medicare regulation. When medicare does not specify a limitation, an item is limited to a reasonable amount as defined by MAD and published in its DME and medical supplies billing instructions which are available on the HCA/MAD website. MAD covers the following for a non-institutionalized MAP eligible recipient:

(a) needles, syringes and intravenous (IV) equipment including pumps for administration of drugs, hyper-alimentation or enteral feedings;

(b) diabetic supplies, chemical reagents, including blood, urine and stool testing reagents;

(c) gauze, bandages, dressings, pads, and tape;

(d) catheters, colostomy, ileostomy and urostomy supplies and urinary drainage supplies;

(e) parenteral nutritional support products prescribed by a PCP on the basis of a specific medical indication for a MAP eligible recipient who has a defined and specific pathophysiologic process for which nutritional support is considered specifically therapeutic and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet the MAP eligible recipient's medical needs;

(f) apnea monitors: prior authorization is required if the monitor is needed for six months or longer; and

(g) disposable gloves (sterile or non-sterile) are limited to 200 per month.

(8) Covered oxygen and oxygen administration equipment: MAD covers the following oxygen and oxygen administration systems, within these specified limitations:

(a) oxygen contents, including oxygen gas and liquid oxygen;

(b) oxygen administration equipment purchase with prior authorization; oxygen administration equipment may be supplied on a rental basis for one month without prior authorization; rental beyond the initial month requires a prior authorization;

(c) oxygen concentrators, liquid oxygen systems and compressed gaseous oxygen tank systems. MAD approves the most economical oxygen delivery system available that meets the medical needs of the MAP eligible recipient;

(d) cylinder carts, humidifiers, regulators and flow meters;

(e) purchase of cannulae or masks; and

(f) oxygen tents and croup or pediatric tents.

(g) MAD does not cover oxygen tank rental (demurrage) charges as separate charges when renting gaseous tank oxygen systems. If MAD pays rental charges for a system, tank rental is included in the rental payments. MAD follows the medicare rules for:

(i) limiting or capping reimbursement for oxygen rental at 36 months;

(ii) requirements for the provider to maintain and repair the equipment; and

(iii) to providing ongoing services and disposable supplies after the capped rental;

(h) a NF is administratively responsible for overseeing oxygen supplied to the MAP eligible recipient resident.

(9) Augmentative and alternative communication devices: MAD covers medically necessary electronic or manual augmentative communication devices for a MAP eligible recipient. Medical necessity is determined by MAD or its designee. Communication devices whose purpose is also educational or vocational are covered only when it has been determined the device meets medical criteria. A MAP eligible recipient must have the cognitive ability to use the augmentative communication device, and not be able to functionally communicate verbally or through gestures.

(a) All of the following criteria must be met before an augmentative communication device can be considered for prior authorization. The communication device must be:

(i) a reasonable and necessary part of the MAP eligible recipient's treatment plan;

(ii) consistent with the MAP eligible recipient's symptoms, diagnosis or medical condition of the illness or injury under treatment;

(iii) not furnished for the convenience of the MAP eligible recipient, the family, the attending practitioner or other practitioner or supplier;

(iv) necessary and consistent with generally accepted professional medical standards of care;

(v) established as safe and effective for the MAP eligible recipient's treatment protocol;

(vi) furnished at the most appropriate level suitable for use in the MAP eligible recipient's home environment;

(vii) augmentative and alternative communication devices are authorized every 60 months for a MAP eligible recipient 21 years of age and older and every 36 months for a MAP eligible recipient under 21 years of age, unless earlier authorization is dictated by medical necessity; and

(viii) repairs to, and replacement parts for augmentative and alternative communication devices owned by the MAP eligible recipient.

(10) Rental of DME: MAD covers the rental of DME.

(a) MAD does not cover routine maintenance and repairs for rental equipment as it is the provider's responsibility to repair or replace the MAP eligible recipient's equipment during the rental period.

(b) Low cost items, defined as those items for which the MAD allowed payment is less than $150, may only be purchased. For these items, the purchased DME becomes the property of the MAP eligible recipient for whom it was approved.

(c) MAD covers the rental and purchase of used equipment. The equipment must be identified and billed as used equipment. The equipment must have a statement of condition or warranty, and a stated policy covering liability.

(11) Delivery of equipment and shipping charges: MAD covers the delivery of a DME item only when the equipment is initially purchased or rented and the round trip delivery is over 75 miles. A provider may bill delivery charges as a separate additional charge when the provider customarily charges a separate amount for delivery to its clients who are not a MAP eligible recipient of the service. MAD does not pay delivery charges for equipment purchased by medicare, for which MAD is responsible only for the coinsurance and deductible. MAD covers the shipping charges for DME and medical supplies when it is more cost effective or practical to ship items to the MAP eligible recipient rather than have them travel to pick up items. Shipping charges are defined as the actual cost of shipping an item from a provider to a MAP eligible recipient by a means other than that of provider delivery. MAD does not pay shipping charges for an item purchased by medicare for which MAD is only responsible for the coinsurance and deductible.

(12) Wheelchairs and seating systems:

(a) MAD covers customized wheelchairs and seating systems made for a specific MAP eligible recipient, including a MAP eligible recipient who is institutionalized. Written prior authorization is required by MAD or its designee. MAD or its designee cannot give verbal authorizations for customized wheelchairs and seating systems. A customized wheelchair and seating system is defined as one that has been uniquely constructed or substantially modified for a specific MAP eligible recipient and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. There must be a customization of the frame for the wheelchair base or seating system to be considered customized.

(b) Repairs to a wheelchair owned by a MAP eligible recipient residing in an institution are covered.

(c) A customized or motorized wheelchair required by a MAP eligible recipient who is institutionalized to pursue educational or employment activity outside the institution may be covered, but must be reviewed on a case-by-case basis by MAD or its designee.

D. Prosthetics and orthotics supplies: MAD covers medically necessary prosthetics and orthotics supplied by a MAD provider to a MAP eligible recipient only when specified requirements or conditions are satisfied. Prosthetic devices are replacements or substitutes for a body part or organ, such as an artificial limb or eye prosthesis. Orthotic devices support or brace the body, such as trusses, compression custom-fabricated stockings and braces. MAD covers prosthetics and orthotics only when all the following conditions are met:

(1) the device has been ordered by the MAP eligible recipient's PCP or other appropriate practitioner and is medically necessary for MAP eligible recipient's mobility, support or physical functioning;

(2) the need for the device is not satisfied by the existing device the MAP eligible recipient currently has;

(3) the device is covered by MAD and all prior approval requirements have been satisfied;

(4) coverage of compression stockings for a MAP eligible recipient 21 years and older is limited to stockings that are custom-fabricated to meet their medical needs;

(5) coverage of orthopedic shoes for a MAP eligible recipient 21 years and older is limited to the shoe that is attached to a leg brace;

(6) replacement of items is limited to one item every three years, unless there is a change in the MAP eligible recipient's medical necessity; and

(7) therapeutic shoes furnished to a diabetic is limited to one of the following within one calendar year:

(a) no more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts; and

(b) no more than one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes).

[8.324.5.12 NMAC - Rp, 8.324.5.12 NMAC, 1/1/2014]

8.324.5.13 UTILIZATION REVIEW AND PRIOR AUTHORIZATION: All MAD services are subject to UR for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made or after payment is made; see 8.302.5 NMAC. MAD makes available on its website and other websites UR instructions. It is the provider'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. Prior authorization does not guarantee that an individual is eligible for a MAD service.

A. Prior authorization: Certain procedures or services may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. When services are billed to and paid by a coordinated services contractor authorized by MAD, the provider must follow that contractor's instructions for the authorization of a service. Written requests for items not included in the categories listed or for a quantity greater than that covered by MAD in this rule may be submitted by the MAP eligible recipient's PCP, with a prior authorization request to MAD or its designee for consideration of medical necessity.

B. Eligibility determination: The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance.

C. Reconsideration: A provider who disagrees with a prior authorization denial or another review decision may request a reconsideration; see 8.350.2 NMAC.

D. Prior authorization for specific services: The following services and procedures require prior authorization from MAD or its designee:

(1) hearing appliances:

(a) hearing aid dispensing, purchase, rental and replacement;

(b) hearing aid repairs for which the provider's billed charge exceeds $100;

(c) services for which prior authorization was obtained remain subject to review at any point in the payment process; and

(d) medical clearance: PCP medical approval is required on any request for prior authorization for hearing aids; the MAP eligible recipient's PCP must certify that her or she is a suitable candidate for hearing aids by signing the hearing aid evaluation and information MAD prior authorization form; documentation must be on the PCP's letterhead or prescription pad; this documentation must be submitted with the prior approval request; a MAP eligible recipient under 16 years of age, must be examined by a physician who is board certified in the diagnosis and treatment of diseases and conditions of the ear for all hearing aid fittings.

(2) DME, oxygen and medical supplies: MAD covers certain medical supplies, nutritional products and DME provided to a MAP eligible recipient with prior authorization. Please refer to criteria in 8.301.3 NMAC for DME or medical supplies that are not covered. MAD covers the following benefits with prior authorization for a non-institutionalized MAP eligible recipient:

(a) enteral nutritional supplements and products for a MAP eligible recipient who must be tube fed oral nutritional supplements;

(b) oral nutritional support products prescribed by the MAP eligible recipient's PCP:

(i) on the basis of a specific medical indication for a MAP eligible recipient who has a defined need for which nutritional support is considered therapeutic, and for which regular food,

blenderized food, or commercially available retail consumer nutritional supplements would not meet their medical needs;

(ii) when medically necessary due to inborn errors of metabolism;

(iii) medically necessary to correct or ameliorate physical illnesses or conditions in a MAP eligible recipient under 21 years of age; or

(iv) coverage does not include commercially available food alternatives, such as low or sodium-free foods, low or fat-free foods, low or cholesterol-free foods, low or sugar-free foods, low or high calorie foods for weight loss or weight gain, or alternative foods due to food allergies or intolerance;

(c) either disposable diapers or underpads prescribed for a MAP eligible recipient age three years and older who suffers from neurological or neuromuscular disorders or who has other diseases associated with incontinence is limited to either 200 diapers per month or 150 underpads per month;

(d) supports and positioning devices that are part of a DME system, such as seating inserts or lateral supports for a specialized wheelchair;

(e) protective devices, such as helmets and pads;

(f) bathtub rails and other rails for use in the bathroom;

(g) electronic monitoring devices, such as electronic sphygmomanometers, oxygen saturation, fetal or blood glucose monitors and pacemaker monitors;

(h) passive motion exercise equipment;

(i) decubitus care equipment;

(j) equipment to apply heat or cold;

(k) hospital bed and full length side rails;

(l) compressor air power sources for equipment that is not self-contained or cylinder driven;

(m) home suction pump and lymph edema pump;

(n) hydraulic patient lift;

(o) ultraviolet cabinet;

(p) traction equipment;

(q) prone stander and walker;

(r) trapeze bar or other patient-helpers that are attached to bed or freestanding;

(s) home hemodialysis or peritoneal dialysis system and its replacement supplies or accessories;

(t) wheelchair and functional attachments to a wheelchair; a wheelchair is authorized every 60 months for a MAP eligible recipient 21 years and older; for a MAP eligible recipient under 21 years of age, a wheelchair can be authorized every 36 months; and earlier authorization is possible when dictated by their medical necessity;

(u) wheelchair tray;

(v) whirlpool bath designed for home use;

(w) intermittent or continuous positive pressure breathing equipment;

(x) manual or electronic augmentative and alternative communication device;

(y) truss and anatomical supports that require fitting or adjusting by trained individuals, including a JOBST hose;

(z) custom-fitted compression stockings; and

(aa) artificial larynx prosthesis.

(3) Prosthetics and orthotics: All prosthetic devices require prior authorization from MAD or its designee. The only prior authorization requirement exception is for a prosthetic limb attached immediately following a surgery for a traumatic injury while the MAP eligible recipient is a hospital inpatient. Prior authorization is required for orthotic devices for the foot or for shoes. Services for which prior authorization was obtained remain subject to UR at any point in the payment process.

[8.324.5.13 NMAC - Rp, 8.324.5.13 NMAC, 1/1/2014]

8.324.5.14 SERVICE LIMITATIONS AND COVERAGE RESTRICTIONS:

A. Special requirements for the purchase of wheelchairs: Before billing for a customized wheelchair, the provider who delivers the wheelchair and seating system to a MAP eligible recipient must make a final evaluation to ensure that the wheelchair and seating system meets the medical, social and environmental needs of the MAP eligible recipient for whom it was authorized.

(1) The provider assumes responsibility for correcting defects or deficiencies in the wheelchair and seating systems that make them unsatisfactory for use by the MAP eligible recipient.

(2) The provider is responsible for consulting physical therapists, occupational therapists, special education instructors, teachers, parents or guardians as necessary to ensure that the wheelchair meets the MAP eligible recipient's needs.

(3) Evaluations by a physical therapist or occupational therapist are required when ordering customized wheelchair and seating system. The therapist should be familiar with the brands and categories of wheelchairs and appropriate seating systems and work with the MAP eligible recipient and those consultants listed in Paragraph (2) above to assure that the selected system matches physical seating needs. The physical or occupational therapist may not be a wheelchair vendor or under the employment of a wheelchair vendor or wheelchair manufacturer.

(4) MAD does not pay for special modifications or replacement of a customized wheelchair after the wheelchair is furnished to the MAP eligible recipient.

(5) When the equipment is delivered to the MAP eligible recipient and the MAP eligible recipient accepts the order, the provider will submit the claim for reimbursement.

B. Special requirements for purchase of augmentative and alternative communication devices:

(1) The purchase of augmentative communication devices requires prior authorization. In addition to being prescribed by the MAP eligible recipient's PCP, the communication device must also be recommended by a speech-language pathologist, who has completed a systematic and comprehensive evaluation. The speech pathologist may not be a vendor of augmentative communication systems nor have a financial relationship with a vendor.

(2) A trial rental period of up to 60 calendar days is required for all electronic devices to ensure that the chosen device is the most appropriate device to meet the MAP eligible recipient's medical needs. At the end of the trial rental period, if purchase of the device is recommended, documentation of the MAP eligible recipient's ability to use the communication device must be provided showing that the MAP eligible recipient's ability to use the device is improving and that the MAP eligible recipient is motivated to continue to use this device.

(3) MAD does not pay for supplies for augmentative and alternative communication devices, such as, but not limited to: paper, printer ribbons, and computer discs.

(4) Prior authorization is required for equipment repairs.

(5) A provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or their authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have in excess of a 15 calendar day supply of the item before releasing the next supply order to the MAP eligible recipient. A provider must keep documentation in their files available for audit that show compliance with this requirement.

[8.324.5.14 NMAC - Rp, 8.324.5.14 NMAC, 1/1/2014]

8.324.5.15 NONCOVERED SERVICES: The following services are subject to the limitations and coverage restrictions that exist for other MAD services; see 8.302.1 NMAC and 8.310.2 NMAC. The provider must notify the MAP eligible recipient of the coverage limitations prior to providing services.

A. Vision appliances: MAD does not cover the following specific vision services:

(1) orthoptic assessment and treatment;

(2) photographic procedures, such as fundus or retinal photography and external ocular photography;

(3) polycarbonate lenses other than those listed in Subsection A of Section 13 of this part;

(4) ultraviolet (UV) lenses;

(5) trifocals;

(6) progressive lenses;

(7) tinted or photochromic lenses, except in cases of documented medical necessity; see Subsection D of Section 12 of this part;

(8) oversize frames and oversize lenses;

(9) low vision aids;

(10) eyeglass cases;

(11) eyeglass or contact lens insurance; and

(12) anti-scratch, anti-reflective, or mirror coating.

B. Hearing appliances: Hearing aid selection and fitting is considered included in the hearing aid dispensing fee, and will not be reimbursed separately.

C. **DME, oxygen and medical supplies:** MAD does not cover certain DME and medical supplies. See 8.301.3 NMAC for an overview of which DME or supply item is not covered by MAD.

D. **Prosthetic and orthotics:** The following services are not covered:

(1) orthotic supports for the arch or other supportive devices for the foot, unless they are integral parts of a leg brace or therapeutic shoes furnished to diabetics; and

(2) prosthetic devices or implants that are used primarily for cosmetic purposes.

[8.324.5.15 NMAC - Rp, 8.324.5.15 NMAC, 1/1/2014]

8.324.5.16 **REIMBURSEMENT:** Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement to a provider for covered services is made at the lesser of the following: (1) the provider's billed charge; or (2) the MAD fee schedule for the specific service or procedure.

A. The provider's billed charge must be their usual and customary charge for services.

B. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

C. **Vision appliances:** A vision service provider, except an IHS facility, must submit claims for reimbursement on the CMS 1500 claim form or its successor.

D. **Hearing appliances:** A hearing aid or related service provider must submit claims for reimbursement on the CMS 1500 claim form or its successor. Reimbursement for hearing aids is made at the lesser of the provider's billed charge, at the cost to the billing provider as indicated by the manufacturer's, the distributor's or wholesaler's invoice, which shall not exceed MAD's maximum reimbursement limitation amounts.

(1) Reimbursement for rental of hearing aids includes the following:

(a) rental charge for hearing aid; and

(b) hearing aid mold and batteries.

(2) Rental payments apply to the allowed amount for purchase. When the rental payments equal the amount allowed for purchase, the aid is considered purchased and owned by the MAP eligible recipient.

(3) Reimbursement for repairs to hearing aids is based on the MAD fee schedule. Reimbursement for repairs to hearing aids done by a manufacturer is the lesser of the provider's billed charge or the manufacturer's charge for the repairs plus a predetermined handling fee. If complications in securing the manufacturer's repair cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented.

(4) Reimbursement is made for additional accessories and supplies, including batteries, when required. Reimbursement is made for an additional mold when a single aid type is used for both ears.

(5) Reimbursement is made for replacement ear molds.

(6) Reimbursement for insurance for hearing aid loss and accidental damage is paid at the lesser of the provider's billed charge or the maximum fee allowed by MAD. If the insurance policy cost exceeds the maximum fee established by MAD, reimbursement can be made at the actual policy rate if the actual cost is documented.

(7) Hearing appliances reimbursement limitations:

(a) Hearing aid purchase: Hearing aid purchase is limited to one monaural or binaural purchase per four year period with the following exceptions:

(i) a MAP eligible recipient under 21 years of age and is subject to prior approval;

(ii) progressive hearing loss, such as otosclerosis;

(iii) changes due to surgical procedures;

(iv) traumatic injury; and

(v) replacement of lost hearing aid in accordance with their insurance coverage.

(b) Dispensing fees: The hearing aid dispensing fee includes payment for the services listed below. If a binaural dispensing fee is paid, it includes payment for all services listed below for both hearing aids:

(i) hearing aid selection and the fitting of the aids;

(ii) testing of the hearing aids;

(iii) one ear mold per hearing aid;

(iv) one package of batteries per hearing aid;

(v) any other accessories required to fit the aid;
(vi) all follow-up visits and adjustments necessary for a successful fitting;
(vii) cleaning and adjustments for the life of the aid; and
(viii) shipping and handling.

(c) Hearing aid evaluation: MAD covers the evaluation of a MAP eligible recipient for the hearing aid, subject to the following limitations:

(i) the evaluation for hearing aid is not payable to the same billing provider who bills for the hearing aid dispensing fee incidental to the purchase of a hearing aid;

(ii) the evaluation for hearing aid is not payable to a billing provider under the same corporate ownership as another billing provider who bills for the hearing aid dispensing fee incidental to the purchase of the hearing aid; therefore,

(iii) physicians and audiologists can be reimbursed for audiologic and vestibular function studies in addition to a dispensing fee.

[8.324.5.16 NMAC - Rp, 8.324.5.16 NMAC, 1/1/2014]

8.324.5.17 REIMBURSEMENT OF DME, MEDICAL SUPPLIES AND NUTRITIONAL PRODUCTS:

A. Reimbursement for purchase or rental: Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. The term "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific item or service. Reimbursement for DME, medical supplies and nutritional products is made at the lesser of:

(1) the provider's billed charges or the MAD fee schedule; or

(2) when there is no applicable MAD fee schedule, payment is limited to the provider's acquisition invoice cost plus a percentage, as follows.

(a) DME, medical supplies and nutritional products:

(i) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000, payment is limited to the provider's actual acquisition cost plus twenty percent;

(ii) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus ten percent;

(b) for a custom specialized wheelchair and its customized related accessories, payment is limited to the provider's actual acquisition cost plus fifteen percent.

B. Rental payments must be applied towards the purchase with the exception of ventilators: Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. Reimbursement for rental of DME is made at the lesser of:

(1) the provider's billed charges; or

(2) the MAD fee schedule, when applicable; payment for the month of rental is limited to the provider's acquisition invoice cost plus a percentage as follows:

(a) the provider must keep a running total of rental payments for each piece of equipment;

(b) the provider must consider the item sold and the item becomes the property of the MAP eligible recipient when 13 rental payments have been made for the item;

(c) the provider must consider the item sold and the item becomes the property of the MAP eligible recipient when the rental payments total the lesser of the provider's usual and customary charge for the purchase of the item or the MAD fee schedule for the purchase of the item;

(d) or for an item for which a fee schedule purchase price has not been established by MAD when the provider has received rental payments equal to one of the following:

(i) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000, payment is limited to the provider's actual acquisition cost plus twenty percent;

(ii) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus ten percent;

(3) MAD follows medicare regulations regarding capped rental; for rental months one through three, the full fee schedule rental fee is allowed; for rental months four through 13, the rental fee schedule

rental fee is reduced by twenty-five percent; no additional rental payments are made following the 13th month or to the most current schedule determined by medicare; the provider may only bill for routine maintenance and for repairs, and oxygen contents to the extent as allowed by medicare;

(4) oxygen is paid using the medicare billing, capped rental period, and payment rules;

(5) the provider must retain a copy of their acquisition invoice showing the provider's purchase of an item and make it available to MAD or its designee upon request;

(6) set-up fees are considered to be included in the payment for the equipment or supplies and are not reimbursed as a separate charge.

C. Reimbursement for home infusion drugs: Unless otherwise specified in this rule, the provider's billed charges must be the usual and customary charge for the item or service. Home infusion drugs are reimbursed at the lesser of:

(1) the provider's billed charge; or

(2) the MAD fee schedule;

(3) for home infusion drugs for which a fee schedule price has not been established by MAD, or for which the description associated with the appropriate billing code is too broad to establish a reasonable payment level, payment is limited to the provider's acquisition cost plus twenty percent; a provider must retain a copy of their acquisition invoice showing the provider's purchase of an item and make it available to MAD or its designee upon request.

D. Reimbursement for delivery and shipping charges: Delivery charges are reimbursed at the MAD maximum amount per mile. Shipping charges are reimbursed at actual cost if the method used is the least expensive method. MAD does not pay for charges for shipping items from a supplier to the provider.

E. Reimbursement limitations: MAD does not cover DME or medical supplies that do not meet the definition of DME as described in Section 12 of this rule. The following criteria are applied to each request as part of the determination of non-coverage:

(1) items that do not primarily serve a therapeutic purpose or are generally used for comfort or convenience purposes;

(2) environment-control equipment that is not primarily medical in nature;

(3) institutional equipment that is not appropriate for home use;

(4) items that are not generally accepted by the medical profession as being therapeutically effective or are determined by medicare regulations to be ineffective or unnecessary;

(5) items that are hygienic in nature;

(6) hospital or physician diagnostic items;

(7) instruments or devices manufactured for use by PCP;

(8) exercise equipment not primarily medical in nature or for the sole purpose of muscle strengthening or muscle stimulation without a medically necessary purpose;

(9) support exercise equipment primarily for institutional use;

(10) items that are not reasonable or necessary for monitoring the pulse of a homebound MAP eligible recipient with or without a cardiac pacemaker;

(11) items that are used to improve appearance or for comfort purposes;

(12) items that are precautionary in nature except those needed to prevent urgent or emergent events; and

(13) a provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or their authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have an excess of a 15 calendar day supply of the item before releasing the next supply to the MAP eligible recipient.

[8.324.5.17 NMAC - N, 1/1/2014]

8.324.5.18 REIMBURSEMENT FOR PROSTHETICS AND ORTHOTICS:

A. A prosthetic and orthotic service provider must submit claims for reimbursement on the CMS-1500 claim form or its successor. Reimbursement for repairs made by the provider is made at the actual repair cost plus fifty percent. Repairs made by the manufacturer are reimbursed to the provider at the actual manufacturer's repair cost plus a handling fee of $20. If complications in securing the manufacturer's repair cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented. Reimbursement for additional accessories and supplies is made at the lower of the actual cost of the supply or accessory or the MAD fee schedule for the particular item.

B. Reimbursement limitations: The amount billed for the item includes all minor attachments, adjustments, additions, modifications, fittings and other services necessary to make the device functional. These items cannot be billed separately.

(1) MAD does not cover an additional charge for a hospital visit or home visit if fittings or measurements take place away from the provider's office.

(a) If the place of service is outside the provider's city limits, mileage can be billed for travel to the place of service.

(b) A prosthetic or orthotic device for a MAP eligible recipient hospitalized in a diagnostic related group (DRG) reimbursed hospital is reimbursed by the DRG methods described in 8.311.3 NMAC.

(2) Date of service: The date of service declared on a claim is the date when the device is supplied to the MAP eligible recipient, not the fitting date or measuring date.

(3) No specification of brand or quality: When an ordering provider requests an item and does not specify the brand or quality of the item to be dispensed, the item chosen must be of a quality and minimal cost which adequately serves the purpose for which the device is required.

[8.324.5.18 NMAC - N, 1/1/2014]

HISTORY OF 8.324.5 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.0800, Medical Supplies, filed 2/29/1980.
MAD Rule 310.08, Medical Supplies, filed 12/1/1987.
MAD Rule 310.08, Medical Supplies, filed 5/31/1988.
MAD Rule 310.08, Medical Supplies, filed 4/3/1992.
MAD Rule 310.08, Durable Medical Equipment and Medical Supplies, filed 4/21/1992.

History of Repealed Material:

MAD Rule 310.08, Durable Medical Equipment and Medical Supplies, filed 4/21/1992 - Repealed effective 2/1/1995.
8.324.5 NMAC, Durable Medical Equipment and Supplies, filed 6/16/2004 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 7 TRANSPORTATION SERVICES AND LODGING

8.324.7.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.324.7.1 NMAC - Rp, 8.324.7.1 NMAC, 1/1/2014; A, 7/1/2024]

8.324.7.2 SCOPE: The rule applies to the general public.
[8.324.7.2 NMAC - Rp, 8.324.7.2 NMAC, 1/1/2014]

8.324.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.324.7.3 NMAC - Rp, 8.324.7.3 NMAC, 1/1/2014; A, 7/1/2024]

8.324.7.4 DURATION: Permanent.
[8.324.7.4 NMAC - Rp, 8.324.7.4 NMAC, 1/1/2014]

8.324.7.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.324.7.5 NMAC - Rp, 8.324.7.5 NMAC, 1/1/2014]

8.324.7.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.324.7.6 NMAC - Rp, 8.324.7.6 NMAC, 1/1/2014]

8.324.7.7 DEFINITIONS: [**RESERVED**]

8.324.7.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.324.7.8 NMAC - Rp, 8.324.7.8 NMAC, 1/1/2014]

8.324.7.9 TRANSPORTATION SERVICES: The New Mexico medical assistance division (MAD) covers expenses for transportation and other related expenses that MAD or its coordinated services contractor determines are necessary to secure covered medical and behavioral health examinations and treatment for a medical assistance program (MAP) eligible recipient in or out of their home community [42 CFR Section 440.170]. Travel expenses include the cost of transportation by long distance common carriers, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the MAP eligible recipient. Related travel expenses include the cost of meals and lodging made necessary by receipt of medical or behavioral health care away from the MAP eligible recipient's home community. When medically necessary, MAD covers similar expenses for an attendant who accompanies the MAP eligible recipient to the medical or behavioral health examination or treatment.
[8.324.7.9 NMAC - Rp, 8.324.7.9 NMAC, 1/1/2014]

8.324.7.10 ELIGIBLE PROVIDERS: Health care to a MAP eligible recipient is furnished by a variety of providers and provider groups. Reimbursement and billing for these services are administered by MAD. Upon approval of a New Mexico MAD 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 a MAP eligible recipient. Providers must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program specific websites, and in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review (UR) instructions, and other pertinent material. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. Providers must contact HCA, or its

authorized agents, for answers to billing questions or any of these materials. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. The following providers are eligible to be reimbursed for providing transportation or transportation related services to MAP eligible recipients:

A. air ambulances certified by the state of New Mexico department of health (DOH), emergency medical services bureau;

B. ground ambulance services certified by the New Mexico public regulation commission (NMPRC) or by the appropriate state licensing body for out-of-state ground ambulance services, within those geographic regions in the state specifically authorized by the NMPRC;

C. non-emergency transportation vendors (taxicab, vans and other vehicles) and certain bus services certified by the NMPRC, within those geographic regions in the state specifically authorized by the NMPRC;

D. long distance common carriers, that include buses, trains and airplanes;

E. certain carriers exempted or warranted by the NMPRC within those geographic regions in the state specifically authorized by the NMPRC;

F. lodging and meal providers; and

G. when services are billed to and paid by a MAD MAP coordinated services contractor authorized by HCA, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[8.324.7.10 NMAC - Rp, 8.324.7.10 NMAC, 1/1/2014]

8.324.7.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of the provider participation agreement (PPA). A provider must adhere to MAD program rules as specified in the New Mexico MAD administrative code (NMAC) rules, and policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to a MAP eligible recipient.

C. MAD services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority. See 8.302.1 NMAC.

[8.324.7.11 NMAC - Rp, 8.324.7.11 NMAC, 1/1/2014]

8.324.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: MAD reimburses a transportation provider for transportation only when the transport is of a MAP eligible recipient and is subject to the following conditions.

A. Free alternatives: Alternative transportation services that can be provided free of charge include volunteers, relatives or transportation services provided by nursing facilities (NF) or other residential centers.

B. Least costly alternatives: MAD covers the most appropriate and least costly transportation alternatives suitable for the MAP eligible recipient's medical or behavioral health condition. If a MAP eligible recipient can use a private vehicle or public transportation, those alternatives must be used before a MAP eligible recipient can use more expensive transportation alternatives.

C. Non-emergency transportation service: MAD covers non-emergency transportation services for a MAP eligible recipient who has no primary transportation and who is unable to access a less costly form of public transportation except as described under non-covered services. See 8.324.7.13 NMAC.

D. Long distance common carriers: MAD covers long distance services furnished by a common carrier if a MAP eligible recipient must leave their home community to receive medical or behavioral health services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through local county income support division (ISD) offices.

E. Ground ambulance services: MAD covers services provided by ground ambulances when:

(1) an emergency that requires ambulance service is certified by a physician or is documented in the provider's records as meeting emergency medical necessity criteria: terms are defined as follows:

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

(b) "medical necessity" is established for ambulance services if the MAP eligible recipient's physical, or behavioral health condition is such that the use of any other method of transportation is contraindicated and would endanger the MAP eligible recipient's health.

(2) Scheduled, non-emergency ambulance services are ordered by a primary care provider (PCP) who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's physical, or behavioral health condition. MAD covers non-reusable items and oxygen required during transportation, if needed; coverage for these items is included in the base rate reimbursement for ground ambulance.

F. Air ambulance services: MAD covers services provided by air ambulances, including private airplanes, if an emergency exists and the PCP certifies the medical necessity for the service.

(1) An emergency that would require air over ground ambulance services is defined as a medical or behavioral health condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in one of the following:

(a) a MAP eligible recipient's death;

(b) placement of a MAP eligible recipient's health is in serious jeopardy (or with respect to a pregnant woman, the health of the woman or her unborn child);

(c) serious impairment of bodily functions; or

(d) serious dysfunction of any bodily organ or part.

(2) Coverage for the following is included in the base rate reimbursement for air ambulance:

(a) non-reusable items and oxygen required during transportation;

(b) professional attendants required during transportation;

(c) detention time or standby time; and

(d) use of equipment required during transportation.

G. Lodging services: MAD covers lodging services if a MAP eligible recipient is required to travel to receive medical services more than four hours one way and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15 days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the medical or behavioral health provider's statement of need. Authorization forms for direct payment by MAD to its lodging providers are available through local county ISD offices.

H. Meal services: MAD covers meals if a MAP eligible recipient is required to leave their home community for eight hours or more to receive medical or behavioral health services. Authorization forms for direct payment to MAD meal providers by MAD are available through local county ISD offices.

I. Coverage for attendants: MAD covers transportation, meals and lodging for one attendant if the medical necessity for the attendant is certified in writing justified by the MAP eligible recipient's medical provider or the MAP eligible recipient who is receiving medical service is under 18 years of age. The attendant for a child under 18 years of age should be the parent or legal guardian. If the medical appointment is for an adult MAP eligible recipient, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the adult MAP eligible recipient.

J. Coverage for medicaid home and community-based services waiver recipients: Transportation of a medicaid waiver recipient to or from a provider of waiver service is only covered when the service is a physical therapy, occupational therapy, speech therapy or a behavioral health service.
[8.324.7.12 NMAC - Rp, 8.324.7.12 NMAC, 1/1/2014]

8.324.7.13 NONCOVERED SERVICES: Transportation services are subject to the same limitations and coverage restrictions that exist for other MAD services. See 8.301.3 NMAC. Payments for transportation for any non-covered service is subject to retroactive recoupment.

A. MAD does not pay to transport a MAP eligible recipient to a medical or behavioral health service or provider that is not covered under the MAD program.

B. A provider will not be eligible to seek reimbursement from a MAP eligible recipient if the provider fails to notify the MAP eligible recipient or their authorized representative that the service is not covered by MAD. See 8.302.1 NMAC.

C. Transportation services will not be provided when other alternatives are available, such as mail delivery or free delivery. Retail pharmacies may mail, ship or deliver prescriptions to medicaid recipients consistent with applicable state and federal statutes and regulations.

[8.324.7.13 NMAC - Rp, 8.324.7.13 NMAC, 1/1/2014]

8.324.7.14 OUT-OF-STATE TRANSPORTATION AND RELATED EXPENSES: Out-of-state transportation and related expenses require prior authorization by MAD or its designee. Out-of-state transportation is authorized only if the out-of-state medical or behavioral health service is approved by MAD or its designated contractor. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in New Mexico.

A. Requests for out-of-state transportation must be coordinated through MAD.

B. Authorization for lodging and meal services by an out-of-state provider can be granted for up to 30 days by MAD. Re-evaluation authorizations are completed prior to expiration and every 30 days, thereafter.

C. Transportation to border cities, is defined as those cities within 100 miles of the New Mexico border (Mexico excluded), are treated as an in-state provider service. See 8.302.4 NMAC.

[8.324.7.14 NMAC - Rp, 8.324.7.14 NMAC, 1/1/2014]

8.324.7.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: 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, and before payment is made or after payment is made. See 8.302.5 NMAC. The provider must contact HCA or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or request hard copies to be provided, to understand the information, 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 MAD fee-for-service coordinated services contractor, the provider must follow that contractor's instructions for authorization of services.

A. Prior authorization: Certain procedures or services may require prior authorization from MAD or its designee. Services for which prior authorization is received remain subject to UR at any time during the payment process.

B. Referrals for travel outside the home community:

(1) If a MAP eligible recipient must travel over 65 miles from their home community to receive medical or behavioral health care, the transportation provider must obtain and retain in its billing records written verification from the referring provider or the service provider containing the following:

(a) the medical, behavioral health or diagnostic service for which the MAP eligible recipient is being referred;

(b) the name of the out of community provider; and

(c) justification that the medical or behavioral health care is not available in the home community.

(2) Referrals and referral information must be obtained from a MAD provider. For continued out-of-community, non-emergency transportation, the required information must be obtained every six months.

C. Eligibility determination: Prior authorization does not guarantee that individuals are eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

[8.324.7.15 NMAC - Rp, 8.324.7.15 NMAC, 1/1/2014]

8.324.7.16 REIMBURSEMENT:

A. Transportation providers must submit claims for reimbursement on the CMS-1500 form or its successor. See 8.302.2 NMAC. Reimbursement to transportation, meal or lodging providers for covered services is made at the lesser of the following:

(1) the provider's billed charge:

(a) the billed charge must be the provider's usual and customary charge for services; for a provider with a tariff, the billed charge must be the lesser of the charges allowed by the provider's tariff or the provider's usual and customary charge.

(b) "usual and customary charge" refers to the amount an individual provider charges the general public in the majority of cases for a specific procedure or service; or

(2) the MAD fee schedule for the specific service or procedure; reimbursement by the MAD program to a transportation provider is inclusive of gross-receipts taxes and other applicable taxes; an air ambulance provider is exempt from paying gross receipts tax; therefore, the rates paid for air ambulance service do not include gross receipts tax.

B. Ground ambulance: A provider of ground ambulance services is reimbursed at the lesser of their billed charge for the service or the MAD maximum allowed amount.

(1) The MAD maximum allowed amount for transports up to 15 miles is limited to the base rate amount. The allowable base rate for advanced life support (ALS) or basic life support (BLS) includes reimbursement for the ALS or BLS equipped service, oxygen, disposable supplies and medications used in transport. The base rate reimbursement includes mileage reimbursement for the first 15 miles of transport.

(2) The allowable base rate for a scheduled non-emergency transport includes reimbursement for oxygen, disposable supplies and medications used in transport. The base rate includes mileage reimbursement for the first 15 miles of transport.

C. Air ambulance: A provider of air ambulance services is reimbursed at the lesser of billed charges or the MAD maximum allowed rate.

D. Non-emergency transportation services:

(1) A provider of non-emergency transportation is reimbursed at the lesser of their approved tariff or the MAD rate for one or multiple MAP eligible recipient transports not meeting the "additional passenger" criteria below.

(2) Reimbursement will be limited to the MAD reimbursement limitation per one-way trip for a MAP eligible recipient being transported for medical care. MAD does not provide reimbursement for any portion of the trip for which the MAP eligible recipient is not in the vehicle.

(3) An "additional passenger transport" is a non-emergency transport of two or more MAP eligible recipients who are picked up at the same location and are being transported to the same provider. Additional passenger transport services will not be covered. When more than one MAP eligible recipient is being transported from the same location to the same provider and each MAP eligible recipient has a scheduled MAD-covered medical or behavioral health appointment, MAD will allow coverage for one MAP eligible recipient.

(4) MAD covers transportation for one attendant when the MAP eligible recipient is a child 10 years of age or younger not meeting the additional passenger criteria if the medical necessity for the attendant is justified in writing by the MAP eligible recipient's medical or behavioral health provider for each transport. In cases where the MAP eligible recipient's condition is ongoing and the need for a medical attendant will not change, the attestation must be renewed every six months, unless the MAP eligible recipient who is receiving medical or behavioral health service is under 18 years of age. If the medical or behavioral health appointment is for a MAP eligible recipient 21 years of age and older, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the MAP eligible recipient.

(5) MAD covers transportation to scheduled, structured counseling and therapy sessions for a MAP eligible recipient, family, or multi-family groups, based on individualized needs as specified in the treatment plan. Claims for services are to be filed under the name of the MAP eligible recipient being primarily treated through these sessions.

[8.324.7.16 NMAC - Rp, 8.324.7.16 NMAC, 1/1/2014]

HISTORY OF 8.324.7 NMAC:

History of Repealed Material:

8.324.7 NMAC, Transportation Services, filed 6/16/2004 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 325 SPECIALTY SERVICES
PART 8 REHABILITATION SERVICE PROVIDERS

8.325.8.1 ISSUING AGENCY: New Mexico Health Care Authority.
[2/1/1995; 8.325.8.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.325.8.2 SCOPE: The rule applies to the general public.
[2/1/1995; 8.325.8.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/2012]

8.325.8.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.325.8.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.325.8.4 DURATION: Permanent
[2/1/1995; 8.325.8.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/2012]

8.325.8.5 EFFECTIVE DATE: February 1, 1995
[2/1/1995; 8.325.8.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/2012]

8.325.8.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/1995; 8.325.8.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/2012]

8.325.8.7 DEFINITIONS: [**RESERVED**]

8.325.8.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/1995; 8.325.8.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012]

8.325.8.9 REHABILITATION SERVICE PROVIDERS: Rehabilitation services are optional services covered for New Mexico medicaid program (medicaid) recipients [42 CFR Section 440.110]. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.
[2/1/1995; 8.325.8.9 NMAC - Rn, 8 NMAC 4.MAD.767, 3/1/2012]

8.325.8.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following providers are eligible to be reimbursed for furnishing outpatient rehabilitation services to recipients:

(1) rehabilitation centers with a primary emphasis on physical therapy, occupational therapy or speech therapy which are licensed and certified by the public health division of the department of health. Alcohol or drug treatment centers are excluded;

(2) physical therapists licensed as physical therapists and certified in independent practice for participation in the medicare program by the public health division of the department of health;

(3) occupational therapists licensed as occupational therapists and certified in independent practice for participation in the medicare program by the public health division of the department of health;

(4) home health agencies licensed and certified by the public health division of the department of health; and

(5) general hospitals eligible to provide outpatient rehabilitation services licensed and certified by the public health division of the department of health.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
[2/1/1995; 8.325.8.10 NMAC - Rn, 8 NMAC 4.MAD.767.1, 3/1/2012]

8.325.8.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*.
[2/1/1995; 8.325.8.11 NMAC - Rn, 8 NMAC 4.MAD.767.2, 3/1/2012]

8.325.8.12 COVERED SERVICES AND SERVICE LIMITATIONS: Medicaid covers physical therapy, occupational therapy, and speech therapy services which are reasonable and necessary for the treatment of the recipient's specific condition.

A. For all services, there must be an expectation that the recipient's condition will improve significantly in a reasonable and generally predictable period of time based on an assessment by physicians of the recipient's restoration potential.

(1) If the recipient's expected restoration potential is insignificant in relation to the extent and duration of therapy required to achieve the potential, the therapy is not considered reasonable and necessary.

(2) If a determination that the expectations for restoration will not materialize is made at any point in the treatment, the services are no longer covered by medicaid.

B. Recipients who require low nursing facility level of care and reside in nursing facilities (NFs) can receive services furnished by home health agencies, certified outpatient rehabilitation centers, certified independent physical therapists, and certified independent occupational therapists. Therapy providers can bill directly for these services. Reimbursement for rehabilitation services for recipients who require high NF level of care is included in the NF's per diem rate and cannot be billed separately by the therapy provider.

C. Physical, occupational and speech therapy services must be ordered by physicians and specifically related to active written treatment plans developed by physicians in consultation with qualified physical, occupational or speech therapists.

D. Medicaid covers speech therapy services furnished by hospitals, home health agencies, outpatient hospitals, rehabilitation hospitals and rehabilitation centers licensed and certified by the department of health.

(1) Speech therapy services can be furnished by employees of the previously described providers or by an outside source such as an agency or clinic, under arrangements with the provider facility. Reimbursement for services is made to the facility.

(2) Speech therapy services must be furnished by individuals who are licensed as speech pathologists by the New Mexico regulation and licensing department.

E. Services furnished in PPS-exempt psychiatric units of general acute care hospitals, PPS-exempt rehabilitation units of general acute care hospitals and free-standing psychiatric hospitals are included in the hospital reimbursement rate and cannot be billed separately by independent providers.
[2/1/1995; 8.325.8.12 NMAC - Rn, 8 NMAC 4.MAD.767.3, 3/1/2012]

8.325.8.13 NONCOVERED SERVICES: Rehabilitation services are subject to the limitations and coverage restrictions of other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following rehabilitation services:

A. services furnished by providers who are not licensed and/or certified to furnish services;

B. educational programs or vocational training not part of an active treatment plan for residents in an intermediate care facility for the mentally retarded or for recipients under the age of twenty-one (21) receiving inpatient psychiatric services [42 CFR Section 441.13 (b)];

C. services billed separately by home health agencies, independent physical therapists, independent occupational therapists, or outpatient rehabilitation centers to recipients in high nursing facilities or inpatient hospitals;

D. transportation, for recipients in low level nursing facilities or other medicaid recipients, to travel to outpatient hospital facilities unless there are no home health agencies, independent physical therapists or independent occupational therapists available in the area to provide the therapy at the recipient's residence; and

E. services solely for maintenance of the recipient's general condition; these services include repetitive services needed to maintain a recipient's functional level that do not involve complex and sophisticated therapy procedures requiring the judgement and skill of a therapist; services related to activities for the general good and welfare of recipients, such as general exercises to promote overall fitness and flexibility and activities to provide general motivation, are not considered physical or occupational therapy for medicaid reimbursement purposes.

[2/1/1995; 8.325.8.13 NMAC - Rn, 8 NMAC 4.MAD.767.4, 3/1/2012]

8.325.8.14 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: All therapy services with the exception of the initial evaluation for physical or occupational therapy require prior approval for medical necessity from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/1995; 8.325.8.14 NMAC - Rn, 8 NMAC 4.MAD.767.5, 3/1/2012]

8.325.8.15 REIMBURSEMENT: Outpatient rehabilitation providers must submit claims for reimbursement on the HCFA-1500 or UB-92 claim form or their successor, as appropriate for the provider. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

A. Reimbursement for outpatient hospital rehabilitation medical services: For services reimbursed under the Title XVIII (medicare) allowable cost methodology, medicaid reduces the medicare allowable costs by three percent. The interim rate of payment is seventy-seven percent of billed charges. Medicaid reimbursement does not exceed reasonable costs as defined by medicare. See 8.311.2 NMAC, *Hospital Services*.

B. Reimbursement for home health agency rehabilitation: See Section MAD-768, *Home Health Services.*

C. Reimbursement for independent physical therapists, independent occupational therapists and rehabilitation centers:

(1) Reimbursement to providers is made at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure.

(2) The provider's billed charge must be their usual and customary charge for services.

(3) "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

(4) Medicaid does not pay a professional component amount to a physical, occupational, or speech therapist if the therapy is performed in a hospital setting. Medicaid reimburses the institutional provider for all components of the service.

[2/1/1995; 8.325.8.15 NMAC - Rn, 8 NMAC 4.MAD.767.6, 3/1/2012]

HISTORY OF 8.325.8 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.1400, Rehabilitation Medical Services, filed 2/18/1980.
MAD Rule 310.14, Rehabilitation Medical Services, filed 12/15/1987.
MAD Rule 310.14, Rehabilitation Medical Services, filed 9/1/1988.
MAD Rule 310.14, Rehabilitation Medical Services, filed 12/8/1994.

History of Repealed Material:
MAD Rule 310.14, Rehabilitation Medical Services, filed 12/8/1994 - Repealed effective 2/1/1995.

TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 3 CASE MANAGEMENT SERVICES FOR PREGNANT INDIVIDUALS AND THEIR INFANTS

8.326.3.1 ISSUING AGENCY: New Mexico Health Care Authority.
[2/1/1995; 8.326.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.3.2 SCOPE: The rule applies to the general public.
[2/1/1995; 8.326.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/2012]

8.326.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.3.4 DURATION: Permanent.
[2/1/1995; 8.326.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/2012]

8.326.3.5 EFFECTIVE DATE: February 1, 1995.
[2/1/1995; 8.326.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/2012]

8.326.3.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, non-covered services, utilization review, and provider reimbursement.
[2/1/1995; 8.326.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/2012]

8.326.3.7 DEFINITIONS: [**RESERVED**]

8.326.3.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[2/1/1995; 8.326.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012; A, 4/5/2022]

8.326.3.9 CASE MANAGEMENT SERVICES FOR PREGNANT INDIVIDUALS AND THEIR INFANTS: The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients, including case management services furnished to medicaid eligible pregnant individuals on the day the pregnancy ends through the last day in which the 12-month postpartum period ends. This part describes eligible providers, eligible recipients, covered services, service limitations and general reimbursement methodology.
[2/1/1995; 5/15/1996; 8.326.3.9 NMAC - Rn, 8 NMAC 4.MAD.772, 3/1/2012; A, 4/5/2022]

8.326.3.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following certified agencies are eligible to be reimbursed for furnishing case management services to eligible pregnant individuals and their infants:

(1) public health offices of the New Mexico department of health;
(2) Indian tribal governments or Indian health services;
(3) federally qualified health centers (FQHC); and
(4) other community-based agencies which meet the requirements for participation.

B. Agency qualifications: Community-based agencies must be certified by the department of health and meet the following criteria:

(1) agencies must have demonstrated direct experience in successfully serving the target population; and

(2) agencies must have demonstrated knowledge of available community services and methods for accessing them.

C. Case manager qualifications: Case managers employed by the agency must possess the education, skills, abilities, and experience to perform case management services. It can be important that case managers have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area. At a minimum, case managers must have one of the following qualifications:

(1) case managers must be licensed as a registered nurse and have a bachelors degree in nursing or be licensed as a social worker; the nurse or social worker must have two years of experience in community health and at least one year of experience in maternal health or child health;

(2) or be a licensed registered nurse or have a bachelors degree in social work with a minimum of two years of experience in community health and at least two years experience in maternal health or child health nursing;

(3) in the event that there are no candidates with the above qualifications, an individual with an associates degree and four years of experience in social, community health or maternal health and child health may be employed as a case manager;

(4) if no individuals with a college degree and appropriate experience are available, an individual with a high school diploma and five years of experience in social services, community health or maternal health and child health may be considered; agencies that are considering hiring individuals listed in Paragraph (3) and (4) of 8.326.3.10 NMAC must complete a waiver process.

D. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2/1/1995; 5/15/1996; 8.326.3.10 NMAC - Rn, 8 NMAC 4.MAD.772.1, 3/1/2012; A, 4/5/2022]

8.326.3.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result and relationship of the service furnished to goals identified in the individual service plan.

[2/1/1995; 5/15/1996; 8.326.3.11 NMAC - Rn, 8 NMAC 4.MAD.772.2, 3/1/2012]

8.326.3.12 ELIGIBLE RECIPIENTS: Case management services are available to medicaid eligible pregnant individuals and their infants up to 12-months following the delivery in accordance with 8.291.400.14 NMAC.

[2/1/1995; 5/15/1996; 8.326.3.12 NMAC - Rn, 8 NMAC 4.MAD.772.3, 3/1/2012; A, 4/5/2022]

8.326.3.13 COVERED SERVICES AND SERVICE LIMITATIONS: Medicaid covers case management services for pregnant individuals and their infants which help recipients gain access to medical, social, educational or other needed services. Case management services provide necessary coordination with providers of non-medical services, such as nutrition or education programs, when these services are necessary to enable recipients to benefit from the health services paid for by medicaid.

A. Medicaid covers the following case management service activities furnished to pregnant individuals:

(1) identification of programs appropriate for the recipient's needs, including those which teach basic maternal and child health skills;

(2) help in accessing the identified programs;

(3) assessment of the service needs of recipients to coordinate the delivery of services when multiple providers or programs are involved in the provision of care;

(4) reassessment to ensure that the services which were obtained are necessary and appropriate in meeting the recipient's needs; and

(5) determination of whether any additional services are warranted.

B. Medicaid covers five hours of case management services per client per pregnancy. The five hours include services to both the pregnant recipient and the infant. Additional units of service require prior approval by MAD or its designee.

[2/1/1995; 5/15/1996; 8.326.3.13 NMAC - Rn, 8 NMAC 4.MAD.772.4, 3/1/2012; A, 4/5/2022]

8.326.3.14 NONCOVERED SERVICES: Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible, who are not pregnant, or who are not residents of New Mexico;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocational services which are related to traditional academic subjects or job training;

D. outreach and identification activities in which providers attempt to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. institutional discharge planning;

G. services which are furnished by other practitioners, such as therapies, transportation and homemaker or personal care services; and

H. services considered by MAD or its designee to be excessive based on the needs of the recipient and on the documentation by the case manager.

[2/1/1995; 5/15/1996; 8.326.3.14 NMAC - Rn, 8 NMAC 4.MAD.772.5, 3/1/2012]

8.326.3.15 PLAN OF CARE:

A. Case managers develop and implement plans of care for each medicaid recipient. Plans of care are developed in consultation with the recipients, families or legal guardian(s), physicians and others involved with care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and needs of the woman or infant;

(2) description of the intermediate and long-range goals with the projected timetable for their attainment, including specific information on the duration and scope of services; and

(3) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

C. The plan of care must be retained by agency providers and be available for utilization review purposes. Plans of care must be updated and revised, as indicated, at least every six months or more often, as indicated by the recipient's condition.

[2/1/1995; 5/15/1996; 8.326.3.15 NMAC - Rn, 8 NMAC 4.MAD.772.6, 3/1/2012; A, 4/5/2022]

8.326.3.16 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services which are part of the treatment plan can require prior approval from MAD or its designee. See utilization instruction for those services. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/1995; 5/15/1996; 8.326.3.16 NMAC - Rn, 8 NMAC 4.MAD.772.7, 3/1/2012]

8.326.3.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for case management services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or procedure.

B. The provider's billed charge must be their usual and customary charge for services.

C. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

D. For case management services furnished by an institution, costs associated with case management must be removed from their cost reports prior to cost settlement or rebasing

[2/1/1995; 5/15/1996; 8.326.3.17 NMAC - Rn, 8 NMAC 4.MAD.772.8, 3/1/2012]

HISTORY OF 8.326.3 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 4 CASE MANAGEMENT SERVICES FOR THE CHRONICALLY MENTALLY ILL

8.326.4.1 ISSUING AGENCY: New Mexico Health Care Authority.
[2/1/1995; 8.326.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.4.2 SCOPE: The rule applies to the general public.
[2/1/1995; 8.326.4.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/2012]

8.326.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.4.4 DURATION: Permanent
[2/1/1995; 8.326.4.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/2012]

8.326.4.5 EFFECTIVE DATE: February 1, 1995
[2/1/1995; 8.326.4.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/2012]

8.326.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/1995; 8.326.4.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/2012]

8.326.4.7 DEFINITIONS: [RESERVED]

8.326.4.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/1995; 8.326.4.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012]

8.326.4.9 CASE MANAGEMENT SERVICES FOR THE CHRONICALLY MENTALLY ILL: The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients for case management services furnished to recipients who are chronically mentally ill [42 U.S.C. Section 1396n(g)(1)(2)]. This part describes eligible providers, eligible recipients, covered services, service restrictions and general reimbursement methodology.
[2/1/1995; 8.326.4.9 NMAC - Rn, 8 NMAC 4.MAD.773, 3/1/2012]

8.326.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are reimbursed for furnishing case management services to recipients who are chronically mentally ill:

(1) community mental health centers funded by the mental health division of the department of health;

(2) Indian tribal governments; and

(3) other community-based agencies which have demonstrated direct experience in case management services and success in serving the target population, as certified by the department of health.

B. Agency qualifications: Agencies must be certified by the mental health division of the department of health. Agencies must meet the following criteria.

(1) agencies must have demonstrated direct experience in successfully serving the target population; and

(2) agencies must demonstrate knowledge of available community services and methods for accessing them.

C. Case manager qualification: Case managers employed by the agency must possess the education, skills, abilities, and experience to perform case management services for recipients who are chronically mentally ill. Case managers must meet at least one of the following requirements:

(1) bachelor's degree in social work, counseling, psychology or a related field, from an accredited institution and one year of experience in the mental health field; or

(2) licensed as a registered nurse with one year of experience in the mental health field;

(3) in the event that there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers:

(a) associate's degree and a minimum of three years of experience working with individuals with chronic mental illness;

(b) high school graduation or general educational development (GED) test and a minimum of four years of experience working with individuals with chronic mental illness.

D. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2/1/1995; 8.326.4.10 NMAC - Rn, 8 NMAC 4.MAD.773.1, 3/1/2012]

8.326.4.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result, and relationship of the service furnished to goals identified in the plan of care.

[2/1/1995; 8.326.4.11 NMAC - Rn, 8 NMAC 4.MAD.773.2, 3/1/2012]

8.326.4.12 ELIGIBLE RECIPIENTS: Medicaid covers case management services furnished to medicaid recipients who are chronically mentally ill and who are not residents of an institution for mental disease. Chronic mental illness is defined by diagnosis, disability and duration. The major diagnoses include schizophrenia, affective disorders, bipolar disorders, and serious personality disorders, such as borderline personality. The illness must be of a duration of more than one year and cause serious impairment of functions relative to daily living.

[2/1/1995; 8.326.4.12 NMAC - Rn, 8 NMAC 4.MAD.773.3, 3/1/2012]

8.326.4.13 COVERED SERVICES: Medicaid covers the following case management service activities for recipients who are chronically mentally ill:

A. assessment of the recipient's medical and social needs and functional limitations using standardized needs assessment instruments;

B. development and implementation of individualized plan of care;

C. mobilizing the use of "natural helping" networks, such as family members, church members and friends;

D. development of increased opportunities for community access and involvement including assistance in the location of housing, community living skills, teaching, vocational, civil and recreational service programs;

E. coordination and monitoring of the delivery of services; and

F. evaluation of the effectiveness of services furnished under the plan of care and revision of the plan as conditions warrant.

[2/1/1995; 8.326.4.13 NMAC - Rn, 8 NMAC 4.MAD.773.4, 3/1/2012]

8.326.4.14 NONCOVERED SERVICES: Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible or who are not eligible for these services;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocational services related to traditional academic subjects or job training;

D. outreach and identification activities in which providers attempt to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. institutional discharge planning;

G. services which are furnished under other categories, such as therapies, transportation or counseling; or

H. services considered by MAD or its designee to be excessive based on the needs of recipient and documentation in the case management file.

[2/1/1995; 8.326.4.14 NMAC - Rn, 8 NMAC 4.MAD.773.5, 3/1/2012]

8.326.4.15 PLAN OF CARE:

A. Case managers develop and implement plans of care in conjunction with the recipients, families or legal guardian(s), therapists, physicians, or others who assist with the recipient's care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and the specific needs of the recipient;

(2) description of the functional level of the recipient, including an assessment and evaluation of the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medication assessment; and

(h) physical assessment.

(3) description of the intermediate and long-range goals with the projected timetable for their attainment, including information about the duration and scope of services;

(4) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

(5) the plan of care must be retained by agency providers and available for utilization review purposes; plans of care must be updated and revised, as indicated, at least every six months or more often, as indicated by the recipient's condition.

[2/1/1995; 8.326.4.15 NMAC - Rn, 8 NMAC 4.MAD.773.6, 3/1/2012]

8.326.4.16 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures or services which are part of the plan of care can require prior approval from MAD or its designee. See utilization instructions for the specific service. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/1995; 8.326.4.16 NMAC - Rn, 8 NMAC 4.MAD.773.7, 3/1/2012]

8.326.4.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for case management services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or procedure.

B. The provider's billed charge must be their usual and customary charge for services.

C. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

D. For case management services rendered by an institution, the costs associated with case management services must be removed from their cost reports prior to cost settlement or rebasing.

[2/1/1995; 8.326.4.17 NMAC - Rn, 8 NMAC 4.MAD.773.8, 3/1/2012]

HISTORY OF 8.326.4 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center: MAD Rule 310.28, Case Management Services for the Chronically Mentally Ill, filed 7/13/1990.

History of Repealed Material:

MAD Rule 310.28, Case Management Services for the Chronically Mentally Ill, filed 7/13/1990 - Repealed effective 2/1/1995.

TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 5 CASE MANAGEMENT SERVICES FOR TRAUMATICALLY BRAIN INJURED ADULTS

8.326.5.1 ISSUING AGENCY: New Mexico Health Care Authority.
[2/1/1995; 8.326.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.5.2 SCOPE: The rule applies to the general public.
[2/1/1995; 8.326.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/2012]

8.326.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.5.4 DURATION: Permanent
[2/1/1995; 8.326.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/2012]

8.326.5.5 EFFECTIVE DATE: February 1, 1995
[2/1/1995; 8.326.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/2012]

8.326.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/1995; 8.326.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/2012]

8.326.5.7 DEFINITIONS: [**RESERVED**]

8.326.5.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/1995; 8.326.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012]

8.326.5.9 CASE MANAGEMENT SERVICES FOR TRAUMATICALLY BRAIN INJURED ADULTS: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including covered case management services furnished to adult recipients who are traumatically brain injured [42 U.S.C. Section 1396n (g)(1)(2)]. This part describes eligible providers, eligible recipients, covered services, service limitations and general reimbursement methodology.
[2/1/1995; 10/15/1996; 8.326.5.9 NMAC - Rn, 8 NMAC 4.MAD.774, 3/1/2012]

8.326.5.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are eligible for certification as case management agencies:

(1) government or community agencies which meet certification standards developed by MAD or its designee;

(2) Indian tribal governments;

(3) Indian health services; and

(4) federally qualified health centers (FQHC).

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are

responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

C. Qualification of case management agencies: Case management agencies must have direct experience in serving traumatically brain-injured adults and must demonstrate knowledge of available community services and methods for gaining access to those services.

D. Qualifications of case managers: Case managers employed by case management agencies must have the education, skills, abilities and experience to perform case management services for adults with traumatic brain injuries. Case managers may also need language skills, cultural sensitivity and acquired knowledge and expertise unique to a geographic area. Case managers must have at least one of the following qualification:

(1) bachelor's degree from an accredited institution in social work, counseling, psychology or a related field and one year of experience working with traumatically brain injured adults;

(2) licensed as a registered nurse with one year of experience working with traumatically brain injured adults; or

(3) if there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers:

(a) associate's degree and a minimum of three years experience in the mental health or traumatic brain injury field; or

(b) high school graduation or general educational development (GED) test and a minimum of five years experience in the mental health or traumatic brain injury field.

(4) This individual must work under the direct supervision of an experienced case manager within the agency who meets the educational and experience requirements, described above.

[2/1/1995; 10/15/1996; 8.326.5.10 NMAC - Rn, 8 NMAC 4.MAD.774.1, 3/1/2012]

8.326.5.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*.

A. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

B. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*.

C. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service of intended result and relationship of the service furnished to goals identified in the individual plan of care.

[2/1/1995; 10/15/1996; 8.326.5.11 NMAC - Rn, 8 NMAC 4.MAD.774.2, 3/1/2012]

8.326.5.12 ELIGIBLE INDIVIDUALS:

A. Case management services are available for eligible medicaid recipients who meet all of the following criteria:

(1) twenty-one (21) years of age or older;

(2) resident of the state of New Mexico;

(3) resident of Santa Fe, Chavez, Dona Ana, San Juan, McKinley or San Miguel counties;

(4) suffer from traumatic brain injury; and

(5) reside outside an institution.

B. Definition of traumatic brain injury: "Traumatic brain injury" is defined as an insult to the brain which is not caused by a degenerative or congenital process, but by an external physical force. The physical force produces a diminished or altered state of consciousness resulting in impairment of cognitive abilities or physical functioning. It can also result in the disturbance of behavioral or emotional functioning. These impairments can be either temporary or permanent and cause partial or total functional disability or psychological maladjustment.

C. Recipient freedom of choice: Adults with traumatic brain injuries are not required to receive case management services even if they are eligible for the service. Case management services can only be furnished at the request of recipients. Recipients have the freedom to choose among medicaid-eligible case management agencies and specific case managers within an agency.

[2/1/1995; 10/15/1996; 8.326.5.12 NMAC - Rn, 8 NMAC 4.MAD.774.3, 3/1/2012]

8.326.5.13 COVERED SERVICES: Medicaid covers those case management services for traumatic brain-injured adults which are medically necessary to help these recipients gain access to needed medical, social, educational and other services. Medicaid covers the following specific case management services:

A. identification of programs which are appropriate for a recipient's needs and provision of assistance to the recipient in accessing those programs;

B. assessment of the service needs of recipients to coordinate the delivery of services if multiple providers or programs are involved in the provision of care; and

C. reassessment to ensure that the services obtained are medical necessary and appropriate to meet the recipient's needs.

[2/1/1995; 10/15/1996; 8.326.5.13 NMAC - Rn, 8 NMAC 4.MAD.774.4, 3/1/2012]

8.326.5.14 NONCOVERED SERVICES: Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid-eligible, who do not meet the definition of traumatically brain injured, or who are not residents of Santa Fe county or the state of New Mexico;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. daily independent living skills training;

D. outreach and identification activities in which providers attempt to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. institutional discharge planning: if recipients are in medical institutions, medicaid covers case management only for the 30 days prior to discharge; this service cannot duplicate required discharge planning activities conducted by medical institutions;

G. actual provision of services or treatment identified in the case management assessment; or

H. services furnished by other practitioners, such as therapies, transportation, homemaker or personal care services or psycho-social rehabilitation services.

[2/1/1995; 10/15/1996; 8.326.5.14 NMAC - Rn, 8 NMAC 4.MAD.774.5, 3/1/2012]

8.326.5.15 PLAN OF CARE:

A. Case managers develop and implement individualized plans of care in consultation with recipients, families or legal guardians, physicians and others involved in the care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and needs of the recipients;

(2) description of the functional level of the recipient, including an assessment and evaluation of the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medication assessment; and

(h) physical assessment.

(3) description of the intermediate and long-range goals, with the projected timetable for their attainment, including information on the duration and scope of services; and

(4) statement and rationale of the plan of care for achieving these intermediate and long-range goals, including review and modification of the plan;

(5) the plan of care must be retained by agency providers and available for utilization review purposes; plans of care must be updated and revised, at least every six months or more often, as indicated by the recipient's condition.

[2/1/1995; 10/15/1996; 8.326.5.15 NMAC - Rn, 8 NMAC 4.MAD.774.6, 3/1/2012]

8.326.5.16 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are

furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures or services which are a part of the plan of care can require prior approval from MAD or its designee. See utilization instructions for the specific service. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/1995; 10/15/1996; 8.326.5.16 NMAC - Rn, 8 NMAC 4.MAD.774.7, 3/1/2012]

8.326.5.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for case management services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service.

B. The provider's billed charge must be their usual and customary charge for services.

C. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

D. For case management services furnished by an institution or clinic, the costs associated with case management services must be removed from cost reports prior to cost settlement or rebasing.

[2/1/1995; 10/15/1996; 8.326.5.17 NMAC - Rn, 8 NMAC 4.MAD.774.8, 3/1/2012]

HISTORY OF 8.326.5 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center: MAD Rule 310.36, Case Management Services for the Traumatically Brain Injured, filed 7/19/94.

History of Repealed Material:

MAD Rule 310.36, Case Management Services for the Traumatically Brain Injured, filed 7/19/1994 - Repealed effective 2/1/1995.

TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 6 CASE MANAGEMENT SERVICES FOR CHILDREN UP TO AGE THREE

8.326.6.1 ISSUING AGENCY: New Mexico Health Care Authority.
[2/1/1995; 8.326.6.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.6.2 SCOPE: The rule applies to the general public.
[2/1/1995; 8.326.6.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/2012]

8.326.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.6.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.6.4 DURATION: Permanent
[2/1/1995; 8.326.6.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/2012]

8.326.6.5 EFFECTIVE DATE: February 1, 1995
[2/1/1995; 8.326.6.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/2012]

8.326.6.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/1995; 8.326.6.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/2012]

8.326.6.7 DEFINITIONS: [**RESERVED**]

8.326.6.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/1995; 8.326.6.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012]

8.326.6.9 CASE MANAGEMENT SERVICES FOR CHILDREN UP TO AGE THREE: The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients, including case management services furnished to medicaid eligible children up to the age of three years who are medically at risk due to family conditions [42 U.S.C. Section 1396n(g)(1)(2)]. This part describes eligible providers, eligible recipients, covered services, service limitations and general reimbursement methodology.
[2/1/1995; 5/15/1996; 8.326.6.9 NMAC - Rn, 8 NMAC 4.MAD.775, 3/1/2012]

8.326.6.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following certified agencies are eligible to be reimbursed for furnishing case management services to children up to the age of three years who are medically at risk due to family conditions:

(1) public health offices of the New Mexico department of health;
(2) Indian tribal governments or Indian health services;
(3) federally qualified health centers (FQHC); and
(4) other community-based agencies which meet the requirements for participation.

B. Agency qualifications: Community-based agencies must be certified by the department of health and meet the following criteria.

(1) Agencies must have demonstrated direct experience in successfully serving the target population; and

(2) Agencies must have demonstrated knowledge of available community services and methods for accessing them.

C. Case manager qualifications: Case managers employed by the agency must possess the education, skills, abilities, and experience to perform case management services. It can be important that case managers have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area.

(1) At a minimum, case managers must have one of the following qualifications:

(a) case managers must be licensed as a registered nurse and have a bachelors degree in nursing or be licensed as a social worker; the nurse or social worker must have two years of experience in community health and at least one year of experience in maternal health or child health;

(b) or be a licensed registered nurse or have a bachelors degree in social work with a minimum of two years of experience in community health and at least two years experience in maternal health or child health nursing;

(c) in the event that there are no candidates with the above qualifications, an individual with an associates degree and four years of experience in social, community health and/or maternal health and child health may be employed as a case manager;

(d) if no individuals with a college degree and appropriate experience are available, an individual with a high school diploma and five years of experience in social services, community health or maternal health and child health may be considered; agencies that are considering hiring individuals in option (c) or (d) must complete a waiver process.

(2) Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2/1/1995; 5/15/1996; 8.326.6.10 NMAC - Rn, 8 NMAC 4.MAD.775.1, 3/1/2012]

8.326.6.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result and relationship of the service furnished to goals identified in the individual service plan.

[2/1/1995; 5/15/1996; 8.326.6.11 NMAC - Rn, 8 NMAC 4.MAD.775.2, 3/1/2012]

8.326.6.12 ELIGIBLE RECIPIENTS: Case management services are available to medicaid eligible children under the age of three who are medically at risk due to family conditions but who are not developmentally delayed.

[2/1/1995; 5/15/1996; 8.326.6.12 NMAC - Rn, 8 NMAC 4.MAD.775.3, 3/1/2012]

8.326.6.13 COVERED SERVICES AND SERVICE LIMITATIONS: Medicaid covers case management services for children up to the age of three which help recipients gain access to medical, social, educational or other needed services. Case management services provide necessary coordination with providers of non-medical services, such as nutrition or education programs, when these services are necessary to enable recipients to benefit from the health services paid for by medicaid.

A. Medicaid covers the following case management service activities furnished children up to the age of three:

(1) identification of programs appropriate for the recipient's needs, including those which teach basic maternal and child health skills;

(2) help in accessing the identified programs;

(3) assessment of the service needs of recipients to coordinate the delivery of services when multiple providers or programs are involved in the provision of care;

(4) reassessment to ensure that the services which were obtained are necessary and appropriate in meeting the recipient's needs; and

(5) determination of whether any additional services are warranted.

B. Medicaid covers four hours of case management services per child per year. Additional units of service require prior approval by MAD or its designee.
[2/1/1995; 5/15/1996; 8.326.6.13 NMAC - Rn, 8 NMAC 4.MAD.775.4, 3/1/2012]

8.326.6.14 NONCOVERED SERVICES: Case management services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible or who are not residents of New Mexico;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocational services which are related to traditional academic subjects or job training;

D. outreach and identification activities in which providers attempt to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. institutional discharge planning;

G. services which are furnished by other practitioners, such as therapies, transportation and homemaker or personal care services; and

H. services considered by MAD or its designee to be excessive based on the needs of the recipient and on the documentation by the case manager.
[2/1/1995; 5/15/1996; 8.326.6.14 NMAC - Rn, 8 NMAC 4.MAD.775.5, 3/1/2012]

8.326.6.15 PLAN OF CARE:

A. Case managers develop and implement plans of care for each medicaid recipient. Plans of care are developed in consultation with the recipients, families or legal guardian(s), physicians and others involved with care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and needs of the child;

(2) description of the intermediate and long-range goals with the projected timetable for their attainment, including specific information on the duration and scope of services; and

(3) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

C. The plan of care must be retained by agency providers and be available for utilization review purposes. Plans of care must be updated and revised, as indicated, at least every six months or more often, as indicated by the recipient's condition.
[2/1/1995; 5/15/1996; 8.326.6.15 NMAC - Rn, 8 NMAC 4.MAD.775.6, 3/1/2012]

8.326.6.16 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services which are part of the treatment plan can require prior approval from MAD or its designee. See utilization instruction for those services. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.
[2/1/1995; 5/15/1996; 8.326.6.16 NMAC - Rn, 8 NMAC 4.MAD.775.7, 3/1/2012]

8.326.6.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Instructions on documentation, billing and

claims processing are sent to approved medicaid providers. Reimbursement for case management services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or procedure.

B. The provider's billed charge must be their usual and customary charge for services.

C. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

D. For case management services furnished by an institution, costs associated with case management must be removed from their cost reports prior to cost settlement or rebasing.

[2/1/1995; 5/15/1996; 8.326.6.17 NMAC - Rn, 8 NMAC 4.MAD.775.8, 3/1/2012]

HISTORY OF 8.326.6 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 7 ADULT PROTECTIVE SERVICES CASE MANAGEMENT

8.326.7.1 ISSUING AGENCY: New Mexico Health Care Authority.
[2/1/1995; 8.326.7.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.7.2 SCOPE: The rule applies to the general public.
[2/1/1995; 8.326.7.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/2012]

8.326.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.7.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.7.4 DURATION: Permanent
[2/1/1995; 8.326.7.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/2012]

8.326.7.5 EFFECTIVE DATE: January 31, 1996
[2/1/1995; 8.326.7.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/2012]

8.326.7.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/1995; 8.326.7.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/2012]

8.326.7.7 DEFINITIONS: [RESERVED]

8.326.7.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/1995; 8.326.7.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012]

8.326.7.9 ADULT PROTECTIVE SERVICES CASE MANAGEMENT: The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients, including case management services furnished to medicaid eligible adults, individuals who are 18 years or older, who have been neglected, abused, or exploited [42 U.S.C. Section 136n(g)(1)(2)]. This part describes eligible providers, eligible population, covered services, service limitations, and general reimbursement information.
[1/31/1996; 8.326.7.9 NMAC - Rn, 8 NMAC 4.MAD.776, 3/1/2012]

8.326.7.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are eligible to be reimbursed for furnishing case management services to an eligible recipient.

(1) Government agencies or their delegates which by law receive reports or allegations of abuse, exploitation or neglect and who by New Mexico state law are required to provide adult protective services for the target population.

(2) Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

B. **Agency qualifications:** Agencies must demonstrate direct experience in successfully serving the target population; and past performance of such agencies must demonstrate knowledge of available community services and methods for gaining access to those services.

C. **Case manager qualifications:** Case managers employed by an agency must possess the education, skills, abilities, and experience to perform case management services. Case managers must have the necessary skills to meet the needs of specified recipients. In some instances, it is important that individuals have language skills, cultural sensitivity and acquired knowledge unique to a geographic area. Case managers must also at a minimum, have a current license at the baccalaureate level issued by the New Mexico board of social work. These individuals must work under the direct supervision of an experienced case manager within the agency who meets the educational requirements specified above.

[1/31/1996; 8.326.7.10 NMAC - Rn, 8 NMAC 4.MAD.776.1, 3/1/2012]

8.326.7.11 **PROVIDER RESPONSIBILITIES:** Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*. Documentation must substantiate the date of services, type of contact, category of case management services furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result and relationship of the service furnished to the goals identified in the individual service plan.

[1/31/1996; 8.326.7.11 NMAC - Rn, 8 NMAC 4.MAD.776.2, 3/1/2012]

8.326.7.12 **ELIGIBLE RECIPIENTS:** Case management services are available for eligible medicaid recipients who meet all of the following criteria:

A. individuals who are 18 years of age or older;

B. individuals who are residents of the state of New Mexico;

C. individuals who are not residents of an institution; and

D. individuals who through investigation are found to be abused, neglected or exploited; abuse is defined as knowingly, intentionally or negligently and without justifiable cause inflicting physical pain, injury or mental anguish, or the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of an adult; neglect is defined as failure of the caretaker of an adult to provide basic needs such as clothing, food, shelter, supervision and care for the physical and mental health for that adult or failure by an adult to provide such basic needs for him/herself; exploitation is defined as an unjust or improper use of an adult's resources for another's profit or advantage, pecuniary or otherwise.

[1/31/1996; 8.326.7.12 NMAC - Rn, 8 NMAC 4.MAD.776.3, 3/1/2012]

8.326.7.13 **COVERED SERVICES:** Medicaid covers the following case management services for adults who have been abused, neglected or exploited:

A. services which help recipients gain access to medical, social, educational or other needed services.

B. assessment of a recipient's medical and social needs and functional limitations using standardized needs assessment instruments;

C. development and implementation of an individualized plan of care designed to help recipients retain or achieve the maximum degree of independence;

D. mobilization of the use of "natural helping" networks such as family members, church members, community organizations, support groups and friends; and

E. coordination and monitoring of the delivery of services, evaluation of the effectiveness and quality of the services, and revision of the plan of care, if necessary.

[1/31/1996; 8.326.7.13 NMAC - Rn, 8 NMAC 4.MAD.776.4, 3/1/2012]

8.326.7.14 **NONCOVERED SERVICES:** Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. Medicaid does not cover the following specific services as adult protective services case management:

A. services furnished to individuals who are not medicaid eligible or who do not meet the definition of an adult who is abused, neglected or exploited;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocation services related to traditional academic subjects or vocational training;

D. client outreach activities in which a provider attempts to contact potential recipients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. case management for a recipient who is institutionalized, except for the last 30 days of the institutionalization to ensure follow-up services;

G. institutional discharge planning which is a required condition for payment of hospital, nursing home or residential treatment center services;

H. services which are furnished under other categories, such as therapies, transportation or counseling; or

I. services considered by MAD or its designee to be excessive based on the needs of the recipient and documentation in the case management file.

[1/31/1996; 8.326.7.14 NMAC - Rn, 8 NMAC 4.MAD.776.5, 3/1/2012]

8.326.7.15 PLAN OF CARE:

A. Case managers develop and implement plans of care for each medicaid recipient. Plans of care are developed in consultation and cooperation with recipients, families or legal guardian(s), primary physicians, as appropriate and others involved with the recipient's care.

B. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and the specific needs of the recipient;

(2) description of the functional level of the recipient, including the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medical assessment; and

(h) physical assessment.

(3) description of the intermediate and long-range goals, with the projected timetable for their attainment and duration and scope of services; and

(4) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for review and modification of the plan and plans for discontinuation of services, criteria for discontinuation of services and projected date service will be discontinued.

C. The plan of care must be retained by agency providers and be available for utilization review purposes. Plans of care must be updated and revised, as indicated, at least every six months or more often, as indicated by the recipient's condition.

[1/31/1996; 8.326.7.15 NMAC - Rn, 8 NMAC 4.MAD.776.6, 3/1/2012]

8.326.7.16 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services which are specified in the treatment plan can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[1/31/1996; 8.326.7.16 NMAC - Rn, 8 NMAC 4.MAD.776.7, 3/1/2012]

8.326.7.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, instructions on documentation, billing and claims processing are sent to the medicaid providers. Reimbursement for case management providers is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service.

B. The provider's billed charge must be its usual and customary charge for the services.

C. "Usual and customary charge" refers to the amount which an individual provider charges the general public in the majority of cases for a specific procedure or service.

D. For case management services furnished by an institution, costs associated with case management must be removed from their cost reports prior to any cost settlement or rebasing.

[1/31/1996; 8.326.7.17 NMAC - Rn, 8 NMAC 4.MAD.776.8, 3/1/2012]

HISTORY OF 8.326.7 NMAC: **[RESERVED]**

TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 8 CASE MANAGEMENT SERVICES FOR CHILDREN PROVIDED BY JUVENILE PROBATION AND PAROLE OFFICERS

8.326.8.1 ISSUING AGENCY: New Mexico Health Care Authority.
[2/1/1995; 8.326.8.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.326.8.2 SCOPE: The rule applies to the general public.
[2/1/1995; 8.326.8.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/2012]

8.326.8.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.326.8.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.326.8.4 DURATION: Permanent
[2/1/1995; 8.326.8.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/2012]

8.326.8.5 EFFECTIVE DATE: March 1, 2000
[2/1/1995; 8.326.8.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/2012]

8.326.8.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/1995; 8.326.8.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/2012]

8.326.8.7 DEFINITIONS: [**RESERVED**]

8.326.8.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/1995; 8.326.8.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012]

8.326.8.9 CASE MANAGEMENT SERVICES FOR CHILDREN PROVIDED BY JUVENILE PROBATION AND PAROLE OFFICERS: The New Mexico health care authority (HCA) pays for medically necessary case management services furnished to identified clients under 19 years of age who are under the supervision of a juvenile probation and parole officer (JPPO) and have an identified physical or mental condition which has a high probability of impairing their cognitive, emotional, neurological, social or physical development. See Section 1915(g) of the Social Security Act. This part describes eligible providers, eligible clients, covered services, service restrictions and general reimbursement methodology.
[3/1/2000; 8.326.8.9 NMAC - Rn, 8 NMAC 4.MAD.778, 3/1/2012]

8.326.8.10 ELIGIBLE PROVIDERS: Upon approval of a New Mexico medical assistance program provider participation agreement by the New Mexico medical assistance division (MAD), the following agency is reimbursed for furnishing case management services to clients in the identified population: New Mexico children, youth and families department. See the New Mexico Children's Code, Chapter 32A-2-5.

A. Agency qualifications:

B. Case manager qualification:

(1) Case managers employed by the New Mexico children, youth and families department must possess the knowledge, skills, abilities and experience to perform case management services for the targeted population and when necessary, possess language skills, cultural sensitivity and acquired knowledge unique to a

geographic area. Case managers must meet at least one of the following qualifications: a bachelor's degree in social work, counseling, psychology or a related field and experience serving the targeted population.

(2) All children, youth and families department, juvenile probation and parole officers (JPPOs) and JPPO supervisors performing targeted case management services must have documentation in their personnel file of completion of structured decision making training and any other additional or supplemental training developed by CYFD specific for this program.

(3) Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[3/1/2000; 8.326.8.10 NMAC - Rn, 8 NMAC 4.MAD.778.1, 3/1/2012]

8.326.8.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid clients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to clients. See 8.302.1 NMAC, *General Provider Policies*. Documentation must substantiate the date of service, nature of contact, reason the service was furnished, nature/content of the service furnished, result of service or intended result and relationship of the service furnished to goals identified in the plan of care.

[3/1/2000; 8.326.8.11 NMAC - Rn, 8 NMAC 4.MAD.778.2, 3/1/2012]

8.326.8.12 ELIGIBLE RECIPIENTS (TARGET POPULATION): Medicaid covers case management services furnished to medicaid clients under 19 years of age who are involved with the juvenile justice system or who have committed a delinquent act and have an identified physical or mental condition which has a high probability of impairing their cognitive, emotional, neurological, social or physical development. Juveniles who are adjudicated and incarcerated or who are placed in a detention center for longer than 60 pre-adjudication days) are not eligible for medicaid and/or case management services paid for by medicaid.

[3/1/2000; 8.326.8.12 NMAC - Rn, 8 NMAC 4.MAD.778.3, 3/1/2012]

8.326.8.13 COVERED SERVICES: Case management is defined as services which assist clients in the target population in gaining access to needed medical, social, educational and other services.

A. Medicaid covers the following case management service activities for clients in the target population:

(1) assessment of the client's medical, social, educational and other service needs and functional limitations using standardized needs assessment instruments;

(2) development and implementation of individualized plan of care;

(3) mobilizing the use of "natural helping" networks, such as family members, church members and friends;

(4) development of increased opportunities for community access and involvement including assistance in the location of housing, community living skills, vocational, social, educational or other service programs;

(5) coordination and monitoring of the delivery of services; and

(6) evaluation of the effectiveness of services furnished under the plan of care and revision of the plan as conditions warrant.

B. For clients in the target population that participate in the medicaid managed care program, HCA covers only those activities that relate to accessing social, educational, and other services. The medicaid managed care organizations are responsible for ensuring that clients have access to medical services and coordination occurs with other case managers.

C. For clients in the target population that are not enrolled in the medicaid managed care program, HCA covers all delineated case management activities.

[3/1/2000; 8.326.8.13 NMAC - Rn, 8 NMAC 4.MAD.778.4, 3/1/2012]

8.326.8.14 NONCOVERED SERVICES: Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*. In addition, medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible or who are not eligible for these services;

B. services furnished by case managers which are not substantiated with appropriate documentation in the client's file;

C. formal educational or vocational services related to traditional academic subjects or job training;

D. outreach and identification activities in which providers attempt to contact potential clients;

E. administrative activities, such as medicaid eligibility determinations and intake processing;

F. discharge planning from inpatient hospital, residential facility or community-based placement;

G. services which are furnished under other categories, such as therapies, transportation or counseling;

H. services provided to clients that are not part of the target population or services which are not documented in the client file; or

I. services provided to clients that relate to the legal and/or corrections functions performed by JPPOs.

[3/1/2000; 8.326.8.14 NMAC - Rn, 8 NMAC 4.MAD.778.5, 3/1/2012]

8.326.8.15 PLAN OF CARE:

A. Case managers develop and implement plans of care in conjunction with the clients, families or legal guardian(s), therapists, physicians or others who assist with the client's care.

B. The following must be contained in the plan of care or documents used in the development of the plan of care. The plan of care and all supporting documentation must be available for review in the client's file:

(1) statement of the nature of the specific problem and the specific needs of the client;

(2) description of the functional level of the client, including an assessment and evaluation using the structured decision making assessment tool developed by CYFD and approved by HCA or its successor.

(3) description of the intermediate and long-range goals with the projected timetable for their attainment, including information about the duration and scope of services;

(4) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

C. The plan of care must be retained by agency providers and available for utilization review purposes. Plans of care must be updated and revised, as indicated, at least every six months or more often, as indicated by the client's condition.

[3/1/2000; 8.326.8.15 NMAC - Rn, 8 NMAC 4.MAD.778.6, 3/1/2012]

8.326.8.16 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Case management services furnished to clients in this targeted population do not require prior approval. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures or services which are part of the plan of care can require prior approval from MAD or its designee. See utilization instructions for the specific service. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[3/1/2000; 8.326.8.16 NMAC - Rn, 8 NMAC 4.MAD.778.7, 3/1/2012]

8.326.8.17 REIMBURSEMENT: Case management providers must submit claims for reimbursement on the HCFA 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Instructions on documentation, billing and claims processing are sent to approved medicaid providers.

A. Reimbursement for non-governmental providers: For community agencies, tribal government, or Indian health services, reimbursement for case management services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or procedure.

B. The provider's billed charge must be the provider's usual and customary charge for services.

C. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

D. **Reimbursement for governmental providers:** For case management services rendered by governmental agencies to the target population, reimbursement rates, rate setting methodology and reimbursement process will be delineated under the terms of the joint powers agreement between the government agencies and the HCA.

[3/1/2000; 8.326.8.17 NMAC - Rn, 8 NMAC 4.MAD.778.8, 3/1/2012]

HISTORY OF 8.326.8 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 10 BRAIN INJURY SERVICES FUND PROGRAM

8.326.10.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.326.10.1 NMAC - Rp, 8.326.10.1 NMAC, 4/1/2021; A, 7/1/2024]

8.326.10.2 SCOPE: This rule applies to the general public.
[8.326.10.2 NMAC - Rp, 8.326.10.2 NMAC, 4/1/2021]

8.326.10.3 STATUTORY AUTHORITY: Subsection E of Section 9-23-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.326.10.3 NMAC - Rp, 8.326.10.3 NMAC, 4/1/2021; A, 7/1/2024]

8.326.10.4 DURATION: Permanent.
[8.326.10.4 NMAC - Rp, 8.326.10.4 NMAC, 4/1/2021]

8.326.10.5 EFFECTIVE DATE: April 1, 2021, unless a later date is cited at the end of a section.
[8.326.10.5 NMAC - Rp, 8.326.10.5 NMAC, 4/1/2021]

8.326.10.6 OBJECTIVE: The objective of this rule is to establish policies and procedures and define standards of the New Mexico health care authority (HCA) brain injury services fund program. The brain injury services fund program provides timely short term in-state non-medicaid services for persons with qualifying brain injuries that are of traumatic or other acquired origin in order to promote independence and to assist the individual in resolving a brain-injury related crisis need and access available payer sources and community resources, when there is no other funding available.
[8.326.10.6 NMAC - Rp, 8.326.10.6 NMAC, 4/1/2021]

8.326.10.7 DEFINITIONS:

A. "Acquired brain injury" (ABI) means a brain injury that is the result of trauma arising from an insult to the brain from an outside physical force via open or closed head injury; shaken baby syndrome; anoxia; near-drowning; electrical shock; brain infection; brain tumors; cerebrovascular lesions or insults, including stroke and aneurysm; or unintended toxic or chemical exposure. The definition excludes conditions that are congenital, degenerative, induced by birth trauma, or resulting from abuse of alcohol or other substances. The injury may be focal or diffuse, causing temporary or permanent impairments in cognitive, psychosocial or physical functioning affecting one or more areas of the brain and result in partial or total functional disability. Brain injury related impairments may affect one or more areas of functioning such as: cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; information processing; sensory, perceptual, and motor abilities; physical functioning; sleep; psychosocial and behavioral functioning; and, or speech.

B. "Activities of daily living" (ADL) means the basic tasks that are necessary for independent functioning to care for one's personal needs and may include bathing and showering, personal hygiene and grooming, dressing, toileting, transferring or moving the physical body in space while performing activities, and self-feeding. Instrumental activities of daily living (IADLs) are not necessary for fundamental functioning but do allow an individual to live independently in their home or community; these include cleaning and maintaining the home, doing laundry, managing personal finances, preparing meals, shopping for groceries, taking prescribed medications, and using the telephone or other communication devices.

C. "Brain injury". See definition for acquired brain injury and traumatic brain injury.

D. "Brain injury services fund (BISF) program" means a non-medicaid program administered by HCA through programmatic oversight and contractual management of agencies, providing short-term crisis interim home and community-based services for eligible individuals living with brain injury, who have a defined crisis related to living with brain injury and no responsible funding source to pay for needed services or goods. Direct participant care services are provided through service coordination or BISF home and community-based services.

E. "Crisis" means an emergency or unstable situation that has reached a critical phase with a distinct possibility of adverse outcome and poses a serious potential danger. As related to a brain injury, a crisis may include homeless status, unemployment, substantial loss of income, lack of health insurance or means to pay for

brain-injury related healthcare, separation from support systems, abandonment or other endangering circumstances. For the purposes of the BISF, the absence of service coordination, long-term care, long-term case management or need for long-term case management does not constitute a crisis.

F. **"Crisis interim period**" means a short-term period of six months upon which an enrolled participant can be reassessed to extend approved services for another six month period depending upon available funding and limited to no more than one consecutive year, if the crisis has not resolved and goals for independent living have not reached completion, or until another funding source has been obtained. Time limitations on services apply to both service coordination and to BISF HCBS.

G. **"Education"** means providing individuals living with brain injury training and understanding of brain injury, acquiring life skills or fulfilling activities of daily living, which can be applied day to day, to assist in the attainment of an independent lifestyle.

H. **"Fiscal intermediary agency"** means an agency that arranges for BISF home and community-based services and goods and processes payment or reimbursement for services and goods for eligible participants of the New Mexico health care authority brain injury services fund program.

I. **"Formulary" or "BISF formulary"** means the list of medications approved by the BISF program for treatment of specific categories of brain injury symptoms and related conditions. Coverage is in the form of copayments for participants who have no other responsible payer sources. Approved generic and brand name medications are categorized by class or function. BISF service coordinators are authorized to review prescribed participant medications against the formulary in the event that other responsible payer sources to cover the medication do not exist prior to referral for BISF HCBS.

J. **"Grievance"** means a complaint or disagreement with regard to how or whether a service provided through the program is or can be provided.

K. **"Home and community-based services" (HCBS)** are defined as services to promote independent living that are provided in a person's home or community, i.e., those not provided under institutional care. BISF HCBS are those that may be required when there is an imminent risk to a participant's health and safety; there has been a sudden change in the medical, psychological or physical condition of a participant; when there is acceleration in the amount of services needed; when needs have suddenly changed; or when another payer source will not pay for the unique brain injury services assessed as a need.

L. **"Health care authority (HCA)"** is the New Mexico state government agency that administers services to New Mexico's more vulnerable populations to improve health outcomes through state and federal funding. The brain injury services fund is administered through the medical assistance division and receives only state funding.

M. **"ICD code"** means an international classification of diseases diagnosis, which includes codes for traumatic and other acquired brain injuries and has been documented in writing by a duly licensed medical professional or psychologist for the purpose of assisting an individual with brain injury to qualify for the BISF program. Current ICD codes may be accepted from medical doctors (MDs), osteopathic doctors (DOs), certified nurse practitioners (CNPs), physician assistants (PAs), and Ph.D. psychologists.

N. **"Imminent"** means impending and threatening, referring to a crisis that is bound to happen with a clear and present danger to the health and safety of a person who has sustained a brain injury and who has exhausted all available resources.

O. **"Independence"** means the ability to live in a home and community setting and perform activities of daily living with little or no assistance from others while having access to available community resources.

P. **"Individual"** means a person living with brain injury and may be an applicant or a program participant.

Q. **"Independent living plan"** (ILP) means a written person-centered plan that outlines definite goals for resolving a participant's identified crisis which is designed to assist the participant toward greater independence; lists measurable objectives in the form of action steps and strategies that are targeted to comprehensively address and resolve each identified crisis; and specifies a plan for discharge. The ILP identifies all services and supports as well as payer sources that are assisting the participant toward greater independence, specifying those that pertain directly to service coordination and BISF HCBS. It must also list ancillary services and supports, not paid for by the BISF program, noting related payer sources, as well as services refused but needed to resolve or address identified crises.

R. **"Interim"** means a time period defined by the BISF program in which temporary services are provided. The interim period for the BISF program is six months.

S. **"Legal resident of New Mexico"** means a person residing in New Mexico at the time of application.

T. **"Life skills coach"** means a person, who may be defined as a "life coach", is certified through an accredited organization, and provides targeted customized training to an individual with brain injury to assist in relearning and completing activities of daily living while addressing related cognitive, behavioral or social impairments that are preventing the return to independent functioning.

U. **"Participant"** means a person living with brain injury, who has qualified for, been approved for, and is actively receiving BISF program services, while working toward greater independence and resolution of crisis needs.

V. **"Payer of last resort"** refers to the BISF Program as a source of funding available to pay for BISF HCBS only after all payer sources with responsibility to pay have been denied or exhausted including private insurance, medicaid, medicare, Indian health services, veterans administration, adult protective services and other state or federal programs, or community programs in which the participant participates voluntarily.

W. **"Residency"** means the status of a person who is a legal resident of New Mexico and is able to produce documentation of a physical address within New Mexico at which the person resides within a home and community setting. It does not include residence in an institution wherein the individual is unable to function independently.

X. **"Risk"** means a possible loss or injury, a hazard increasing the probability or chance that loss or injury will occur.

Y. **"Self-determination"** means the right of individuals to make decisions that direct the path their life follows with regard to medical, financial and all other matters, including the right to refuse measures needed to improve their outcome.

Z. **"Service coordination"** means the goal-oriented initiation, organization and management of a BISF participant's services, including determination of eligibility, initial and interim assessments, development and monitoring of the participant's independent living plan (ILP), referrals for BISF program and community resources, assistance with benefits applications for other payer sources, and problem-solving to assist in the resolution of the crisis that motivated entry to the BISF program, while moving the participant toward greater independence in daily living. Service coordination may continue during resolution of an identified crisis need. Service coordination is not defined as case management, and the need for long-term case management does not constitute a qualifying crisis for remaining on the BISF.

AA. **"Short-term"** means an intervention period with beginning and end points within which BISF funding for service coordination or BISF HCBS may be used to prevent or alleviate a crisis situation until circumstances stabilize or other funding is obtained.

BB. **"Traumatic brain injury (TBI)"** means an insult to the brain from an outside physical force that may or may not have produced a diminished or altered state of consciousness causing temporary or permanent impairments in one or more areas of the brain and resulting in partial or total functional disability and or psychosocial disorientation. The term applies to open or closed head injuries resulting in an impairment of cognitive, psychosocial or physical functions. Brain injury related impairments may occur in one or more areas such as: cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; information processing, sensory, perceptual, and motor abilities; physical functioning; sleep; psychosocial and behavioral functioning; and speech.

[8.326.10.7 NMAC - Rp, 8.326.10.7 NMAC, 4/1/2021]

8.326.10.8 **MISSION STATEMENT:** To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.326.10.8 NMAC - Rp, 8.326.10.8 NMAC, 4/1/2021]

8.326.10.9 **BISF ELIGIBILITY REQUIREMENTS:** Enrollment into the BISF, as a non-entitlement program, is on a voluntary basis and occurs in up to six month increments. To be eligible for the BISF program, an applicant with a crisis need must meet the following requirements:

A. **Diagnosis:** Individuals are eligible for BISF services if they have a qualifying diagnosis of brain injury of ABI or TBI which has been documented in writing by a duly licensed medical professional or psychologist. A qualifying diagnosis of brain injury is confirmed by the licensed health practitioner's assignment of the current international classification of diseases (ICD) code.

B. **Residency:** Eligible individuals must be legal residents of the state of New Mexico. Eligible participants must be able to produce documentation of the physical location of their New Mexico residence. Those residing in an institution or are in the process of transitioning to an institutional setting are not eligible for services

through the BISF program. Those participants who have a confirmed discharge date from an institutional setting and are transitioning into the community are eligible for BISF services for a 30-day period prior to the planned discharge date to assist with setting up needed supports and services. For homeless participants with brain injury, the physical address constitutes the agreed-upon location at which the participant routinely meets with the BISF service coordinator and at least one other community case manager, if available.

C. Service Coordination Duplication: Those participants served by other service coordination programs, care coordination or case management systems are not eligible to receive service coordination through the BISF program, unless transitioning between programs and with HCA approval. Such programs might include comparable services offered through any of the following:

(1) medicaid managed care organization (MCO), including community benefit;
(2) medicaid home and community-based services waivers;
(3) early and periodic screening, diagnosis and treatment;
(4) family infant toddler;
(5) program of all-inclusive care for the elderly (PACE);
(6) health management organizations (HMOs); and
(7) other private insurances.

D. Determination of eligibility: The service coordination contractor is responsible for determining eligibility for the BISF program and maintaining documentation of eligibility status. Proof of eligibility status including current qualifying ICD codes must be provided to the HCA or its designee upon request.

E. Re-enrollment into the BISF for reactivation of services: Former program participants, who disenrolled from the program due to resolution of their crisis needs, may seek to re-enroll in the BISF, in the event that a new crisis arises with which they require the program's assistance. Re-enrollment allows for the reactivation of service coordination and BISF HCBS without providing a new ICD code, in the event that a qualifying code continues to be on file.

F. Continuation of BISF services beyond one consecutive service year. Program participants who have not experienced a resolution of their crisis need(s) within two consecutive six month interims of service may be eligible to continue service coordination or BISF HCBS for additional interim periods for up to another service year as funding allows. The petition for continuation of services requires written justification by the service coordination agency, following the standards established by HCA. In no case will continuation of services be permitted without written approval by HCA to extend services beyond one service year.

G. Disenrollment from the BISF: Disenrollment from the BISF may be voluntary or involuntary.

(1) Voluntary disenrollment: Participants may voluntarily disenroll from the program without cause at any time. In addition, participants are no longer eligible to receive service coordination or BISF HCBS services when any of the following apply:

(a) other responsible payer sources have been identified and have begun coverage;
(b) the crisis or crises that caused the participant to seek enrollment have been resolved; or
(c) upon a permanent move out of the state of New Mexico. The service coordination agency will give such participants reasonable advance notice of pending disenrollment and continue furnishing any needed services until the terms for disenrollment have been met and the disenrollment is complete. Upon disenrollment, all services will be inactivated.

(2) Involuntary disenrollment: Participants of the BISF may be disenrolled involuntarily if any of the following circumstances apply, subsequent to reasonable efforts of the service coordination agency to provide technical assistance to improve the participant's understanding of program expectations and as noted below:

(a) The participant refuses to act in accordance with the requirements of their independent living plan (ILP) or otherwise participate in the resolution of their crisis needs, exercising the capabilities that remain within their power or that of their authorized representative. This describes participants who repeatedly fail to follow through with keeping appointments with the service coordinator or access needed and recommended services;

(b) The participant refuses to act in accordance with the program's participant rights and responsibilities, as explained by the service coordination agency and signed by the participant upon program intake;

(c) The participant's physical, behavioral, psychosocial or service needs exceed that which can be reasonably provided by the program or be met with available funding;

(d) The participant engages in disruptive or threatening behavior. This describes a participant whose behavior jeopardizes their or her health or safety, or the safety of others. In these cases, and with

justifiable cause for the service coordinator's safety, the service coordination agency may elect to disenroll such participant without providing further remedy or technical assistance.

(e) Prior to disenrollment for any of the above, the service coordination agency proposing to disenroll a participant involuntarily is required to:

(i) document the reasons for proposing to disenroll the participant as well as any and all efforts to remedy the situation; and

(ii) submit the written request to involuntarily disenroll the participant to HCA, along with supporting documentation for HCA's review and determination that the service coordination agency has provided acceptable grounds for the participant's disenrollment.

[8.326.10.9 NMAC - Rp, 8.326.10.9 NMAC, 4/1/2021]

8.326.10.10 BISF CONTRACTED ENTITIES AND CONTRACTORS: Brain injury services fund (BISF) services are provided through two contractor components, service coordination and fiscal intermediary agent for BISF HCBS.

A. Service coordination services: Service coordination services serve a problem-solving function. They are intended to resolve a participant's stated crisis need, ensure service continuity, prevent fragmentation of services and endeavor to tap into any and all resources that are appropriate and accessible, including community-based supports, while resolving the crisis that brought the participant into the program. The intent of service coordination is to augment, not replace, the participant's natural supports in a manner that facilitates independent living and self-determination. All participants must have a BISF program service coordinator before they can receive any other BISF program services.

(1) Qualifications for service coordination: Service coordination agencies serving the BISF program must ensure the following pertaining to staff qualifications:

(a) have a current social worker license in good standing with the New Mexico board of social work examiners; or

(b) have a current registered nurse license, in good standing from the New Mexico board of nursing; or

(c) have a bachelor's degree in social work, counseling, nursing, special education or closely related field plus one-year clinical experience related to the brain injury population working in any of the following settings:

(i) home health or community health program;

(ii) hospital;

(iii) private practice;

(iv) publicly funded institution or long-term care program;

(v) mental health program;

(vi) school or school health setting;

(vii) community-based social service program; or

(viii) other programs addressing the needs of individuals with brain injury.

(d) With prior approval from the HCA BISF program manager or designee, exceptions to service coordinator qualifications can be made; contractors requesting qualification exceptions must demonstrate that applicant candidates have relevant education, internships or volunteer experience. Other qualifications may be:

(i) associates degree and a minimum of three years of experience in the mental health or brain injury field; or

(ii) high school graduation or general educational development (GED) test and a minimum of five years of experience in the mental health or brain injury field.

(e) All BISF service coordinators whether subcontracting or employed by a BISF program contracted agency must meet these requirements and attend continuing education as determined by HCA.

(2) Scope of services: Service coordination includes but is not limited to facilitating eligibility determination for individuals applying to the BISF; conducting an in-person assessment; developing an independent living plan (ILP); coordination and documentation of the delivery of services; maintaining a complete permanent case record for each participant which includes documentation as prescribed by HCA; and creating a transition plan for discharge from the BISF program, coordinating with other case managers, as needed.

(a) Service coordinators must identify, and resolve known or suspected issues that may have an impact on the safety and well-being of the participant.

(b) Service coordinators must evaluate and monitor direct service and implementation of the ILP through face-to-face contact with the participant at a frequency prescribed by HCA.

(c) Service coordination agencies are required to maintain a 24-hour emergency response system that allows participants to contact the agency and respond to individual emergency situations within a reasonable amount of time after notification on a 24-hour basis. An emergency response written policy is to be provided to all program participants.

B. Fiscal intermediary agent (FIA): The fiscal intermediary agent (FIA) serves as the intermediary for the arrangement and payment of brain injury specific home and community-based services (HCBS). BISF services are only accessible through the coordination of a BISF program service coordination agency and are limited to filling a participant's needs as outlined in the participant's independent living plan (ILP), when there is an imminent risk to the participant's health and safety.

(1) Qualifications for FIA: FIA service staff must demonstrate the following qualifications:

(a) have a bachelor's degree in business, social work, counseling, nursing, special education or closely related field; and

(b) have experience related to the brain injury population, working in any of the following settings:

(i) home health or community health program;

(ii) hospital;

(iii) private practice;

(iv) publicly funded institution or long-term care program;

(v) mental health program; or

(vi) community-based social service program; or other program addressing the needs of individuals with brain injuries.

(c) With prior approval from the BISF program manager or designee, exceptions to FIA personnel qualifications can be made. Contractors requesting qualification exceptions must demonstrate relevant education internships or volunteer experience. Other qualifications may be:

(i) associate degree and experience in the mental health or brain injury field; or

(ii) high school graduation or general educational development (GED) test and extensive experience in the mental health or traumatic brain injury field.

(d) All BISF FIA staff employed by the agent, must meet these requirements and attend continuing education as determined by HCA. Contracted FIA service providers must have the required education and be duly licensed by the state of New Mexico within their respective disciplines.

(2) Scope of services: Fiscal intermediary agent services include but are not limited to the following activities: maintain a network of providers of brain injury related services and goods and ensure that subcontracted providers are duly licensed by the state of New Mexico or otherwise certified within their respective disciplines; procure goods and arrange contracts and letters of agreement with vendors and contractors who provide the goods, services and supports; receive service and goods referral requests submitted by BISF service coordinators for prior authorization; and arrange for delivery of BISF goods and services.

(a) Prior to arranging for and funding requested services or goods, the FIA must verify that other responsible payer source coverage is not available to pay for services or goods and that the participant has exhausted any other financial resources.

(b) The FIA must monitor and document service expenditures for participants receiving BISF HCBS and ensure that coverage does not exceed the allowable limits set by HCA;

(c) The FIA must assure that subcontracted providers and vendors are providing the services and goods as contracted and ensure timely reimbursement to such providers and vendors.

C. General administrative requirements: Agencies contracted to provide BISF service coordination or fiscal intermediary services are required to:

(1) have and follow confidentiality standards;

(2) maintain a current business license issued by the state, county or city government if required;

(3) comply with all applicable federal or state regulations, policies and procedures that apply to their business and to their contract with HCA;

(4) demonstrate financial solvency;

(5) maintain full professional liability insurance coverage;

(6) establish and maintain written policies and procedures related to:

(a) service provision and appropriate supervision;
(b) professional documentation standards;
(c) training and education on brain injury; and
(d) grievances and appeals as outlined in 8.326.10.15 NMAC in a manner that is accommodating to those living with brain injury and agreeable to the HCA BISF program; and
(7) have a governing board with at least one external member with a brain injury, a family member with a brain injury or professional working with brain injury;
(8) maintain an in-house directory of brain injury resources for each region served.
[8.326.10.10 NMAC - Rp, 8.326.10.10 NMAC, 4/1/2021]

8.326.10.11 CONFLICT OF INTEREST: Contracted entities and providers, who provide direct BISF services, must avoid conflict of interest or duplication of services and may not:
A. provide direct intervention services, such as individual therapy, group therapy, support groups, homemaker services, personal attendant services, life skills coaching services, psychosocial rehabilitation services, or duplicate BISF HCBS or fiscal intermediary services for enrolled BISF participants, when they are also contracted to provide service coordination services;
B. accept gifts from existing or potential vendors in exchange for a contract relationship or other favorable treatment;
C. charge BISF program participants for their services; and
D. in no instance shall a service coordination agency or fiscal intermediary agent, contracted by HCA for BISF program services, direct the provider, vendor or contractor that shall provide a participant's services or goods.
[8.326.10.11 NMAC - Rp, 8.326.10.11 NMAC, 4/1/2021]

8.326.10.12 INDEPENDENT LIVING PLAN: An independent living plan (ILP) is required for each interim service period that includes all the services, goods, and supports recommended to the participant including referrals to BISF HCBS and any other potential resources available in the local community that are needed to resolve the identified crisis. BISF HCBS cannot be initiated until the service coordinator has included the services in the ILP and completed the appropriate referrals. The ILP is to be written and developed by the service coordinator with the participation of the participant and shall include:
A. person-centered goals and action steps needed to complete goals;
B. education and support necessary to reach goals and objectives;
C. number of hours per month the participant will receive BISF service coordination and other identified BISF services;
D. expected measurable outcomes;
E. time frames for reaching goals and meeting objectives;
F. plans for discharge or transference to another program or payer source;
G. identification of all persons, services or products necessary to reach the participant's goals and accomplish their objectives; and
H. estimation of cost of services or goods provided by HCBS.
[8.326.10.12 NMAC - Rp, 8.326.10.12 NMAC, 4/1/2021]

8.326.10.13 BRAIN INJURY SERVICES FUND HOME AND COMMUNITY-BASED SERVICES: BISF home and community-based services (HCBS) and goods are for outpatient care administered within the state of New Mexico and must address the participant's assessed needs and include the expectation of individual and family participation. BISF HCBS are designed to resolve a participant's identified crisis, enhance the individual's self-determination and promote independence. BISF HCBS funding can only be used for services and goods that are documented in the participant's ILP and or substantiated by physician's orders or other required documentation, as appropriate. As the payer of last resort, BISF funding may be used for the purchase of authorized services or goods that are not covered by medicaid, medicare, the special education-individuals with disability education act (IDEA) program, department of vocational rehabilitation (DVR), private insurance or other responsible payer sources. The delivery of all BISF HCBS will be in accordance with the standards set by HCA.
A. BISF HCBS eligibility requirements: BISF HCBS can only be provided to program participants who have a current BISF service coordinator and have met BISF program requirements. Eligibility for BISF HCBS is based upon the service coordinator's assessment of participant needs, verification that no responsible payer source exists, and receipt of supporting medical documentation, as appropriate to justify the need for a requested service or

good. Referrals for qualifying participants are submitted to the FIA, who arranges and pays for authorized goods and services in 90-day increments.

B. Funding limits per participant: There is a maximum yearly and lifetime coverage for eligible participants as determined by their assessed needs. Funding is also limited by legislative or HCA appropriation. Coverage limitations for qualifying participants are as follows:

(1) No more than the annual budgetary cap per participant as prescribed by HCA, unless through approved written exception by HCA; this value represents a maximum amount that may be budgeted and is not a guaranteed annual budget assignment.

(2) $75,000 lifetime maximum for combined services and goods;

(3) $10,000 lifetime limit on environmental modifications; and

(4) only one emergency housing assistance per participant in a lifetime, unless an exception is made in writing by the BISF program manager at the HCA.

C. Duration of services: BISF HCBS funding and approved services are provided in six month increments with the following provisions:

(1) BISF HCBS are provided as funding limits allow only until other responsible payer sources are available, or the crisis has been otherwise resolved.

(2) BISF HCBS can only be continued for one additional interim, up to one year with documentation that the needs being addressed still exist and cannot be provided by another responsible payer. Continuation of BISF HCBS for requested services is contingent upon completion of a six-month written recertification conducted by the participant's service coordinator in accordance with program standards. As applicable, this will include orders from a physician or licensed medical provider stating support for ongoing services.

(3) BISF HCBS may be extended or continue past the six-month duration, until a necessary product can be obtained or in the case of environmental modification and retrofit automobile services, the modification to the participant's environment or automobile can be completed. Any cause for delay must be recorded by the service provider in the participant's record and provided to the service coordination agency. The record must be updated, until completion of the project or modification has been completed or the goods ordered are delivered.

(4) Exceptions to the six-month interim timeline beyond two consecutive interims, may be requested by the service coordination agency in writing through HCA's process for extending services and referrals on the basis of one or more unresolved crises, ongoing participant needs and available funding.

(5) After a participant's BISF HCBS have been inactivated, services may be reestablished through the BISF service coordinator due to an exacerbated condition or situation that has caused a critical need that cannot be covered by other responsible payer sources.

(6) Participants who are receiving BISF HCBS may be eligible to access additional BISF HCBS funding, beyond the prescribed limits, if the person has experienced a sudden, drastic and accelerated change in needs impacting health and safety, such as an exacerbated medical or psychological condition. Participants accessing BISF HCBS on an escalated basis will require medical documentation to establish a higher order of need. Escalated services may or may not be provided as funding allows on a short-term basis, per program requirements.

D. Freedom of choice: Each participant receiving BISF HCBS shall be informed of all available service providers, vendors or contractors that are eligible to provide the needed services or goods in their region. The participant shall be the sole decision maker of who is to provide services or goods from all eligible entities that could fill his or her needs. The BISF program cannot guarantee that all services will be available in all regions or that a preferred provider will agree to work with the program.

E. Service descriptions: Services that require physician's orders include but are not limited to home health aide, nursing services, neuropsychological evaluations, novel or unconventional therapies, durable medical equipment over $250, and other non-standard services and goods. Requested services and goods cannot be accessed until authorized in writing by the FIA, who arranges and pays for approved BISF HCBS and goods. BISF HCBS funding may be used to pay for services and goods that meet the noted criteria in the following categories, with special requirements, as noted:

(1) Assistive technology assessment services: Assistive technology assessment services are the systematic application of technologies to assist persons diagnosed with brain injury to improve communication skills and the ability to perform activities of daily living. An assistive technology assessment is required to justify the purchase of assistive technology or adaptive equipment that is needed to address symptoms of the participant's brain injury. Services shall be provided by an individual or agency with a minimum of a master's degree in assistive technologies; an individual or agency certified by the rehabilitation engineering and assistive technologies society of

North America (RESNA); an individual or agency demonstrating a working knowledge of assistive technologies; or a licensed physician or rehabilitation provider agency. Services shall include assessment, recommendations and training by a qualified healthcare professional.

(2) Durable medical equipment and assistive technology: Durable medical equipment (DME) refers to any equipment that is used to serve a medical purpose or provides therapeutic benefits to a patient in need because of certain medical conditions, related to a participant's brain injury. Assistive or adaptive technology refers to any "product, device, or equipment, whether acquired commercially, modified or customized, that is used to maintain, increase, or improve the functional capabilities" of a person living with brain injury. DME or adaptive equipment is intended to fill the assessed medical, therapeutic or functional needs of participant and a prescription and a written assessment provided by a physician or licensed therapist must be submitted to justify the equipment requested if the cost of the DME is more than $250.

(3) Environmental modifications: Environmental modifications refer to alterations required to make the participant's home more accessible because of their brain injury and related physical limitations. Environmental modifications include but are not limited to, widening doorways, installing ramps and modifying bathrooms. Funds cannot be used to cover home improvements; expenses related to home maintenance or other repairs that would otherwise be incurred as a responsible homeowner or tenant; or be applied toward the purchase of a home. The following criteria for environmental modifications must be adhered to:

(a) An assessment for the proposed environmental modification must be done by a licensed physical or occupational therapist to justify the service.

(b) For any modification over $250, contractor bids must be obtained by the service coordinator which must include blueprint, written description of plan and price itemization for materials and labor, along with any other supporting documentation.

(c) Only contractors with a current license in good standing can be engaged to do environmental modifications.

(d) Funds for environmental modifications are limited to a $10,000 lifetime maximum.

(e) The participant shall provide proof of property ownership, and, if residing in or renting property owned by another party, provide written permission from the landlord prior to pursuing any BISF funded environmental modification;

(f) The FIA in collaboration with the participant's service coordinator shall show evidence that BISF funding was the most appropriate payer source to fund the requested environmental modification;

(g) For instances when costs related to a needed environmental modification cannot be covered in total by another funding source, documentation of collaboration with other funding sources must be submitted to the FIA and include:

(i) a detailed description and plan for the project including total cost;

(ii) the specific portion to be funded by the BISF program as the payer of last resort; and

(iii) the contractor's written acknowledgment of the specific portion and amount of the project for which the BISF program is responsible.

(h) All requests, plans and related documentation for environmental modifications shall be submitted by the BISF service coordinator for review and written approval by HCA, prior to submitting a referral.

(4) Home health aide, homemaker or companion: A home health aide, homemaker or companion from a licensed agency may be contracted to assist participants in gaining functional independence with activities of daily living, performance of general household tasks, and enable the eligible participant to accomplish tasks they would normally do for themselves if they did not have a brain injury. Providers of these services must meet the quality personnel standards as stipulated by the agency and state licensing. The required license of contractors providing these services must be in good standing and current. Provision of authorized services must adhere to the following requirements:

(a) Participants must require regular assistance with activities and or instrumental activities of daily living, as prescribed by the HCA BISF program.

(b) Family members, who reside in the same household, cannot serve as paid caregivers, unless:

(i) the participant and family member reside in a remote area, where no professional caregiver or respite services are available, and the needs of the participant prevent the in-home caregiver from engaging in employment outside the home; or

(ii) the intensiveness of the participant's behavioral or mental health needs prevent outside caregivers from entering the home and administering effective care. These needs shall be justified in writing through a signed letter from the participant's licensed medical or mental health care providers and submitted to HCA or designated representative for review and approval. Such justification shall be updated annually, for as long as the participant remains eligible for BISF services.

(c) In-home family caregivers who meet the criteria noted in Subparagraphs (a) and (b) of Paragraph (4) of Subsection E of 8.326.10.13 NMAC must be trained and employed by a licensed agency that meets the quality personnel standards, as stipulated by the agency and state licensing, and timesheets shall be submitted, as requested.

(5) Initial and emergency housing costs: Assistance to pay initial or emergency rent, security deposit and utility start-of-service or one-month maintenance of service charges may be provided as once in a lifetime occurrence. Documentation submitted by BISF service coordinators with any housing referral to the FIA shall adhere to the guidelines below and be maintained in the participant's BISF record:

(a) a completed housing plan worksheet and budget, which includes documentation that the participant has sufficient resources to sustain ongoing housing expenses for the chosen housing; documentation that no other payer source was available to cover the housing expenses; the rental price range that would be sustainable for the participant; and detail regarding the manner in which initial housing or utility costs will be paid.

(b) a copy of a lease or rental agreement letter that contains the name of the leaser, the address of the property and a contact name and phone number for verification of rental intent.

(c) start up and or emergency utility costs shall be submitted to the FIA to be paid within 90 days of the signed rental agreement.

(6) Nursing care: Brain injury related private duty nursing services covered by BISF HCBS must be in compliance with the New Mexico Nurse Practice Act and provided in the participant's home under the orders of the participant's physician. These services may be provided by a licensed registered nurse (RN) or a licensed practical nurse (LPN).

(7) Nutritional consultation: Coverage includes consultation and follow-up with a registered dietician or nutritionist, who is licensed with the New Mexico board of nutrition and dietetics; qualified providers may include specialists such as MDs, DOs, Ph.D.s, RDs, LDs, or DCs.

(8) Physician or medical provider services for outpatient health insurance: Coverage of copayments for physician services or the treatment of a participant's brain injury or conditions directly related to the brain injury requires treatment verification by the office of the licensed medical professional or therapist. Payments of insurance premiums and or deductibles are not covered by the BISF program.

(9) Prescribed medications: Copayment assistance may be used to cover prescription medications that are medically necessary to treat symptoms arising from a participant's brain injury or directly related conditions. Reimbursement for this service requires adherence to the following guidelines:

(a) prescription medications eligible for reimbursement must be listed in the approved BISF program formulary. Exceptions to the BISF program formulary must be approved in writing from the HCA BISF program manager or designee;

(b) participants may not be reimbursed for prescription medications in cases where the receipt evidencing purchase is submitted more than 90 days past the date the prescription was filled;

(c) the participant must submit the pharmacy print out, which identifies the participant's name, the date, doctor's name, name of the medication and the price paid; and

(d) if feasible, and the FIA is able to set up an agreement with certain pharmacies, participants may have scripts filled with the billing sent directly to the FIA for payment; the service coordinator is responsible for checking receipts submitted by participants to avoid duplicate payments on those submitted through the pharmacy.

(10) Professional life skills coaching and organizer services: This interim service may be accessed to assist a participant in learning or re-learning life skills that are required in order to function independently in their home environment, in their job or in their community. These services are provided by individuals with appropriate certification and require the provider to address the cognitive, behavioral or social impairments that are preventing the return to independent functioning. The service may include assistance with home organization or management, time management, records management, and organization and management of

finances, as well as coaching in appropriate social interactions; effective communication skills; anger management; self-care/health management; pursuit of education or employment; childcare and parenting skills; accessing and navigating community resources; mindfulness training and any other cognitive, social, or behavioral skills identified in the participant's ILP. The services of the life skills coach are not to be used as a substitute for the participant's task performance. The services are customized for each participant and are usually provided in the person's home, place of work or wherever an activity would normally occur. Services are to be provided at a frequency that will best facilitate the transfer of needed skills, following an evaluation conducted by the coach. Life skills may also be provided to family members to help them adjust to their changed roles and circumstances following the brain injury of their family member. Service limitations apply as prescribed by HCA.

(11) Respite care: A participant's primary caregiver may be provided temporary respite, if the caregiver lives in the same household as the participant. Respite may be provided for a period up to 72 hours per week and may or may not include overnight hours. BISF HCBS funds cannot be used to pay for respite care provided by home health aides or salaried employees.

(12) Retrofit automobile: This service is used to modify an automobile specifically for the use of a participant with brain injury. The service is limited to installation of a van lift; hand or pedal controls; and modified seating. Funds cannot be used for the purchase of an automobile or be applied toward the cost of auto repairs or maintenance that would be otherwise incurred by the responsible vehicle owner or lessee. Any request for retrofit of an automobile will begin with a referral by the service coordinator identifying a certified driver rehabilitation specialist (CDRS), who will assess the abilities of the participant with brain injury, complete an evaluation, make recommendations for the vendor who will perform the installation, and provide any training on the use of specialized equipment or controls, once the installation is completed. The CDRS may or may not be affiliated with the vendor who completes the installation; a separate referral may be needed for the vendor completing the installation.

(13) Transportation (public or private): Requests to cover private or public in-state transportation for participants with brain injury must adhere to the following guidelines:

(a) Funds may be authorized for mileage reimbursements for the use of the participant's private vehicle for the purpose of getting to medical and therapy care for treatment of conditions directly related to the brain injury. Approved mileage reimbursements will:

(i) require prior approval by the BISF service coordinator for identified destinations and be authorized for payment by the BISF FIA;

(ii) cover costs of actual mileage at no more than the current state approved rates;

(iii) not be authorized to pay for gas, mileage or wear and tear on any other vehicle not privately owned by the participant with brain injury;

(iv) not cover overnight costs for participant or caregiver lodging or per diem; and

(v) not be covered for requests submitted more than 90 days past the date the transportation was provided, or the trip was taken.

(b) Funds may be used to purchase public transportation in the form of bus, van or rail passes for participants and their caregivers.

(14) Therapies and alternative therapies: All therapists providing traditional and alternative therapy services must hold a current license and be in good standing from their respective licensing authority. Service limitations on alternative therapies, such as massage, acupuncture and chiropractic care may apply, as specified by the HCA. BISF HCBS funds may be used to cover copayments for medically necessary therapies, as listed below:

(a) outpatient mental or behavioral health;
(b) physical therapy;
(c) occupational therapy;
(d) speech and language therapy;
(e) massage therapy;
(f) acupuncture; and
(g) chiropractic care.

(15) Other use of BISF HCBS funds: BISF HCBS funds may be used to provide other limited services in the absence of another payer source. Those services provided by a licensed practitioner may require an order or a letter of recommendation from a licensed physician or therapist. Requests for these services

must be submitted by the service coordinator in writing for written authorization by the HCA BISF program manager or designee and include:

(a) Special training and education to the participant and family in the use of tools and methods needed to promote recovery and independence of the participant.

(b) Neuropsychological evaluations to determine a course of treatment for a participant who has already met the BISF program's eligibility criteria. The participant must present a physician's order or letter of recommendation for prior authorization, before accessing the service.

(c) Special health and dietary items that are needed because of conditions directly related to the brain injury.

(d) Health and housing advocate through independent contractors or peer mentors for attendance and advocacy at medical or therapy appointments or providing assistance in locating safe and affordable housing.

F. Providers or vendors of BISF HCBS sub-contracted by the FIA may not charge program participants for services already arranged and authorized through the BISF, unless the program has authorized direct reimbursement to the participant.

G. Only the HCA BISF program manager or designee can make exceptions or waivers of requirements regarding the provision of BISF HCBS with the following stipulations:

(1) requests for waivers to the provisions and services provided by the BISF program must be made by the service coordination agency in writing;

(2) requests must have accompanying documentation justifying the exception; and

(3) written approval from HCA must be placed in the participant's record by both the FIA and the service coordination agency.

[8.326.10.13 NMAC - Rp, 8.326.10.13 NMAC, 4/1/2021]

8.326.10.14 NON-COVERED SERVICES AND GOODS: Costs not covered by BISF HCBS include:

A. Dental exams, visits, procedures or equipment;

B. Optical exams, visits, glasses, lenses or other equipment;

C. Hearing exams, visits or aids or other equipment;

D. Experimental therapies;

E. Computers and internet;

F. Cell phones or cell phone carrier service;

G. Organizational supplies;

H. Service animals, certification or training of service animals, veterinary, grooming, boarding or maintenance costs;

I. Health insurance deductibles or premiums; and

J. Institutional care, nursing facility or hospital care costs.

[8.326.10.14 NMAC - Rp, 8.326.10.14 NMAC, 4/1/2021]

8.326.10.15 SERVICE AUTHORIZATION AND REIMBURSEMENT: Funding for BISF service coordination, BISF HCBS and fiscal intermediary agent services is based upon trust fund revenues and legislative or HCA appropriation. Billings and receipts for all approved goods, services and supports, shall be submitted for payment or reimbursement within 90 days of the service date, by the participant, service coordinator or vendor, following all HCA BISF program instructions. Reimbursement for goods, services and supports are made at a predetermined reimbursement rate. The HCA reserves the right to approve or disapprove any and all vendors or subcontractors used by the BISF HCBS fiscal intermediary agent.

[8.326.10.15 NMAC - Rp, 8.326.10.15 NMAC, 4/1/2021]

8.326.10.16 GRIEVANCE AND APPEALS PROCESSES FOR THE BRAIN INJURY SERVICES FUND PROGRAM: The BISF program allows for a grievance or complaint process that affords program participants the opportunity to register grievances or complaints concerning the provision of services that are administered through the BISF program.

A. Grievances:

(1) Program participants may register complaints with the service coordination and FIA contractors.

(2) Individual BISF contractors will have written grievance procedures approved by HCA, which provide the participant or their representative with a process for expressing dissatisfaction with the program services.

(3) The contractor's written grievance procedure is to be available upon request by program participants, HCA or its assigns.

B. Appeals:

(1) If the participant or their representative do not agree with the outcome of a formal grievance filed and reviewed at the BISF contracted agency, they may appeal, in writing, to the HCA BISF program manager.

(2) The HCA BISF program manager or designee will review the written appeal along with any supporting documentation as applicable and will respond in writing to the participant filing the appeal within 30 days with notification of the outcome to the provider agencies involved.

[8.326.10.16 NMAC - Rp, 8.326.10.15 NMAC, 4/1/2021]

HISTORY OF 8.326.10 NMAC: [**RESERVED**]

History of Repealed Material:

8.326.10 NMAC - Traumatic Brain Injury Trust Fund Program (filed 10/25/2007) repealed effective 4/1/2021.

Other History:

8.326.10 NMAC - Traumatic Brain Injury Trust Fund Program (filed 10/25/2007) was replaced by 8.326.10 NMAC - Brain Injury Services Fund Program, effective 4/1/2021.

TITLE 8 SOCIAL SERVICES
CHAPTER 350 RECONSIDERATION OF UTILIZATION REVIEW
PART 2 RECONSIDERATION OF UTILIZATION REVIEW DECISIONS

8.350.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.350.2.1 NMAC - Rp, 8.350.2.1 NMAC, 8/1/2014; A, 7/1/2024]

8.350.2.2 SCOPE: The rule applies to the general public.
[8.350.2.2 NMAC - Rp, 8.350.2.2 NMAC, 8/1/2014]

8.350.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.350.2.3 NMAC - Rp, 8.350.2.3 NMAC, 8/1/2014; A, 7/1/2024]

8.350.2.4 DURATION: Permanent.
[8.350.2.4 NMAC - Rp, 8.350.2.4 NMAC, 8/1/2014]

8.350.2.5 EFFECTIVE DATE: August 1, 2014, unless a later date is cited at the end of a section.
[8.350.2.5 NMAC - Rp, 8.350.2.5 NMAC, 8/1/2014]

8.350.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medicaid programs.
[8.350.2.6 NMAC - Rp, 8.350.2.6 NMAC, 8/1/2014]

8.350.2.7 DEFINITIONS: [RESERVED]

8.350.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.350.2.8 NMAC - Rp, 8.350.2.8 NMAC, 8/1/2014]

8.350.2.9 UTILIZATION REVIEW DECISIONS:

A. Utilization review (UR) decisions are those decisions the medical assistance division (MAD), its utilization review (UR) contractor or a MAD designee makes regarding the medical necessity of services or items that require authorization for medical necessity or a level of care (LOC) determination prior to reimbursement by MAD and its fee-for-service program. For applicable rules for services and items provided through a MAD managed care organization (MCO), refer to 8.308.15 NMAC. For applicable rules for services and items provided through coordinated service contractors, refer to 8.349.2 NMAC.

B. For services for which payment has already been made for which MAD is recouping payment due to a post payment review of medical necessity or LOC, the applicable rule is 8.532.3 NMAC.

C. Decisions are based on information submitted by the provider in a format specified by MAD, its UR contractor, or a MAD designee, and applicable New Mexico Administrative Code (NMAC) MAD rules.

D. Prior to making a decision, MAD, its UR contractor or a MAD designee may issue a request for information (RFI) to the provider requesting clarification or additional information in order to have sufficient information to render an appropriate decision. The provider must submit the clarification or additional information within 21 calendar days of issuance of the request or a technical denial may be issued.

E. MAD, its UR contractor or a MAD designee may deny or reduce the authorized services or items in frequency, intensity, duration, quantity, scope or level of care after considering the submitted documentation or NMAC MAD rules. An eligible provider or eligible recipient who is dissatisfied with the decision may proceed as detailed in Section 10 of this rule.
[8.350.2.9 NMAC - Rp, 8.350.2.9 NMAC, 8/1/2014]

8.350.2.10 RECONSIDERATION OF UTILIZATION REVIEW DECISIONS: A provider who is dissatisfied with a medical necessity or LOC decision by MAD, its UR contractor or a MAD designee, can request reconsideration. An eligible recipient who is dissatisfied with a medical necessity or LOC decision by MAD, its UR contractor or a MAD designee, can request the provider to pursue reconsideration on their behalf.

A. Time constraints and submission requirements: Requests for reconsideration must be in writing and received by MAD, its UR contractor or a MAD designee within 30 calendar days after the date on the initial notice of action.

B. Requirement for filing an extension: MAD, its UR contractor or a MAD designee will accept a request for reconsideration filed up to 14 calendar days past the 30 calendar day limit if MAD finds that there was good cause for the provider's or the eligible recipient's failure to file a timely request. The provider or the eligible recipient must furnish written documentation of good cause. Good cause includes a death in the family, a disabling personal illness or another significant emergency or other exceptional circumstance.

C. Information required in the request for reconsideration: The request for reconsideration must include the following:

(1) reference to the challenged decision or action;

(2) basis for the challenge;

(3) copies of any document(s) pertinent to the challenged decision or action;

(4) copies of claim form(s) if the challenge involves a claim for payment which is denied due to an UR decision; and

(5) a statement that a reconsideration of the decision is requested.

D. Individuals conducting reconsideration review: Individuals employed by MAD, its UR contractor or a MAD designee who were not participants in the initial UR decision conduct the reconsideration review.

E. Information used in reconsideration process: MAD, its UR contractor or a MAD designee reviews the information and findings upon which the initial action was based and any additional information submitted to, or otherwise obtained by MAD, its UR contractor or a MAD designee. The information can include the following:

(1) case records and other applicable documents submitted to MAD, its UR contractor or a MAD designee by the provider when the request for services was initially submitted;

(2) findings of the reviewer resulting in the initial decision;

(3) complete record of the service(s) provided, including hospital or medical records; and

(4) additional documents submitted by the provider to support a reconsideration review.

F. Decision deadline: MAD, its UR contractor or a MAD designee performs the reconsideration and furnishes the reconsideration decision within 10 business days of receipt of the reconsideration request.

G. Notification of reconsideration decision: MAD, its UR contractor or a MAD designee gives the provider and the eligible recipient written notice of the reconsideration determination. If the decision is adverse to the eligible recipient, the notice also includes information on the eligible recipient's right to a HCA administrative hearing and timeframes to file for a hearing and request for a continuation of their current benefit.

[8.350.2.10 NMAC - Rp, 8.350.2.10 NMAC, 8/1/2014]

8.350.2.11 CLAIMANT HEARINGS: MAD has established a process to determine if an individual is eligible to request a HCA administrative hearing. MAD has also established a process for an individual or the individual's authorized representative to request an HCA administrative hearing when an UR reconsideration decision results in an adverse action that is intended or has been taken by MAD, its UR contractor or a MAD designee. See 8.352.2 NMAC for the definition of an authorized representative. MAD must grant an individual or their authorized representative the opportunity for a HCA administrative hearing under specific circumstances pursuant to 42 CFR Section 431.220(a) and Section 27-3-3 NMSA 1978. A request for a HCA administrative hearing must be received within 30 days of the date of its UR reconsideration decision. A HCA administrative hearing occurs telephonically between the parties to the hearing and the assigned ALJ. See 8.352.2 NMAC for detailed description of a HCA administrative claimant hearing process. At the time the eligible recipient or their authorized representative requests a HCA administrative hearing, the eligible recipient is referred to as the claimant.

A. Record preservation: To preserve a record for review, MAD, its UR contractor or a MAD designee documents and retains a record of the reconsideration determination.

B. Documentation requirements: The record preserved by MAD, its UR contractor or a MAD designee includes all documentation of the initial UR decision, copies of any documents relevant to the initial

decision, any additional evidence presented during the reconsideration, and a copy of the reconsideration determination.
[8.350.2.11 NMAC - Rp, 8.350.2.11 NMAC, 8/1/2014]

HISTORY OF 8.350.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 306.1000, Reconsideration Procedures for Ambulatory Care, filed 1/7/1980.
ISD 306.1000, Reconsideration Procedures for Ambulatory Care, filed 7/8/1982.
ISD 306.2000, Reconsideration Procedures for Delegated Hospitals, filed 1/7/1980.
ISD 306.3000, Reconsideration Procedures for Non-Delegated and Non-Designated Hospitals, filed 1/7/1980.

History of Repealed Material:
8.350.2 NMAC, Reconsideration of Utilization Review Decisions - Repealed 8/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 350 RECONSIDERATION OF UTILIZATION REVIEW
PART 3 ABSTRACT SUBMISSION FOR LEVEL OF CARE DETERMINATIONS

8.350.3.1 ISSUING AGENCY: New Mexico Health Care Authority.
[2/1/1995; 8.350.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/2012; A, 7/1/2024]

8.350.3.2 SCOPE: The rule applies to the general public.
[2/1/1995; 8.350.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/2012]

8.350.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[2/1/1995; 8.350.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/2012; A, 7/1/2024]

8.350.3.4 DURATION: Permanent
[2/1/1995; 8.350.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/2012]

8.350.3.5 EFFECTIVE DATE: November 1, 1996
[11/1/1996; 8.350.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/2012]

8.350.3.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/1995; 8.350.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/2012]

8.350.3.7 DEFINITIONS: [**RESERVED**]

8.350.3.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/1995; 8.350.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/2012]

8.350.3.9 ABSTRACT SUBMISSION FOR LEVEL OF CARE DETERMINATIONS: The medical assistance division (MAD) utilization review (UR) contractor performs prior approval and abstract review on admissions, readmissions, and continued stay requests for all long-term care nursing facilities (NF) and intermediate care facilities for the mentally retarded (ICF-MR). Within 10 working days after a recipient's admission to a nursing facility or intermediate care facility for the mentally retarded (ICF-MR), the facility must submit a long-term care abstract to the UR contractor for review. The initial admission abstract describes the recipient's functional level and level of care needs and includes the physician's history and physical examination and preadmission screening and annual resident review (PASARR). Readmissions and continued-stay request abstracts must be submitted to the UR contractor 10 working days before the expiration of the currently certified length of stay.
[11/1/1996; 8.350.3.9 NMAC - Rn, 8 NMAC 4.MAD.954, 3/1/2012]

8.350.3.10 REQUESTS FOR RETROACTIVE PRIOR APPROVAL REVIEW: MAD permits facilities to request retroactive prior approval review of long-term care abstracts which are not submitted for level-of-care reviews within the applicable time period if certain conditions are met.

A. Initial abstracts: Facilities must submit a request for retroactive prior approval review when delays in the submission of an initial abstract beyond the 10 working day period are caused by circumstances beyond the facility's control, including:

(1) physician does not sign orders or history and physical within the time period; or
(2) medicaid eligibility decisions have not been completed.

B. Initial continued-stay abstract: Facilities must submit a request for retroactive prior approval review when continued-stay abstracts are not submitted at least 10 working days before the expiration of the currently certified length of stay. The delay in submission must be attributed to circumstances beyond the facility's control.

C. Subsequent continued-stay abstract: Facilities must submit a request for retroactive prior approval review when subsequent continued-stay abstracts are not submitted at least 10 working days prior to the expiration of the currently certified length of stay. The delay in submission must be caused by circumstances beyond the facility's control.

D. Delays caused by circumstances within the facility's control: Medicaid allows its UR contractor to accept 10 total late abstracts per facility per calendar year when delays in submission are caused by circumstances within the control of the facility, such as staff illness or staff turnover. Initial admission abstracts and initial and subsequent continued stay abstracts are included in this number.

E. Denial of request for retroactive prior approval reviews: Medicaid does not reimburse facilities for dates of service not covered by an approved abstract. Facilities cannot bill medicaid recipients for those days.

[11/1/1996; 8.350.3.10 NMAC - Rn, 8 NMAC 4.MAD.954.1, 3/1/2012]

8.350.3.11 SUBMITTING ABSTRACTS FOR RETROACTIVE PRIOR APPROVAL REVIEW:

A. To request retroactive prior approval review, a facility must submit the abstract, a request for retroactive prior approval review form and supporting documentation to the UR contractor. Facilities must provide at least the following supporting documentation:

(1) pertinent information, such as physician orders, history and physical, physician progress notes or hospital discharge summaries; all documentation must be date-stamped by the facility verifying date of receipt from the physician or hospital.

(2) dated facility entries and records that document telephone calls to physicians reminding them of the need to complete the abstract, physician orders, history and physical or progress notes;

(3) date-stamped copy of the notification of medicaid eligibility; and

(4) documentation of other reasons for delay.

B. Any request for retroactive prior approval review received without the required supporting documentation is returned to the facility.

[11/1/1996; 8.350.3.11 NMAC - Rn, 8 NMAC 4.MAD.954.2, 3/1/2012]

8.350.3.12 REVIEW OF RETROACTIVE PRIOR APPROVAL REVIEW DENIALS: Providers who disagree with abstract review decisions or denials of retroactive prior approval review can request a re-review and reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions* for specific information on the review process.

[11/1/1996; 8.350.3.12 NMAC - Rn, 8 NMAC 4.MAD.954.3, 3/1/2012]

8.350.3.13 PAYMENT FOLLOWING APPROVAL OF RETROACTIVE PRIOR APPROVAL REVIEW ABSTRACTS: Medicaid reimburses facilities in the following manner after approval of a retroactive prior approval review:

A. for late initial abstracts caused by delayed physician signature, reimbursement is effective back to the date of admission;

B. for late initial abstracts caused by delayed medicaid eligibility decisions, reimbursement is effective back to the date the recipient became medicaid-eligible;

C. for late continued-stay abstracts caused by delays in obtaining physician signature or retroactive medicaid eligibility, reimbursement is effective from the beginning of the certification period for continued stay;

D. for the first 10 late abstracts per facility per calendar when delay is attributed to circumstances within the facility's control, reimbursement is effective back to the date of admission or the beginning of the certification period for continued stay applicable to the situation; and

E. for late abstracts beyond the 10 allowed by medicaid attributed to circumstances within the facility's control, the earliest possible effective date is the date the late abstract was received by the UR contractor.

[11/1/1996; 8.350.3.13 NMAC - Rn, 8 NMAC 4.MAD.954.4, 3/1/2012]

HISTORY OF 8.350.3 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 350 RECONSIDERATION OF UTILIZATION REVIEW
PART 4 RECONSIDERATION OF AUDIT SETTLEMENTS

8.350.4.1 ISSUING AGENCY: New Mexico Health Care Authority.
[1/1/1995; 8.350.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 1/1/2003; A, 7/1/2024]

8.350.4.2 SCOPE: The rule applies to the general public.
[1/1/1995; 8.350.4.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 1/1/2003]

8.350.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[1/1/1995; 8.350.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 1/1/2003; A, 7/1/2024]

8.350.4.4 DURATION: Permanent.
[1/1/1995; 8.350.4.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 1/1/2003]

8.350.4.5 EFFECTIVE DATE: November 1, 1996.
[1/1/1995, 2/1/1995; 8.350.4.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 1/1/2003]

8.350.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[1/1/1995, 2/1/1995; 8.350.4.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 1/1/2003]

8.350.4.7 DEFINITIONS: [**RESERVED**]

8.350.4.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/1995; 8.350.4.9 NMAC - Rn, 8 NMAC 4.MAD.002, 1/1/2003]

8.350.4.9 RECONSIDERATION OF AUDIT SETTLEMENTS:

A. General reconsideration process: Medicaid providers who disagree with an audit settlement can submit a written request for a reconsideration to the New Mexico medical assistance division (MAD) within 30 calendar days of the date on the notice of final settlement. The written request may be submitted by facsimile or by U.S. mail but not by electronic mail. The written request must be received by MAD no later than the 30th day from the date of the notice. Filing of a request for reconsideration does not affect the imposition of the final settlement.

(1) Information included in the request: The written request for reconsideration must identify each point on which the provider takes an issue with the audit agent and include all documentation, citations of authority, and arguments on which the request is based. Any point or issue not raised in the original request for reconsideration may not be raised later and will not be considered in the final decision of the reconsideration.

(2) Audit agent response: The written request and supporting materials is forwarded to the audit agent for reconsideration. The audit agent must file a response with MAD within 30 calendar days of the receipt of the request and supporting material from MAD.

(3) Submission of additional material: MAD forwards the audit agent's response to the provider. Additional material from the audit agent or the provider must be received by MAD within 15 calendar days of the date the response was forwarded to the provider. Any additional information, the request for reconsideration and supporting documentation, and the audit agent's response constitute final submittal. The packet containing the final submittal is provided to the MAD deputy director for final submittal by the responsible bureau for program reimbursement.

(4) Decision by MAD: The deputy director may call on all information and call on all expertise they believe is necessary to decide the issue. The deputy director makes a determination and submits a written copy of their findings to each party within 45 calendar days of the date of final submittal to the MAD director. The decision may be sent to the parties by facsimile or U.S. mail. The provider may appeal an adverse decision on the request for reconsideration to the New Mexico health care authority hearings bureau pursuant to the 8.353.10 NMAC. The MAD director or designee shall make the decision on the recommendation from the hearing officer.

B. Specific reconsideration process for nursing facility, intermediate care facility for the mentally retarded providers: The reconsideration process for audit settlement varies for the aforementioned providers. See 8.312.3 NMAC, *Cost Related Reimbursement for Nursing Facilities*, and 8.313.3 NMAC, *Cost Related Reimbursement of ICF/MR Facilities* for specific information.

[11/1/96; 8.350.4.9 NMAC - Rn, 8 NMAC 4.MAD.955 & A, 1/1/2003]

HISTORY OF 8.350.3 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 351 SANCTIONS OR REMEDIES
PART 2 SANCTIONS AND REMEDIES

8.351.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.351.2.1 NMAC - Rp, 8.351.2.1 NMAC, 1/1/2014; A, 7/1/2024]

8.351.2.2 SCOPE: The rule applies to the general public.
[8.351.2.2 NMAC - Rp, 8.351.2.2 NMAC, 1/1/2014]

8.351.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.351.2.3 NMAC - Rp, 8.351.2.3 NMAC, 1/1/2014; A, 7/1/2024]

8.351.2.4 DURATION: Permanent.
[8.351.2.4 NMAC - Rp, 8.351.2.4 NMAC, 1/1/2014]

8.351.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.351.2.5 NMAC - Rp, 8.351.2.5 NMAC, 1/1/2014]

8.351.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.351.2.6 NMAC - Rp, 8.351.2.6 NMAC, 1/1/2014]

8.351.2.7 DEFINITIONS: [**RESERVED**]

8.351.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.351.2.8 NMAC - Rp, 8.351.2.8 NMAC, 1/1/2014]

8.351.2.9 SANCTIONS AND REMEDIES: The medical assistance division (MAD) is required to impose sanctions or penalties against providers for fraud, violations of federal or state law, violations of HIPAA regulations, failure to meet professional standards of conduct, non-compliance with the medical assistance division's New Mexico administrative code (NMAC) rules, violations of the Medicaid Provider Act, and other misconduct. See 42 CFR Part 455; Section 30-44-3 NMSA 1978 (Repl. Pamp. 1998). HCA recovers overpayments made to MAD enrolled providers, to include HCA contracted managed care organizations (MCO) contracted providers; and to a MCO's out-of-network providers who have billed and received payments from a HCA contracted MCO. For applying sanctions and remedies, any of the following are considered a MAD enrolled provider.

A. Any individual or other entity who has signed a provider participation agreement (PPA) with MAD, or who has signed an agreement or contract with a HCA contracted MCO.

B. Any individual or other entity who has otherwise received payment for treating or providing services to a medical assistance program (MAP) eligible recipient as an out-of-network provider, a participating or non participating provider, a subcontracted provider, or who participates in an entity contracted by HCA or a HCA contracted MCO, including but not limited to, pharmacy benefit managers, dental benefit administrators, and contracted transportation services.

C. Any individual or other entity that provides a service to a MAP eligible recipient which results in a claim for payment by MAD, the HCA contracted fiscal agent, or by a HCA contracted MCO or coordinated care organization with or without a contractual basis for the claim submission.

D. Any individual or other entity who submits a claim to medicare or to a medicare advantage plan for a MAP eligible recipient, for which a copayment, coinsurance, or deductible is applied.

E. An employee, owner, or contractor to any of the above.
[8.351.2.9 NMAC - Rp, 8.351.2.9 NMAC, 1/1/2014]

8.351.2.10 SANCTIONS: MAD is required to impose sanctions against a provider for violation of the provisions outlined in the MAD NMAC rules and federal and state laws and regulations. MAD has discretion to impose monetary or non-monetary sanctions against providers for fraud or other forms of misconduct.

A. Provider fraud: Fraud is the intentional misappropriation, deception or misrepresentation made by a provider with the knowledge that the deception could result in some unauthorized benefit to the provider, other entity or some other person. The term includes any act that constitutes fraud under applicable federal or state law or regulation.

B. Misconduct defined: Provider misconduct includes, but is not limited to, any of the following:

(1) engaging in a course of conduct or performing an act that violates any provision of federal or state statutes, laws, regulation, and rules, to include HIPAA, or the continuation of their conduct after the receipt of the notice that the conduct should cease;

(2) failure to meet federal or state licensing or certification standards required of the provider or other entity, including the revocation or suspension of their license. The provider or other entity must notify MAD of such failure;

(3) failure to correct deficiencies in provider or other entity operations within time limits specified by HCA or its authorized agent after receiving written notice of these deficiencies;

(4) failure to maintain and retain any medical, behavioral health or business records as are necessary to:

(a) verify the treatment or care of a MAP eligible recipient for which the provider or other entity received payment from MAD or a HCA contracted MCO to provide the benefit or service;

(b) services or goods provided to any MAP eligible recipient for which the provider or other entity received payment from MAD or a HCA contracted MCO;

(c) amounts paid by MAD or a HCA contracted MCO on behalf of a MAP eligible recipient;

(d) identify the practitioners and qualifications of practitioners providing the service, and

(e) other records required by MAD for at least six years from the date of creation or until ongoing audits are settled, whichever is longer;

(5) furnishing services to a MAP eligible recipient or billing MAD or a HCA contracted MCO for services which fall outside the scope of the provider's practice board or outside the scope of their prescribed practice or as limited by MAD's NMAC rules;

(6) failure to comply with the terms of the provider certification, electronic signature, or terms of submission for the claim form;

(7) failure to provide complete, accurate, and current information on their MAD provider participation agreement (PPA);

(8) breach of the terms of the provider's MAD PPA;

(9) failure to provide or maintain services which meet professionally recognized standards of care and quality;

(10) engaging in negligent or abusive practices which result in death or physical, emotional, or psychological injury to a MAP eligible recipient;

(11) failure to repay or make arrangements to repay identified overpayments;

(12) failure to make records available upon request to HCA or its delegated agent;

(13) violation of any laws, regulations or code of ethics governing the conduct of providers;

(14) conviction of crimes relating to the neglect or abuse of any of their patients;

(15) conviction of a felony relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

(16) conviction of program-related crimes under medicare to include any other programs administered by the federal government or any state health care program or the suspension or termination of a provider's participation by this or another state's medicaid agency;

(17) seeking payment for a furnished service or for work related charges and penalties from a MAP eligible recipient or their personal or authorized agent, except as allowed and specifically delineated by HCA;

(18) refusing to furnish services to a MAP eligible recipient because they have third-party coverage; or

(19) advising a MAP eligible recipient to terminate their third-party coverage;

(20) failing to follow federal or state regulations and rules regarding the management of pain

with controlled substances, the prescription monitoring program, and prescribing controlled substances;

(21) injudicious or excessive prescribing;

(22) failing to maintain a practitioner-to-patient relationship while prescribing controlled substances;

(23) failure of a provider or other entity to report overpayments identified by the provider or other entity within 60 calendar days of identification which, at that point, are presumed to be false claims and are subject to determination as credible allegations of fraud.

C. Violation of Medicaid Provider Act: Violations of the Medicaid Provider Act include the following:

(1) a material breach of a provider's obligation to furnish services to a MAP eligible recipient or any other duty specified under the terms of their PPA;

(2) a violation of any provision of the Public Assistance Act or the Medicaid Provider Act or any regulations and rules issued pursuant to those acts;

(3) the provider or other entity intentionally or with reckless disregard made false statements with respect to any report or statement required by the Public Assistance Act, Medicaid Provider Act or rules issued pursuant to either of act;

(4) the provider or other entity intentionally or with reckless disregard advertised or marketed or attempted to advertise or market, services to a MAP eligible recipient in a manner to misrepresent its service or capacity for services, or engaged in any deceptive, misleading or unfair practice with respect to advertising or marketing;

(5) the provider or other entity hindered or prevented the HCA secretary, MAD director, or HCA's authorized agent from performing any duty imposed by the Public Assistance Act, the Human Services Act, the Medicaid Provider Act or any regulations and rules issued pursuant to those acts; or

(6) the provider or other entity fraudulently procured or attempted to procure any benefit from MAD or a HCA contracted MCO.

[8.351.2.10 NMAC - Rp, 8.351.2.10 NMAC, 1/1/2014]

8.351.2.11 TYPES OF SANCTIONS: HCA is allowed to impose monetary or non-monetary sanctions against any provider or other entity for misconduct. HCA is required to impose certain sanctions against a provider or other entity for fraud, HIPAA violations, and other actions. Sanctions may be applied to any provider or other entity receiving payment for services either directly through MAD or through its managed care contractor, subcontractor, or other provider.

A. Prior approval: As a condition of payment, MAD or a HCA contracted MCO can require a provider to obtain prior approval before delivering all or certain services including prior to prescribing or ordering services. The prior approval request must be submitted to the HCA's contracted MCO or the MAD UR contractor in a manner prescribed for general utilization review. Failure to obtain prior approval prior to furnishing a service may result in imposition of sanctions. In addition, MAD may sanction a provider or other entity by requiring them to obtain prior approval before furnishing all or certain services, including prior to prescribing or ordering services, even if other providers may furnish that service without the requirement of obtaining prior approval; see 8.302.5 NMAC.

B. Education: As a condition of payment, MAD or a HCA contracted MCO can require a provider or other entity to attend an educational program if misconduct could be remedied with the provision of identified education. MAD or a HCA contracted MCO may also require a provider or other entity who is seeking reinstatement to attend a specific educational program prior to the approval of their new PPA application. Provider education programs may include, but are not limited to, the following:

(1) claim form completion;

(2) use and format of the MAD NMAC rules;

(3) use of procedure codes;

(4) substantive provisions of MAD's NMAC rule, policy, and requirement;

(5) reimbursement rates;

(6) assistance in claims coding and billing; and

(7) continuing medical or behavioral health education.

C. Closed-end agreements: MAD can transfer the provider to a closed-end PPA. A closed-end PPA is for a specified period of time which terminates on a defined date not to exceed 12 months. At the end of this term, a new PPA must be executed for continued MAD participation.

D. Suspension: "Suspension" is an exclusion from participation in MAD or a HCA contracted MCO

for a specified period of time.

(1) MAD suspension: MAD may suspend a provider from MAD or a HCA contracted MCO participation for misconduct or fraud.

(a) HCA is permitted to suspend a provider for up to 36 months. The period of suspension is not less than the term of any court-imposed suspension.

(b) If the suspension is imposed by MAD, the effective date of the suspension is the date on the notice of suspension. If the suspension is concurrent with a court-imposed suspension, the effective date is the date of the court-imposed suspension.

(c) MAD is permitted to suspend a provider when the provider's license is terminated, suspended, or moved to an inactive status whether the action is voluntary on the part of the provider or is an action of their practice or licensing board. When a provider is reinstated by their practice or licensing board, the provider may reapply to MAD. Approval of the provider's PPA will be based on the history, nature, and financial magnitude of the provider's prior misconduct and not solely on the basis of reinstatement of the provider's license.

(2) Medicare suspension: MAD must suspend a provider or other entity that is suspended by medicare or any other federal or state-funded health program. When a MAD suspension is concurrent with a medicare suspension, the effective date of the MAD suspension is the same date of the medicare suspension.

(3) Special exception for health manpower shortage areas: After assessing the nature of the violation or misconduct, MAD has the option of requesting action from the secretary of the federal department of health and human services (DHHS) if the suspension of a provider would result in the lack of adequate medical or behavioral health services for MAP eligible recipients in a given area. The secretary of DHHS can be asked to:

(a) designate the community as a health manpower shortage area and place national health services corps personnel in the community; or

(b) waive the provider's suspension based upon submission of adequate documentation that the suspension would deprive the provider's community of needed medical or behavioral health services because of a shortage of practitioners in the area.

(4) Submission of claims following suspension:

(a) If a provider is suspended from MAD or a HCA contracted MCO participation, the provider is prohibited from submitting claims for payment to MAD, its MAD claims processing contractor, or to a HCA contracted MCO.

(b) MAD or a HCA contracted MCO will not pay claims submitted by clinics, groups, corporations, associations or other entities associated with a provider who is suspended from MAD participation for services furnished by such provider after the effective date of the suspension.

(c) Claims for services, treatment or supplies furnished by the provider before the effective date of the suspension can be submitted. The claims may be subject to pre-payment review.

(5) Reinstatement: A provider can apply for reinstatement at the end of a suspension period. Reinstatement is not automatic or guaranteed. A provider must furnish written documentation that they meet all relevant licensing, certification, or registration requirements as specified by MAD, HCA's behavioral health services division (BHSD), the children, youth and families department (CYFD), or the department of health (DOH).

E. Termination: Termination is the ending of the provider's MAD PPA for a specified period of time. MAD must terminate the provider's PPA in certain specified instances and is permitted to terminate the PPA in other instances.

(1) Mandatory termination: MAD must terminate the PPA when any of the following events occur:

(a) provider is convicted of MAP or medicare fraud;

(b) provider has a previous suspension from MAD with failure to correct identified deficiencies; or

(c) provider is terminated from participation in the medicare program or another federal or state-funded health program.

(2) Discretionary termination: MAD may terminate the provider's PPA when the violation is so egregious, in the discretionary opinion of MAD, that other sanctions are not sufficient to address, reduce or eliminate the violation or when the identified deficiency or violation reflects a pattern of violation.

(3) Effective date of termination: The effective date of the MAD PPA termination is the date of a MAD or a medicare fraud conviction or the date of the provider's medicare termination. If termination follows a prior suspension from MAD or the termination is discretionary, the date of termination is set by MAD.

(4) Termination of a nursing facility (NF) or intermediate care facility's PPA:

(a) MAD or a HCA contracted MCO can terminate a NF or an intermediate care

facility for individuals with intellectual disabilities (ICF-IID) PPA instead of or in addition to other alternative remedies. Termination can occur in the instances which include, but are not limited to, the following:

(i) immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident's health and safety which have not been removed;

(ii) the provider is not in substantial compliance with participation requirements regardless of whether immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident is present;

(iii) the provider fails to submit an acceptable plan of correction within the specified timeframes;

(iv) provider fails to relinquish control to temporary manager; or

(v) DOH recommends termination as the most appropriate remedy.

(b) Termination of the provider's PPA ends payment to the NF or ICF-IID provider.

(c) Notwithstanding other sections of this rule, payment to the NF or ICF-IID provider can be continued for up to 30 calendar days after the effective date of their PPA termination if the following conditions are met:

(i) the payment is for a NF or ICF-IID MAP eligible recipient resident admitted to the NF or ICF-IID before the effective date of the provider's PPA termination; and

(ii) MAD or a HCA contracted MCO is making reasonable efforts to transfer a MAP eligible recipient resident to another MAD enrolled facility or to alternate care;

(iii) for purposes of this provision, the 30 calendar day period begins on the effective date of the provider's PPA termination by the centers for medicare and medicaid services (CMS), MAD, or by the NF or ICF-IID provider.

(d) Before termination of a provider's NF or ICF-IID PPA, MAD or a HCA contracted MCO must notify the provider and the public at least 15 calendar days before the effective date of the termination with non-immediate jeopardy deficiencies that constitute the noncompliance. For termination due to deficiencies that pose immediate jeopardy to a MAP eligible recipient resident, MAD or a HCA contracted MCO must notify the provider and the public at least two working days before the effective date of the termination.

(e) If the termination of the provider's PPA is selected due to immediate jeopardy to a NF or ICF-IID MAP eligible recipient resident, the effective date of the termination is within 23 calendar days of the last date of its DOH survey.

(5) Submission of claims following termination:

(a) If a provider is terminated from MAD participation, the provider is prohibited from submitting claims for payment to a HCA contracted MCO or to the MAD claims processing contractor.

(b) MAD or an HCA contracted MCO will not pay claims submitted by clinics, groups, corporations, associations, or other entities associated with a provider who is terminated from MAD participation for services furnished by such provider after the effective date of the termination.

(c) Claims for services, treatment or supplies furnished by the provider before the effective date of the termination can be submitted. The claims may be subject to pre-payment review.

(6) Re-application for MAD participation: A provider or other entity must submit a new PPA application after the end of the termination period to MAD, before requesting enrollment in one of HCA's contracted MCOs. A provider must meet certification and licensing requirements specified by MAD, CYFD or DOH to be eligible to once again become a provider.

F. Civil monetary penalties: MAD is permitted to impose civil monetary penalties in addition to other penalties, and in accordance with the federal and state laws, regulations and rules.

(1) Amount of penalty: the provider or other entity is liable for the following:

(a) payment of interest on the amount received by the provider or other entity from MAD or a HCA contracted MCO in excess of payment at the maximum legal rate in effect on the date the payment was made, for the period from the date payment was made to the date of repayment to HCA;

(b) a civil monetary penalty in an amount of up to the maximum allowable under federal or state law, regulations or rules;

(c) a civil monetary penalty of $500 for each false or fraudulent claim submitted for furnishing treatment, services, or goods; and

(d) payment of legal fees and costs of investigation and enforcement of civil remedies.

(2) Payment of penalty amounts: Penalties and interest amounts must be remitted to the state of New Mexico (the state). Any legal fees, costs of investigation and costs of enforcement of civil remedies

recovered on behalf of the state must also be remitted to the state.

(3) Criminal action: The filing of a criminal action is not a condition precedent to MAD's imposition of civil monetary penalties.

G. Reduction of payment: MAD may reduce the amount of any payment due a provider or other entity, in addition to other sanctions, if the provider or other entity seeks to collect an amount in excess of the MAD or a HCA contracted MCO's allowable amount from a MAP eligible recipient, their family, their authorized agent or any other source. See 42 CFR Section 447.20 - 447.21.

(1) The reduction may be equal to up to three times the amount that the provider sought to collect.

(2) For purposes of this provision, the MAD allowable amount is equal to the amount payable under the state plan or MAD NMAC rules, a MAD or a HCA contracted MCO fee schedule. The provider may not charge a MAP eligible recipient for any effort or penalties such as researching eligibility, not having cards, completing paper work or billing forms, missed appointments, or any other add-on cost unless specifically allowed in a MAD NMAC rule.

H. **Sanctions and remedies for noncompliance with nursing facility or intermediate care facility certification requirements:** MAD is required to impose additional remedies against a NF provider who fails to comply with federal medicaid and state MAD participation requirements with respect to their licensing and certification. One or more of the following remedies can be imposed by MAD for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance: termination of the NF provider's MAD PPA and all provider contracts with the HCA contracted MCO; temporary management; denial of payment for new admissions; civil money penalties; NF closure or the transfer of MAP eligible recipient residents or both; state monitoring; directed plan of correction; directed inservice training; and other state remedies approved by CMS. MAD is also required to impose remedies against an ICF-IID provider who fail to comply with federal medicaid and state MAD licensing and certification requirements. MAD may terminate an ICF-IID provider's certification or deny payment for new admissions if the provider fails to meet the conditions for participation or certain deficiencies are identified by DOH.

(1) Authority of survey agency: DOH is the survey agency designated by MAD. When the rationale for imposition of the remedies is tied to DOH's licensing and certification responsibilities, criteria for imposition of remedies and description of these specific remedies are based on NMAC rules promulgated by the DOH.

(2) Recommendations for imposition of additional remedies: Following completion of a survey, DOH may recommend that specified remedies be imposed against a NF or an ICF-IID provider for failure to meet certification or licensing requirements which are based on the type, extent and seriousness of an identified deficiency. MAD has five working days from receipt of DOH's recommendations to impose remedies or to oppose the recommendations. Unless a response from MAD is received in writing prior to the expiration of the time period, the recommendations are accepted by MAD as submitted and the recommended remedy is imposed.

(3) Informal reconsideration for an ICF-IID provider: An ICF-IID provider can request an informal reconsideration of the decision to deny, terminate or not renew their MAD PPA when the HCA administrative hearing final decision will not be completed prior to the effective date of the termination. The informal reconsideration must be completed prior to the effective date of the termination. The informal reconsideration includes the following:

(a) written notice to the ICF-IID provider of the denial, termination or nonrenewal of their MAD PPA;

(b) reasonable opportunity for the ICF-IID provider to refute the findings upon which the decision was based; and

(c) a written affirmation or reversal of the denial, termination or nonrenewal of the provider's MAD PPA.

I. Sanction for violation of the Medicaid Provider Act: MAD may take any or any combinations of the following delineated actions against a provider or other entity for a violation of the Medicaid Provider Act.

(1) imposition of an administrative penalty of not more than $5,000 for engaging in any practice that violates the act; each separate occurrence of such practice constitutes a separate offense;

(2) MAD issues an administrative order requiring the provider or other entity to:

(a) cease or modify any specified conduct or practices engaged in by the provider or other entity or their employees, subcontractors, or agents;

(b) fulfill its contractual obligations in the manner specified in the order;

(c) provide any service that has been denied;

(d) take steps to provide or arrange for any service that it has agreed to or is otherwise obligated to make available; or

(e) enter into and abide by the terms of binding or nonbinding arbitration proceeding, if agreed to by the opposing parties;

(3) suspend or terminate the provider's MAD PPA and the provider contracts with a HCA contracted MCO.

[8.351.2.11 NMAC - Rp, 8.351.2.11 NMAC, 1/1/2014]

8.351.2.12 IMPOSITION OF SANCTIONS:

A. Mandatory sanctions: MAD must impose sanctions when a provider receives a formal reprimand or censure for unethical practice by a professional association of the provider's peers or when a provider is suspended or terminated from participation in medicare or any federal or state-funded health care program. Imposition of sanctions are applied to any provider or other entity receiving payment for services either directly through MAD, its contractor, or through any HCA contracted MCO, subcontractor, or provider.

B. Permissive sanctions: MAD can impose monetary or non-monetary sanctions against a provider or other entity for fraud or other forms of misconduct.

C. Criteria used in assessment of permissive sanctions: MAD uses the following criteria to determine the type of permissive or mandatory sanction to impose:

(1) seriousness of the violation;

(2) number and nature of a violation;

(3) history of a prior violation or prior sanction;

(4) action or recommendation of peer review group or licensing board;

(5) nature and degree of adverse impact of the sanction upon a MAP eligible recipient;

(6) cost to MAD or a HCA contracted MCO of the violation;

(7) mitigating circumstances; and

(8) other relevant facts.

[8.351.2.12 NMAC - Rp, 8.351.2.12 NMAC, 1/1/2014]

8.351.2.13 RECOVERY OF OVERPAYMENTS: MAD can seek recovery of overpayments through the recoupment or repayment process. Overpayments are amounts paid to a MAD provider or other entity in excess of the MAD allowable amount. Overpayment amounts must be collected within 24 months of the initiation of recovery. Overpayment includes, but is not limited to, payment for any claim for which the provider or other entity was not entitled to payment because an applicable MAD NMAC rule and its requirements were not followed. Payment made to a pharmacy for a controlled substance or another prescribed drug item for which the prescriber did not follow all state and federal regulations, laws or rules may be subject to recoupment from the prescriber or entity to which the prescriber is associated. Recovery of overpayments through a HCA contracted MCO is also subject to the provisions of 8.308.22 NMAC.

A. Auditing procedures:

(1) Prima facie evidence: The audit findings generated through the audit procedure shall constitute prima facie evidence in all MAD proceedings of the number and amount of requests for payment as submitted by the provider or other entity.

(2) Use of statistical sampling techniques: MAD's procedures for auditing a provider or other entity may include the use of random sampling and extrapolation. When this procedure is used, all sampling will be performed using generally accepted statistical methods and will yield statistically significant results at a confidence level of at least ninety percent. Findings of the sample will be extrapolated to the universe for the audit period.

(3) Burden of proof: When MAD's final audit findings have been generated through the use of sampling and extrapolation, and the provider or other entity disagrees with the findings based on the sampling and extrapolation methodology that was used, the burden of proof of compliance rests with the provider or other entity. The provider or other entity may present evidence to show that the sample was invalid. The evidence must include a one hundred percent audit of the universe of provider records used by MAD in the drawing of its sample. Any such audit must:

(a) be arranged and paid for by the provider or other entity;

(b) be conducted by a certified public accountant;

(c) demonstrate that a statistically significantly higher number of claims and records not reviewed in MAD sample were in compliance with MAD NMAC rules, and

(d) be submitted to MAD with all supporting documentation.

B. Repayment process: A provider or other entity can repay all or part of an overpayment with a lump sum payment or a series of payments based on a schedule developed and mutually agreed to by MAD and the provider or other entity. If a provider or other entity fails to comply with the schedule, HCA will recover the overpayment and interest or initiate other collection efforts.

C. Recoupment process: Upon written notice, MAD may withhold all or a portion of a provider or other entity's payment on pending and subsequently received claims in order to recover an overpayment, or it may suspend payment on all pending or subsequently submitted claims, pending a final determination of the amount of overpayment. All amounts must be recouped within 24 months. Recoupments may be applied to other providers owned by the same entity when necessary to recoup overpayments timely.

D. Combination of processes: MAD can use both recoupment and repayment process to collect an overpayment if:

(1) the provider is unlikely to remain a MAD provider long enough for full recovery using recoupment alone;

(2) the provider is not enrolled through a MAD PPA or contract; or

(3) the average monthly payment to a provider or other entity is so low that recoupment within 12 months is not feasible.

E. Prepayment review: MAD may require pre-payment review of claims submitted during a recoupment or repayment process to ensure that subsequent claims are not inflated to compensate for amounts recovered during the recoupment or repayment process. Prepayment review may also be conducted as part of MAD's administrative responsibilities.

[8.351.2.13 NMAC - Rp, 8.351.2.13 NMAC, 1/1/2014]

8.351.2.14 NOTICE REQUIREMENTS:

A. Content of provider notice: With the exception of a referral based on a credible allegation of fraud, as that term is defined in federal statute or regulation or both, when MAD seeks overpayment recovery, or to impose sanctions or remedies, written notice is sent to the provider or other entity. The notice sent to a non-nursing facility provider or other entity contains the following information:

(1) nature of the violation or misconduct;

(2) dollar value, if applicable, the method, criteria or both used for determining the overpayment, intended sanction, or amount of civil monetary penalty to be imposed;

(3) provider's right to a HCA provider administrative hearing, the right to be represented by counsel at the hearing proceeding, and the process necessary to request a HCA provider administrative hearing.

(4) statement notifying the provider that if they do not request a HCA provider administrative hearing, the action proposed by MAD will be deemed final for purposes of collection of overpayment and imposition of sanctions; and

(5) a statement that provider has 30 calendar days from the date of the notice to request a HCA provider administrative hearing.

B. Notice requirements for credible allegations of fraud:

(1) The notice for contains the following information; see 42 CFR Section 455.23 (b):

(a) a statement that payments are being withheld on a temporary basis and delineate which types or type of MAD claim to which the termination applies, when appropriate;

(b) a statement informing the provider of their right to submit written information for MAD's consideration regarding release of payments, in whole or in part, for a good cause exception; and

(c) the information listing the conditions or circumstances under which the withholding is terminated.

(2) Time limits for withholding for fraud or misrepresentation: If payments are to be withheld in instances of credible allegations of fraud, the notice is sent to the provider within five calendar days of taking such action.

(3) The provider is not afforded any HCA administrative hearing for temporary payment suspension based on refunds or denial of a partial or in whole good cause exception for a credible allegation of fraud.

C. Notice to other organizations: When a MAD provider or other entity is sanctioned, MAD notifies the applicable professional society, board of certification, licensing or registration, and state or federal agencies of the sanctions imposed and rationale for imposition of sanctions. If MAD learns that a provider or other entity is convicted of a MAD-related offense, MAD also notifies the federal secretary of DHHS of the conviction.

D. Notice to a MAP eligible recipient: When MAD terminates or suspends a provider from participation, it notifies each MAP eligible recipient for whom the provider has submitted claims for services after the date of the alleged fraud or misconduct.

E. Notice deadlines for a NF or ICF-IID provider: The notice period begins on the date of the MAD notice. In no event will the effective date of the action be later than 20 calendar days after MAD sends the notice.

(1) The notice informing the NF or ICF-IID provider of MAD's intent to impose remedies is given at least two calendar days before the effective date of the action in instances where there is immediate jeopardy to a NF or ICF-IID MAP eligible resident.

(2) The notice informs the NF or ICF-IID provider of MAD's intent to impose remedies is given at least 15 calendar days before the effective date of the remedies in instances where immediate jeopardy to a NF or ICF-IID MAP eligible resident is not involved.

F. Exceptions to the notice requirements: Notice is not sent and a HCA provider administrative hearing is not available if the basis for the provider sanction is the non-nursing facility provider's failure to meet standards for licensing, certification, or registration required by federal or state laws and rules for MAD participation Additional notice is not required if MAD has notified the provider in writing of the failure to meet standards and has given the provider 30 calendar days notice to correct or produce necessary documentation curing the failure and the provider fails to respond.

[8.351.2.14 NMAC - Rp, 8.351.2.14 NMAC, 1/1/2014]

8.351.2.15 REQUEST FOR PROVIDER HEARING: A provider can request a hearing if they disagree with any of the aforementioned actions taken or sanctions or remedies imposed by MAD, as applicable. Requests for a HCA provider administrative hearing must be made within 30 calendar days or within the time limit specified on the notice of MAD action. A NF or ICF-IID provider must submit the request within 60 calendar days of the notice of the proposed imposition of remedies related to noncompliance with certification or licensing requirements. If a provider fails to request a HCA provider administrative hearing during this time frame, the provider waives its right to an appeal. See 8.352.3 NMAC for information on the MAD provider administrative hearing process and a provider rights and responsibilities.

A. Imposition of remedies: MAD can impose all remedies on a MAD enrolled provider after notifying the provider in a timely manner of the deficiencies an impending sanction, or remedy. Except for the imposition of civil monetary penalties against a NF provider, imposition of sanctions for violation of the Medicaid Provider Act and referrals based on credible allegations of fraud, any applicable sanctions or remedy may be imposed prior to the HCA provider administrative hearing.

B. Stay granted: As applicable, the provider can request that the imposition of sanctions or remedies be stayed while the HCA provider administrative hearing process is pending by submitting such request in writing to MAD. Granting of a stay is at the discretion of the MAD director upon consideration of health service available and other related concerns. Interest on civil money penalties or overpayments accrues from the date of the initial determination.

C. Collection of civil monetary penalties for noncompliance: MAD may not collect a civil money penalty against a NF provider until a final decision is made that supports the imposition of the penalty. In instances where imposition of civil money penalties are proposed due to noncompliance with certification requirements, a NF provider may waive its right to a HCA provider administrative hearing by submitting a written request to DOH. Waiver of the right to such a hearing reduces the amount of the specified penalty by thirty-five percent. A NF provider may submit a plan of correction or request a resurvey without prejudicing its position during the hearing.

[8.351.2.15 NMAC - Rp, 8.351.2.15 NMAC, 1/1/2014]

HISTORY OF 8.351.2 NMAC:

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

ISD 305.3000, Provider Sanctions, filed 1/7/1980.

ISD 305.4000, Provider Notification and Right to Review, filed 1/7/1980.

ISD 305.5000, Repayment of Medicaid Funds, filed 1/7/1980.

ISD 305.6000, Periods of Suspension, filed 1/7/1980.

SP-004.0500, Section 4, General Program Administration Medicaid Agency Fraud Detection and Investigation Program, filed 1/23/1981.

SP-004.3000, Section 4, General Program Administration Suspension of Practitioners Convicted of Crimes Related

to Medicare or Medicaid, filed 3/17/1981.

History of Repealed Material:
8.351.2 NMAC, Sanctions and Remedies, filed 6/16/2003 - Repealed effective 1/1/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 352 ADMINISTRATIVE HEARINGS
PART 2 CLAIMANT HEARINGS

8.352.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.352.2.1 NMAC - Rp, 8.352.2.1 NMAC, 6/15/2014; A, 7/1/2024]

8.352.2.2 SCOPE: The rule applies to the general public.
[8.352.2.2 NMAC - Rp, 8.352.2.2 NMAC, 6/15/2014]

8.352.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.352.2.3 NMAC - Rp, 8.352.2.3 NMAC, 6/15/2014; A, 7/1/2024]

8.352.2.4 DURATION: Permanent.
[8.352.2.4 NMAC - Rp, 8.352.2.4 NMAC, 6/15/2014]

8.352.2.5 EFFECTIVE DATE: June 15, 2014, unless a later date is cited at the end of a section.
[8.352.2.5 NMAC - Rp, 8.352.2.5 NMAC, 6/15/2014]

8.352.2.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.352.2.6 NMAC - Rp, 8.352.2.6 NMAC, 6/15/2014]

8.352.2.7 DEFINITIONS:

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

B. "Appeal" means the process open to a managed care organization's member when their managed care organization (MCO) has taken, or intends to take, an adverse action related to the member's benefits or services.

C. "Authorized representative" means the individual designated to represent and act on the claimant's behalf during the appeal process. The claimant or authorized representative must provide formal 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 claimant.

D. "Claimant" means the individual, or in case of eligibility determinations, the household, requesting a HCA administrative hearing that is claiming to be affected by an adverse action or actions taken or intended to be taken by MAD, its UR contractor or a MCO.

E. "HCA administrative hearing" or "fair hearing" means an informal evidentiary hearing that is conducted by the FHB so that evidence may be presented as it relates to an adverse action taken, or intended to be taken, by MAD, its UR contractor, or the MCO; see Section 10 of this rule for definitions of an adverse action.

F. "MAD" means the medical assistance division, which administers medicaid and other medical assistance programs under HCA.

G. "MAP" means the medical assistance programs administered by MAD.

H. "MCO" means a member's HCA contracted managed care organization.

I. "MCO appeal decision" means the MCO's final decision regarding a member's appealed adverse action it intends to take or has taken against its member.

J. "Member" means a MAP eligible recipient enrolled in a HCA contracted MCO.

K. "Notice of action" means the notice issued by MAD or its UR contractor or a MCO. Adverse actions include:

(1) the intent of MAD or its UR contractor or the MCO to take an adverse action against an individual in the form of a termination, suspension, change or reduction, of an existing service including level of care (LOC) or the transfer or discharge of a nursing facility (NF) resident. If the notice of action is for one of the listed adverse actions, MAD or its UR contractor or the MCO must send the notice of action 10 calendar days prior to the date of the intended adverse action; or

(2) an adverse determination made with regard to preadmission or annual resident review (PASRR) requirements; or

(3) the denial or reduction, or a limited authorization of a service including the type or level of care of a request for a new service or item.

L. "Parties to the hearing" are MAD and as appropriate, its designees, the individual's MCO or the MAD UR contractor, and the claimant or authorized representative.

M. "UR contractor" is a MAD contractor responsible for physical and behavioral health level of care (LOC) reviews, medical necessity reviews, and other determinations as directed by MAD when a MAP eligible recipient is enrolled in a medicaid fee-for-service plan.

[8.352.2.7 NMAC - Rp, 8.352.2.7 NMAC, 6/15/2014]

8.352.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

[8.352.2.8 NMAC - Rp, 8.352.2.8 NMAC, 6/15/2014]

8.352.2.9 CLAIMANT OR THE CLAIMANT'S AUTHORIZED REPRESENTATIVE AND HCA ADMINISTRATIVE HEARING PROCESS: MAD has established a process to determine if an individual is eligible to request a HCA administrative hearing. MAD has also established a process for an individual or the individual's authorized representative to request a HCA administrative hearing when an adverse action is intended or has been taken by MAD, its UR contractor or the MCO against the individual; see Section 10 of this rule.

A. Eligible claimant:

(1) When an adverse eligibility determination is made by HCA against a MAP applicant, they may file as a claimant to request a HCA administrative hearing. See 8.100.970 NMAC for the rules governing a HCA administrative hearing for a MAP adverse eligibility determination.

(2) When an adverse action is taken or intended to be taken against a MAP eligible recipient by MAD or its UR contractor, the MAP eligible recipient may file as a claimant to request a HCA administrative hearing.

(3) When an adverse action is taken or intended to be taken against a member by their MCO, and the member has exhausted their MCO's appeal process, they may file as a claimant to request a HCA administrative hearing.

B. A claimant or the claimant's authorized representative may have legal counsel assist them during the MCO appeal and HCA administrative hearing process. If a claimant or the claimant's authorized representative, MAD, its UR contractor or the MCO retains legal counsel, that legal counsel must submit an entry of appearance to the assigned ALJ and the ALJ will forward this information to the MAD administrative hearings unit (MAD AHU).

[8.352.2.9 NMAC - Rp, 8.352.2.9 NMAC, 6/15/2014]

8.352.2.10 ADVERSE ACTION: The following constitute an adverse action for which an individual may request a MCO appeal and a HCA administrative hearing.

A. The denial or reduction by MAD, its UR contractor, or a MCO of an authorized service or item, including level of care (with the exception of a MCO value-added service).

B. When a notice of action against a member is not from their MCO, but instead is from an entity MAD has authorized to make utilization of service determinations, the member may request a HCA administrative hearing rather than request a MCO appeal.

C. The denial in whole or in part of an individual's provider claim by MAD, its UR contractor, or the MCO which results in the individual becoming liable for payment of all or part of the claim when the denial is based on medical necessity.

D. The failure of MAD, its UR contractor or the MCO to approve a service or item in a timely manner.

E. The failure of the MCO to act on an appeal within the time-frames specified in 42 CFR Section 438.408(b).

F. The MCO's final decision to deny a member a MCO expedited appeal hearing. The HCA administrative hearing will only address the member's request for a MCO expedited appeal hearing.

G. The denial of an individual's application for MAP enrollment.

H. A determination that an individual is to be transferred or discharged.

I. The belief of an individual or the individual's authorized representative that the MAD UR contractor or the MCO's preadmission, change in condition, or annual resident review (PASRR) requirements determination is erroneous. When a claimant requests a HCA administrative hearing due to an adverse PASRR determination, the parties to the hearing will comply with 8.354.2 NMAC in place of this rule.

[8.352.2.10 NMAC - Rp, 8.352.2.10 NMAC, 6/15/2014]

8.352.2.11 RIGHT TO A HCA ADMINISTRATIVE HEARING: MAD must grant an individual or their authorized representative the opportunity for a HCA administrative hearing under specific circumstances pursuant to 42 CFR Section 431.220(a) and 27-3-3 NMSA 1978. A HCA administrative hearing occurs telephonically between the parties to the hearing and the assigned ALJ.

A. An individual or the individual's authorized representative may request a HCA administrative hearing based on their belief that MAD or its UR contractor intends to take, or has taken, an adverse action.

B. A member shall have the right to request a HCA administrative hearing after they have exhausted the MCO's appeal process and:

(1) the member does not agree with the MCO's final decision;

(2) the member requests an HCA administrative hearing within 30 calendar days of the date of the MCO's final decision; and

(3) the basis for the member's request for an HCA administrative hearing meets one of the definitions of an adverse action in Section 10 of this rule.

C. MAD, its UR contractor or the MCO will not be responsible for any fees or costs, incurred by the individual or their authorized representative as a result of a MCO appeal or a HCA administrative hearing, or if they file an appeal of the HCA administrative hearing final decision to a New Mexico district court.

[8.352.2.11 NMAC - Rp, 8.352.2.11 NMAC, 6/15/2014]

8.352.2.12 NOTICE, TIME LIMITS, POSTPONEMENT, OR THE DISMISSAL OF MCO APPEAL OR A HCA ADMINISTRATIVE HEARING REQUEST:

A. Notice:

(1) MAD or its UR contractor shall issue a "notice of action" to an individual when it intends to take an adverse action against an individual. When the notice of action relates to a reduction or termination of a service, LOC, or another benefit the individual already receives, the notice of action shall be sent not less than 10 calendar days prior to the date of MAD's or its UR contractor's intended adverse action.

(2) The MCO appeal process is governed by and set forth in detail in 8.308.15 NMAC.

B. Exceptions to a notice of action: Notwithstanding the notice requirement set forth in the preceding subsection, MAD, its UR contractor or the MCO may mail a notice of action to the individual or the individual's authorized representative or estate (in the event of an individual's death) no later than the actual date of the intended adverse action when:

(1) MAD, its UR contractor or the MCO has confirmed the death of the individual;

(2) MAD, its UR contractor or the MCO has received a clear written statement signed by the individual or the individual's authorized representative that all or a portion of an authorized service is no longer wanted;

(3) the individual or the individual's authorized representative provides information to MAD, its UR contractor or the MCO that indicates their understanding that such information may require MAD, its UR contractor or the MCO to take the adverse action;

(4) MAD, its UR contractor or the MCO learns the individual is residing in an institution, which renders the individual ineligible for MAP enrollment and MAD services;

(5) MAD, its UR contractor or the MCO cannot determine the physical location of either the individual, or if designated, their authorized representative;

(6) MAD, its UR contractor or the MCO has established that the individual has been accepted for medicaid services outside of the state; or

(7) the primary care provider for the individual has prescribed a change in their LOC.

C. Time limits: An individual or their authorized representative must adhere to the time limits for requesting both a continuation of a benefit and a HCA administrative hearing.

(1) Requesting a HCA administrative hearing: an individual who is not enrolled in a MCO has 90 calendar days from the date of the "notice of action" to request a HCA administrative hearing. To be considered timely, the request must be received by FHB, the individual's local income support division (ISD) office or by the MAD director's office no later than the close of business on the 90th calendar day immediately following the date of the notice of action. If the request for a HCA administrative hearing is mailed by the individual, the request must be postmarked by the 90th calendar day from the date of the notice of action. For a member of a MCO, see 8.308.15 NMAC for detailed description of the MCO appeal process.

(2) Continuation of a benefit:

(a) An individual who is not a member of a MCO, may request that the benefit that is the subject of an adverse action continue while their HCA administrative hearing proceeds. A request for a continuation of the benefit shall be accorded to any claimant who requests the continuation within 10 calendar days of the mailing of the notice of action by MAD or its UR contractor. The continuation of a benefit is only available to an individual that is currently receiving the appealed benefit and will be the same as the individual's current allocation, budget or LOC. MAD or its UR contractor must provide information in its notice of action of an individual's rights and limitations to continue a benefit during their HCA administrative hearing process and of the responsibility to repay MAD for the continued benefit if the HCA administrative hearing final decision is against the individual.

(b) A member of a MCO must follow their MCO appeal process. The member may request the benefit that is the subject of an adverse action continue while their MCO appeal process proceeds. A request for a continuation of a benefit shall be accorded to any member who requests the continuation within 10 calendar days of their MCO's mailing of the notice of action. The continuation of a benefit is only available to a member that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the member's current allocation, budget or LOC. The MCO must provide information in its notice of action of a member's rights and limitations to continue a benefit during their MCO appeal process and of the responsibility to repay the MCO for the continued benefit if the MCO final appeal decision is against a member and, if the member requests a HCA administrative hearing, its final decision is also against the member as a claimant. The MCO appeal process is outlined in 8.308.15 NMAC.

(3) For a member who is enrolled in a MCO and who is dissatisfied with the MCO's final appeal process, the time limit to request a HCA administrative hearing is 30 calendar days following the MCO's final decision of their appeal.

(a) Upon requesting a HCA administrative hearing within this time limit, the member is referred to as the claimant and is governed by the remaining sections of this rule.

(b) If the member had a continuation of their benefit during the MCO appeal process, the claimant automatically maintains their continuation of the benefit throughout the remaining HCA administrative hearing process. If the claimant or the claimant's authorized representative opts to discontinue their benefit during the HCA administrative hearing process, the claimant or the claimant's authorized representative must contact the MCO to end services.

(4) The HCA administrative hearing is concluded within 90 calendar days from the date the claimant or the claimant's authorized representative requests a HCA administrative hearing unless the claimant or the claimant's authorized representative agrees to extend the HCA administrative hearing time frame in order to facilitate the process.

D. Dismissal of a hearings request: HCA authorizes FHB to issue a dismissal of a claimant or member's request for a HCA administrative hearing when:

(1) the request is not received within the time periods specified in the rules and notice of action, or if the claimant is a MCO member and the member has not followed or exhausted the appeal process available under the MCO;

(2) the request is withdrawn or cancelled in writing by the individual or the individual's authorized representative;

(3) the sole issue presented concerns a federal or state statue, regulation or rule requiring an adjustment of benefits for all or certain classes of individuals, including, but not limited to, a termination, modification, reduction, or suspension of a service;

(4) the same issue involving the individual has already been subject to a final decision by the MAD director following a HCA administrative hearing;

(5) the sole issue presented is regarding a New Mexico administrative code (NMAC) rule rather than the application of the rule to the claimant or the member; or

(6) the claimant, the member, or the authorized representative fails to appear telephonically or in person at a scheduled hearing without good cause at which time a HCA administrative hearing may be considered abandoned and therefore dismissed. However, if the claimant or the claimant's authorized representative presents to the ALJ good cause for failure to appear within 10 calendar days after the date of the scheduled HCA administrative hearing, the HCA administrative hearing may be rescheduled. Good cause includes a death in the family, a disabling personal illness or another significant emergency or at the discretion of the ALJ, as appropriate, another exceptional circumstance. If the ALJ determines that the claimant or the claimant's authorized representative has shown good cause, the HCA administrative hearing will be rescheduled.

(7) When an ALJ dismisses a claimant's request for a HCA administrative hearing, that decision becomes HCA's administrative hearing final decision. A claimant may elect to then file a state district court judicial appeal.

[8.352.2.12 NMAC - Rp, 8.352.2.13 NMAC, 6/15/2014]

8.352.2.13 SCHEDULING OF A HCA ADMINISTRATIVE HEARING:

A. Scheduling: The ALJ will assign a date for a HCA administrative hearing that affords the MAD director the opportunity to render their HCA administrative hearing final decision within the 90 calendar day time limit. The claimant or the claimant's authorized representative must agree via a recorded message to the assigned ALJ or in writing to the assigned ALJ to extend the 90 calendar day time limit up to an additional 30 calendar days to provide the necessary time for the HCA administrative hearing to be conducted and a final decision rendered. The ALJ has the authority on a case-by-case basis to extent the 90-calendar day time limit to more than 30-calendar days when the claimant or the claimant's authorized representative requests such an extension in writing. If an accommodation is necessary for a disability, the claimant or the claimant's authorized representative must notify FHB at least 10 calendar days prior to the HCA administrative hearing.

B. Rescheduling: Any party to a HCA administrative hearing may request, and is entitled to receive, one postponement of a HCA administrative hearing, as long as it does not interfere with the HCA administrative hearing final decision time frames.

(1) A request for more than one postponement is at the ALJ's discretion on a case-by-case basis.

(2) The claimant or the claimant's authorized representative must agree to allow the ALJ to extend the 90 calendar day time limit up to an additional 30 calendar days to provide the necessary time for the HCA administrative hearing to be conducted and a final decision rendered.

C. Expedited HCA administrative hearing: Any party may request an expedited HCA administrative hearing in cases involving a claimant's health, safety, or service availability issues. The request must be made in writing to the claimant's assigned ALJ. The request must state in detail the reasons why an expedited HCA administrative hearing is necessary. The granting of an expedited HCA administrative hearing is at the discretion of the ALJ.

D. Group hearing: An ALJ may respond to a series of individual claimant or the claimant's authorized representative requests for HCA administrative hearings by conducting a single group hearing. In all group hearings, the rules governing an individual HCA administrative hearing are followed. Each claimant or the claimant's authorized representative is permitted to present their own case. If a group hearing is arranged, any claimant or a claimant's authorized representative has the right to withdraw from the group hearing in favor of an individual HCA administrative hearing.

[8.352.2.13 NMAC - Rp, 8.352.2.15 NMAC, 6/15/2014]

8.352.2.14 SUMMARY OF EVIDENCE (SOE):

A. Summary of evidence.

(1) At a HCA administrative hearing, MAD has the burden to prove through the preponderance of the evidence that an adverse action against a claimant is correct. A summary of evidence (SOE) provides information concerning the basis of MAD, its UR contractor or the MCO's adverse action. MAD may have its designee complete an SOE for final review by MAD; however, MAD is ultimately responsible for the submission of its SOE. An SOE is submitted by MAD to the ALJ and claimant or the claimant's authorized representative within specified timeframes.

(2) A claimant or the claimant's authorized representative may submit an SOE to provide the ALJ with information to refute MAD's SOE. A claimant or the claimant's authorized representative is not required to provide a SOE, as the burden of proof falls on MAD.

(3) The MAD SOE shall, at a minimum, contain:

(a) the claimant's name, and as applicable, their authorized representative's or legal counsel's telephone number and address, and the status of any previous or concurrent appeal through their MCO or MAD UR contractor;

(b) the adverse action against the claimant;

(c) the documentation supporting MAD, its UR contractor, or the MCO basis for the intended or taken adverse action; and

(d) any applicable federal or state statutes, regulations, rules or any combination of these; however, that a failure by MAD, the UR contractor or a MCO to submit an applicable statute, regulation or rule shall not constitute per se grounds for the ALJ to find that MAD, the UR contractor or the MCO failed to meet its burden of proof.

B. Timeframes.

(1) The HCA administrative hearing.

(a) MAD's SOE shall be delivered to the ALJ and the parties to the HCA administrative hearing at least 10 working days prior to the HCA administrative hearing.

(b) MAD's SOE may be amended by MAD at any point prior to the HCA administrative hearing if the ALJ and the claimant or the claimant's authorized representative is delivered copies of the amended SOE at least two working days prior to the HCA administrative hearing. MAD is responsible for providing its UR contractor or MCO the amended SOE.

(c) If the claimant or their authorized representative has an SOE that they want entered into evidence for the HCA administrative hearing, they must provide the ALJ the SOE not less than three working days prior to the HCA administrative hearing. The ALJ will provide MAD AHU with a copy of the claimant's SOE within one working day of its receipt. The MAD AHU will provide a copy of the SOE to either its UR contractor or the MCO within one working day of its receipt.

(d) If the claimant or the claimant's authorized representative has an amendment to their SOE, they shall follow the process in Subparagraph (c) of Paragraph (1) of Subsection B of this section.

(2) The failure of MAD to provide its SOE in a timely manner may, at the ALJ's discretion result in its exclusion or a postponement of the HCA administrative hearing charged against MAD.

(3) If the claimant or the claimant's authorized representative fails to provide the assigned ALJ a SOE or any amendments to the SOE within the specified timeframes, and the claimant or the claimant's authorized representative wishes to submit such documents for consideration at the HCA administrative hearing, the claimant or the claimant's authorized representative will utilize their one allowed postponement opportunity in which to submit the SOE or any amendments to the ALJ. The ALJ will follow the process in Subparagraph (b) of Paragraph (1) of Subsection B of this section for the disbursement of the amended SOE.

C. Availability of information to the claimant or the claimant's representative: MAD, its UR contractor or the MCO shall:

(1) provide upon request to the claimant or their authorized representative, any document in its possession concerning its adverse action against the claimant that is not already in its SOE;

(2) provide the claimant or the claimant's authorized representative the requested documents; such documents will be provided by MAD, its UR contractor or MCO to the claimant or the claimant's authorized representative in a timely manner and without charge.

D. No party to a HCA administrative hearing may present into evidence, as part of an amended SOE, any document or record that any other party of the hearing has not received at least two working days prior to the HCA administrative hearing. The ALJ will not take such information into consideration when reaching their recommendation.

[8.352.2.14 NMAC - Rp, 8.352.2.16 NMAC, 6/15/2014]

8.352.2.15 ADMINISTRATIVE HEARING STANDARDS:

A. Administrative law judge.

(1) A HCA administrative hearing is conducted by an impartial official who:

(a) does not have any personal stake or involvement in the case; and

(b) was not involved in the determination or the action which is being contested; if the ALJ had any involvement with the action in question, including giving advice or consultation on the points at issue, or is personally related in any relevant degree to the parties, the ALJ must disqualify theirself as the assigned ALJ for that case.

(2) In conducting a HCA administrative hearing, the ALJ must:

(a) explain how the HCA administrative hearing will be conducted to participants at the start of the hearing, before administering oaths;

(b) administer oaths and affirmations;

(c) request, receive, and make part of the record all evidence that has been provided to each party within the required time-frames that the ALJ considers necessary to decide the issues raised;

(d) regulate the conduct and the course of the HCA administrative hearing to ensure an orderly HCA administrative hearing;

(e) request, if appropriate, an independent physical or behavioral health assessment or a professional evaluation from a source mutually satisfactory to the parties at no cost to the claimant; and

(f) produce the ALJ HCA administrative hearing report that includes findings of fact and recommendations for the MAD director's consideration.

(3) Appointment of the ALJ: the ALJ is appointed by FHB upon receipt of the request for a HCA administrative hearing. The ALJ will be copied on all written communications between the parties to HCA administrative hearing to ensure all parties are free of undue influence and receive written notices and documents within the required time-frames.

B. Record of the hearing: A HCA administrative hearing is digitally recorded. The digital recording, findings of fact, SOEs and any amendments, pleadings, documents, NMAC rules, other relevant statutes or other exhibits admitted into evidence, as well as the ALJ's recommendations will be available to the parties for one calendar year following the HCA administrative hearing final decision. These items are referred to as the record of the HCA administrative hearing. Parties to the HCA administrative hearing may request one copy of the record without charge. Subsequent copies will be charged at a pre-determined rate set by HCA.

C. Rights at an administrative hearing: A claimant or the claimant's authorized representative will provide the assigned ALJ a signed release-of-information in order for a designated spokesperson to assist or represent the claimant or the claimant's authorized representative in presenting the claimant's case at a HCA administrative hearing. If the claimant or the claimant's authorized representative, MAD, its UR contractor or MCO have retained legal counsel, that legal counsel will submit a notice appearance to the assigned ALJ and the ALJ will forward this information to the MAD administrative hearings unit (MAD AHU). The parties are given an opportunity to:

(1) call witnesses to present information relevant to the case;

(2) submit evidence to establish all pertinent facts and circumstances in the case;

(3) advance arguments without undue interference; and

(4) question or contradict any testimony or evidence, including an opportunity to confront and cross-examine opposing witnesses.

D. Evidence and procedure: Formal rules of evidence and civil procedure do not apply to a HCA administrative hearing. A free, orderly exchange of relevant information is necessary for the decision-making process.

(1) Admissibility: all relevant evidence is admissible subject to the ALJ's authority to limit repetitive, scandalous or unduly cumulative evidence and their ability to conduct an orderly HCA administrative hearing. The ALJ must admit evidence that is relevant to the intended or taken adverse action by MAD, its UR contractor, or the MCO.

(2) Confidentiality: the confidentiality of records is to be maintained;

(3) Information not entered in the hearing record: information which is not presented during the HCA administrative hearing in the presence of the claimant or the claimant's authorized representative, MAD, its UR contractor, or the MCO may not be used by the ALJ in making their record of fact finding and recommendation.

(4) Administrative notice: the ALJ may take administrative notice of any matter in which courts of this state may take judicial notice.

(5) Privilege: the rules of privilege apply to the extent that they are required to be recognized in civil actions in the district courts of New Mexico.

(6) Medical issues: in a case involving physical or behavioral health issues, the parties may submit expert testimony, reports, affidavits or health care records into evidence as necessary. Admission of this evidence is at the discretion of the ALJ and must meet the SOE time-frames for submission. All parties of the HCA administrative hearing have the right to examine any documents which may influence the HCA administrative hearing final decision.

[8.352.2.15 NMAC - Rp, 8.352.2.17 NMAC, 6/15/2014]

8.352.2.16 CONDUCTING THE HCA ADMINISTRATIVE HEARING: A HCA administrative hearing is conducted in an orderly manner and in an informal atmosphere. The HCA administrative hearing is normally conducted telephonically and is not open to the general public. The assigned ALJ has the authority to limit the number of persons in attendance as necessary for the ALJ to control the hearing.

A. Opening the hearing: The HCA administrative hearing is opened by the assigned ALJ. All individuals present at the hearing must identify themselves for the record, including when the claimant or the claimant's authorized representative has other representation or legal counsel to assist them during the HCA administrative hearing. The ALJ shall explain their role in conducting the HCA administrative hearing that they will submit the record of the HCA administrative hearing to the MAD director and that the final decision of the HCA administrative hearing will be made by the MAD director or designee after review of the record of the HCA administrative hearing.

B. Order of testimony: The order of testimony is described, and the oath is administered to all who will testify at the HCA administrative hearing. Because the burden of proof is with MAD, it is at the claimant or the claimant's authorized representative's discretion to call witnesses or to present evidence. The order of testimony at the HCA administrative hearing is as follows:

(1) opening statements of parties, authorized representatives, or designees, or if the claimant or the claimant's authorized representative through a signed statement has identified a designated spokesperson or legal counsel to assist them during the HCA administrative hearing process;

(2) presentation of MAD's case; if witnesses are called, the order of examination of each witness is:

(a) examination by MAD, its UR contractor, the MCO, or another MAD designee;

(b) cross examination by the claimant, the claimant's authorized representative, designated spokesperson, or their legal counsel; and

(c) MAD's opportunity to redirect the witness;

(3) presentation of the claimant's case is at the claimant or the claimant's authorized representative discretion, if witnesses are called, the order of examination of each witness is:

(a) examination by claimant or the claimant's authorized representative, designated spokesperson or legal counsel;

(b) cross examination by MAD, its UR contractor, the MCO or another MAD designee; and

(c) the claimant, claimant's authorized representative or designated spokesperson, or legal counsel's opportunity to redirect the witness;

(4) presentation of rebuttal evidence by MAD, its UR contractor, the MCO or another designee and the claimant or the claimant's authorized representative, designated spokesperson or legal counsel respectively;

(5) the ALJ may direct further questions to any of the parties to the HCA administrative hearing to clarify inconsistencies or obtain an adequate evidentiary record; and

(6) the ALJ may ask specific parties to summarize and present closing arguments.

C. Points of law: The ALJ may direct the parties who have legal counsel to submit memoranda on points of law to assist the ALJ develop the HCA administrative hearing record and recommendation letter. The ALJ may dictate the length and scope of these submissions.

D. Written closing argument: At the discretion of the ALJ, the parties may be directed to make closing arguments, or submit written memoranda on points of law.

E. Continuance: The ALJ may, at their discretion, continue the HCA administrative hearing upon the request of the parties to the HCA administrative hearing or the ALJ's own motion, to allow for the admission of additional testimony or evidence. The reasons for the continuance must be clearly stated for the record. Written notice of the date, time, and place of the continued HCA administrative hearing shall be sent to the parties if they are not set at the time of the approval of the continuance.

F. Additional evidence: If the ALJ requires additional evidence to further clarify documentary evidence presented during the HCA administrative hearing, they may close the HCA administrative hearing but keep the record open and direct the parties to submit such clarifying evidence. The assigned ALJ shall provide each party to the HCA administrative hearing with a copy of the direction for further evidence and the documentary evidence to be submitted. Any party may respond to the ALJ's direction, in writing, within 10 calendar days of its receipt of the ALJ's notice. The ALJ will provide the other parties to the HCA administrative hearing a copy of any such submissions and the additional evidence and responses, subject to the ALJ's discretion and appropriate objections by any of the parties to the HCA administrative hearing, shall become part of the HCA administrative hearing record.

G. Re-opening a closed HCA administrative hearing: The ALJ, at their discretion or subject to an order from a court of competent jurisdiction, may re-open a closed HCA administrative hearing when the evidentiary record fails to address an issue that is relevant to resolution of the HCA administrative hearing request. Written notice of the date, time and place of the re-opened HCA administrative hearing shall be sent by the ALJ to the parties not less than 10 calendar days before the re-opened HCA administrative hearing. Once the MAD director or designee has issued a HCA administrative final decision, the HCA administrative hearing cannot be re-opened absent an order from a court of competent jurisdiction. A claimant or the claimant's authorized representative may request a new HCA administrative hearing if additional material information becomes available that was not available at the time of the first HCA administrative hearing. The previously assigned ALJ has the discretion to determine if the additional information would necessitate a new HCA administrative hearing.
[8.352.2.16 NMAC - Rp, 8.352.2.18 NMAC, 6/15/2014]

8.352.2.17 HCA ADMINISTRATIVE HEARING FINAL DECISION: The final decision concerning the HCA administrative hearing is made by the MAD director or designee after the review of the HCA administrative hearing record and the ALJ's recommendation. If the ALJ had rendered a decision to dismiss a HCA administrative hearing request, that decision becomes the HCA administrative hearing final decision and the following process detailed in this section of the rule does not apply.

A. Decision based on the record: The ALJ's HCA administrative hearing recommendation must be based solely on the record of the HCA administrative hearing.

B. ALJ recommendation: The ALJ shall review the record of the HCA administrative hearing and submit a complete copy of the record to the MAD director.

(1) Content of the ALJ recommendation: the ALJ shall specify the reasons for their conclusions, identifies the supporting evidence, references the pertinent federal and state statutes, regulations, and NMAC rules, and responds to the arguments of the parties within their written report.

(2) The ALJ recommends:

(a) in favor of the claimant if MAD, its UR contractor or the MCO's intended or taken adverse action is not supported by a preponderance of the evidence submitted during the HCA administrative hearing. The ALJ will provide specific recommendations to each appealed adverse action;

(b) in favor of MAD, if the preponderance of evidence submitted during the HCA administrative hearing supports the intended or taken of adverse action or actions; or

(c) any other result supported by the record of the HCA administrative hearing which may be a combination of recommendations for and against the claimant or MAD. If the HCA administrative hearing covered a number of services or components of a service, the ALJ will provide specific recommendations to each intended or taken adverse action.

C. Review of the record: The record of the HCA administrative hearing and the report and recommendation of the ALJ is reviewed by the MAD director or designee to ensure conformity with applicable federal and state statutes, regulations, and rules.

D. Final decision: The ALJ's recommendation may be adopted or rejected in a final written decision by the MAD director or designee on issues that were the subject of the HCA administrative hearing. The MAD director's final decision letter shall specify the reasons for their decision and identify the regulatory authority and those portions of the record, applicable federal and state law, rules and policies or any combination of these that support the final decision. No person who participated during the HCA administrative hearing process may participate in arriving at a HCA administrative hearing final decision.

E. Notice to parties: MAD shall promptly provide all parties with a copy of the HCA administrative hearing final written decision. When the claimant is represented by legal counsel or an authorized representative, each must receive a copy of the final decision. The HCA administrative hearing final decision letter shall include an explanation that the parties have exhausted all HCA administrative remedies and a claimant or the claimant's authorized representative may pursue judicial review of this decision.
[8.352.2.17 NMAC - Rp, 8.352.2.19 NMAC, 6/15/2014]

8.352.2.18 CONTINUATION OF BENEFITS PURSUANT TO A TIMELY APPEAL AND A HCA ADMINISTRATIVE HEARING PROCEEDING: A continuation of an existing benefit is provided to a claimant who is not a member of a MCO when the claimant requests a continuation of the benefit through MAD or its UR contractor as directed on the claimant's notice of action within 10 calendar days of the mailing of the MAD or its UR contractor's notice of action. A continuation of the benefit is provided to a member who requests a continuation of the benefit through their MCO within 10 calendar days of the mailing of the MCO's notice of action. The MAD,

its UR contractor or the MCO's notice of action will include information on the rights to the continued benefit and on the claimant or member's responsibility for repayment if the MCO final appeal decision and, as applicable, the HCA administrative hearing decision is not in their favor. The continuation of a benefit is only available to a member or claimant that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the member or claimant's current allocation, budget or LOC.
[8.352.2.18 NMAC - Rp, 8.352.2.20 NMAC, 6/15/2014]

8.352.2.19 IMPLEMENTATION OF THE HCA ADMINISTRATIVE FINAL DECISION: The HCA administrative hearing final decision is binding on all issues that have been the subject of the HCA administrative hearing as to the claimant unless stayed by either a court order or by the MAD director or designee. MAD is responsible for ensuring that the HCA administrative hearing final decision is fulfilled.

A. If the claimant is a member and they received a benefit under their approved continuation of the benefit and the decision is favorable to the MCO, the claimant's MCO will take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the MCO appeal and the HCA administrative hearing process up to the date of the HCA administrative hearing final decision. The claimant is responsible for repayment to their MCO the amount of paid claims for the continuation of the benefit beginning on the first date of service of the claimant's approved continuation of the benefit up to and including the date of the HCA administrative hearing final decision. The claimant's MCO is charged with the collection of this amount. The repayment amount must be used by the claimant's MCO to benefit its members.

B. If the claimant is not enrolled in a MCO and the HCA administrative hearing final decision is favorable to MAD or its UR contractor, MAD will take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the HCA administrative hearing process up to the date of the HCA administrative hearing final decision.

C. When the HCA administrative hearing final decision is favorable to the claimant, MAD, its UR contractor or MCO will authorize the benefit and coverage set forth in the HCA administrative hearing final decision.

D. A request for a HCA administrative hearing concerning the MAD or MCO repayment claim is limited to alleging errors in how the repayment amount was determined. The HCA final administrative hearing decision serves as the claimant's notice of action from either the MCO or MAD to start collection proceedings.
[8.352.2.19 NMAC - Rp, 8.352.2.21 NMAC, 6/15/2014]

8.352.2.20 JUDICIAL APPEAL: If the HCA administrative hearing final decision upholds MAD, its UR contractor or the MCO's intended or taken adverse action, the claimant or the claimant's authorized representative has the right to pursue judicial review of the HCA administrative hearing final decision and is notified of that right in the HCA administrative final decision letter. Judicial appeals for the HCA administrative hearing final decision are governed by New Mexico statutes and court rules. While the following subsections highlight applicable procedures, they should not be considered a substitute for examining the statutes and rules themselves.

A. Jurisdiction: Administrative appeals for a claimant are governed by the Section 39-3-1.1 NMSA 1978 and by Rule 1-074, Rules of Civil Procedures for the District Courts.

B. Timeliness: Unless otherwise provided by law, a claimant or the claimant's authorized representative must appeal the HCA administrative hearing final decision within 30 calendar days of the date of the HCA administrative hearing final decision by filing a notice of appeal with the clerk of the appropriate New Mexico district court.

C. Jurisdiction and standard of review: All judicial appeals are based on the record made at the HCA administrative hearing, and in accordance with state statute and court rules. HCA files a copy of the HCA administrative hearing record with the court clerk and furnishes one copy to the claimant or the claimant's authorized representative and if applicable, their legal counsel within 30 calendar days after receipt of the notice of appeal. The court may set aside the HCA administrative hearing final decision if it finds the decision is:

(1) arbitrary, capricious, or an abuse of discretion;
(2) is not supported by substantial evidence in the record as a whole; or
(3) is otherwise not in accordance with the applicable law, statutes or rules.

D. Benefits pending state district court appeal: The filing of a notice of appeal shall not stay the enforcement of the HCA administrative hearing final decision. The claimant or the claimant's authorized representative may seek a stay upon a motion to the court or the claimant may request the MAD director or designee to stay the HCA administrative hearing final decision while the adverse action is on appeal in a New Mexico district court. If the court orders a stay, MAD, it UR contractor or the MCO will maintain the benefit at issue in accordance

with the state district court's order. If the New Mexico district court's final decision is in favor of MAD, its UR contractor or the MCO and the claimant continued utilizing their benefit during the district court appeal process, see 8.352.2.19 NMAC for the repayment process.
[8.352.2.20 NMAC - Rp, 8.352.2.22 NMAC, 6/15/2014]

HISTORY OF 8.352.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
SP-004.0200 Section 4, General Program Administration Hearing For Applicants, 1/23/1981
SP-004.2800 Section 4, General Program Administration Appeals Process For Skilled Nursing Facilities And Intermediate Care Facilities, 3/5/1981.
NMAC History: 8 NMAC 4.MAD.970 Oversight Policies, Recipient Hearing Policies, Recipient Hearings, 10/16/1996.
8 NMAC 4.MAD.970 Oversight Policies, Recipient Hearing Policies, Recipient Hearings; 12/15/1999.

History of Repealed Material:
8.352.2 NMAC, Recipient Hearings, filed 6/15/2001 - Repealed effective, 1/1/2014.
8.352.2 NMAC, Claimant Hearings, filed 12/17/2013 - Repealed effective, 6/15/2014.

TITLE 8 SOCIAL SERVICES
CHAPTER 352 ADMINISTRATIVE HEARINGS
PART 3 PROVIDER HEARINGS

8.352.3.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.352.3.1 NMAC - N, 1/1/2014; A, 7/1/2024]

8.352.3.2 SCOPE: The rule applies to the general public.
[8.352.3.2 NMAC - N, 1/1/2014]

8.352.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.352.3.3 NMAC - N, 1/1/2014; A, 7/1/2024]

8.352.3.4 DURATION: Permanent.
[8.352.3.4 NMAC - N, 1/1/2014]

8.352.3.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.352.3.5 NMAC - N, 1/1/2014]

8.352.3.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.352.3.6 NMAC - N, 1/1/2014]

8.352.3.7 DEFINITIONS: [**RESERVED**]

8.352.3.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.352.3.8 NMAC - N, 1/1/2014]

8.352.3.9 PROVIDER ADMINISTRATIVE HEARINGS: With the exception of referrals for credible allegations of fraud, HCA has established a hearing process for MAD fee-for-service (FFS) providers who disagree with its decision concerning their participation as a MAD provider, recoupment of overpayments due to a provider billing error, and the imposition of MAD sanctions. For the provider administrative hearing process concerning decisions on noncompliance with nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF-IID) provider certification requirements also see hearing regulations promulgated by the department of health (DOH) and specific MAD New Mexico administrative code (NMAC) rules applicable to the provider. See 8.311.3 NMAC, 8.312.2 NMAC, and 8.313.3 NMAC for a detailed description of the appeals process for audit settlements. See 8.308.14 NMAC for a detailed description of the grievance and appeal process for resolving provider disputes between a HCA contracted managed care organization (MCO) and its contractor or subcontractor. For applicable rules for services and items provided through a MAD coordinated service contractor, see 8.349.2 NMAC.

A. Provider administrative hearing rights: The right to a provider administrative hearing includes the right to:

(1) be advised of the nature and availability of a provider administrative hearing;

(2) be represented by their authorized representative or legal counsel;

(3) have a provider administrative hearing which safeguards the provider's opportunity to present a case;

(4) have prompt notice and implementation of the final provider administrative hearing decision; and

(5) be advised that judicial review may be invoked to the extent such review is available under state law.

B. Notice of rights: Upon enrollment, a MAD provider receives written notice of provider administrative hearing rights along with any MAD action notice concerning provider participation agreement (PPA) termination, recoupment of overpayment due to provider billing error, or notice of sanction. This information includes a description of the method by which a provider administrative hearing may be requested and a statement that the provider's presentation may be made by the provider or by their authorized representative or legal counsel. [8.352.3.9 NMAC - N, 1/1/2014]

8.352.3.10 INITIATION OF FFS PROVIDER ADMINISTRATIVE HEARING PROCESS:

A. Notice: When applicable, the provider administrative hearing process is initiated by a provider's request for hearing made in response to a MAD action notice. See Section 8.351.2 NMAC for a detailed description of notice requirements when the action is a MAD sanction.

B. Time limits: A MAD FFS provider has 30 calendar days from the date of the MAD action notice to request a provider administrative hearing. To be considered timely, the request must be received by the HCA fair hearings bureau (FHB) no later than the close of business of the 30th day. Provider administrative hearings are conducted and a written decision is issued by the MAD director or designee to the provider within 120 calendar days from the date the FHB receives the provider administrative hearing request, unless the parties otherwise agree to an extension. See 8.351.2 NMAC for information concerning time limits when the action is a MAD sanction. The right to request a stay is cited in 8.351.2.15 NMAC.

C. Scope and limits on provider administrative hearings:

(1) A provider administrative hearing is available to all MAD FFS providers, including providers applying for electronic health record incentive payments, who submit a request in accordance with all sections of this rule. A provider can request a hearing if:

(a) their PPA or renewal of their PPA is denied;

(b) the provider's MAD participation is suspended or terminated;

(c) the provider disagrees with a decision of MAD or its designee with respect to recovery of overpayments due to provider billing error including incorrect billing, or lack of documentation to support the medical necessity of a service, or that the service was provided, or imposition of a sanction or other remedy, with the exception of a temporary payment suspension for credible allegations of fraud; or

(d) the provider believes the requirements for timely filing of a claim as stated in 8.302.2 NMAC were met but a decision by MAD has been made that the timely filing requirements were not met.

(2) Denial or dismissal of request for provider administrative hearing: The assigned fair hearing FHB's administrative law judge (ALJ) may recommend to the MAD director in writing to deny or dismiss a provider's request for an administrative hearing when:

(a) the request is not received within the time period stated in the notice;

(b) the request is withdrawn or canceled in writing by the provider, the provider's authorized representative or legal counsel;

(c) the sole issue presented concerns a federal or state statute, regulation or rule which requires an adjustment of compensation for all or certain classes of FFS providers or services unless the reason for the provider administrative hearing request involves an alleged error in the computation of a provider's compensation;

(d) the provider fails to appear at a scheduled provider administrative hearing without good cause; a request for a provider administrative hearing may be considered abandoned and therefore dismissed if the provider, their authorized representative or legal counsel fails to appear at the time and place of the hearing, unless, within 10 calendar days after the date of the scheduled provider administrative hearing, the provider presents good cause for failure to appear; good cause includes death in the family, disabling personal illness, or other significant emergencies; at the discretion of the ALJ, other exceptional circumstances may be considered good cause;

(e) the same issue has already been appealed or decided upon as to this provider and fact situation;

(f) the matter presented for the provider administrative hearing is outside the scope of issues which are subject to the HCA provider administrative hearing process;

(g) the sole issue presented concerns a HCA contracted MCO or its subcontractor's utilization management decision, such as a decision to terminate, suspend, reduce, or deny services to its member, untimely utilization review, and provider payment issues raised by the MCO or its subcontractor; or

(h) the sole issue presented is regarding a MAD New Mexico administrative code (NMAC) rule rather than the application of the MAD NMAC rule to that provider.

D. Method: A request for a provider administrative hearing must be made in writing and must identify the provider and the one or more of the actions stated in Subsection C above.

E. Acknowledgment of request: The FHB sends acknowledgment of its receipt of a provider administrative hearing request to the provider in writing, as well as sends an electronic copy via email to the MAD designated administrative hearing staff.

[8.352.3.10 NMAC - N, 1/1/2014]

8.352.3.11 PRE-HEARING PROCEDURE:

A. Notice of hearing: Not less than 30 calendar days before the provider administrative hearing, written notice is given to all parties involved of the time, date, and place of the hearing. If an accommodation is necessary, the party must notify the assigned ALJ at least 10 calendar days prior to the hearing. The FHB includes in its written notice to the provider an explanation of the HCA provider administrative hearing process and procedures, and informs the provider HCA does not pay fees or costs incurred by the provider as a result of the provider administrative hearing or district court appeals of the final HCA provider administrative hearing decision.

B. Postponement: A provider may request, and is entitled to receive, one postponement of the scheduled provider administrative hearing, as long as it does not interfere with the 120 calendar day timeframe. Requests for more than one postponement are considered on a case-by-case basis at the ALJ's discretion.

C. Expedited hearing: The parties may request an expedited hearing in cases involving a medical assistance program (MAP) eligible recipient's health, safety, or service availability concerns. The request must be made in writing and state in detail the reasons why an expedited hearing is necessary. Granting an expedited hearing is at the discretion of the ALJ.

D. Group hearing: The ALJ may respond to a series of individual requests for hearings by conducting a single group hearing. In all group hearings, the HCA administrative hearing process governing an individual hearing is followed. Each provider, their authorized representative or legal counsel may present their case individually. If a group hearing is arranged, each affected provider has the right to withdraw from the group hearing in favor of an individual HCA provider administrative hearing.

E. Informal resolution conference: The parties are encouraged to hold an informal resolution conference before the provider administrative hearing to discuss the issues involved in the hearing. The informal resolution conference is optional and does not delay or replace the provider administrative hearing process. Conference participants may include the provider, their authorized representative or legal counsel, MAD or other responsible agency representatives, and the MAD selected claims and provider enrollment processing contractor. The purpose of the informal resolution conference is to informally review MAD's action and to determine whether the issues can be resolved by mutual agreement. The issues to be decided at the provider administrative hearing may also be clarified or further defined. Regardless of the outcome of the informal resolution conference, a provider administrative hearing is still held, unless the provider submits a written withdrawal of the request of the provider administrative hearing.

F. Pre-hearing conference: The assigned ALJ schedules a pre-hearing conference within 30 calendar days of the receipt of the provider's request for a HCA provider administrative hearing. A pre-hearing conference is an informal proceeding and may occur telephonically.

(1) Purpose of conference: The purposes of the pre-hearing conference include, but are not limited to:

(a) expediting the disposition of the action;
(b) identification, clarification, formulation and simplification of issues;
(c) resolution of some or all issues;
(d) exchange of documents and information;
(e) preparing stipulations of fact to avoid unnecessary introduction of evidence at the hearing;
(f) review of audit findings;
(g) reconsideration of a suspension or withholding of payments;
(h) identifying the number of witnesses; and
(i) facilitating the settlement of the case.

(2) Scheduling: A scheduling order shall be entered into, which shall set the due date for the summary of evidence (SOE), due date for exhibits, and sets the date for the provider administrative hearing. The order shall be issued as soon as practicable, but in any event within 30 calendar days of the request for provider administrative hearing.

(3) Continuations and rescheduling: A pre-hearing conference may be continued or rescheduled with the consent of all parties after the 30 calendar day time limit.

(4) Settlements, stipulations and admissions: No offer of settlement made in a pre-hearing conference is admissible as evidence at the later provider administrative hearing. Stipulations and admissions are binding and may be used as evidence at the provider administrative hearing. Any stipulation, settlement or consent order reached between the parties is written and signed by the ALJ and all parties to the provider administrative hearing.

(5) Timeliness: The pre-hearing conference will not delay or replace the provider administrative hearing itself. Pre-hearing conferences may include the provider, their authorized representative or legal counsel, MAD or other responsible agency representatives, and the MAD selected claims and provider enrollment processing contractor. Subsequent to the conference or in the event that any of the parties to the provider administrative hearing fail to participate, the scheduled hearing is still held, unless the provider submits a written request for withdrawal.

(6) Unresolved issues: If all matters in controversy are not resolved at the pre-hearing conference, the ALJ sets a provider administrative hearing date within 30 calendar days of the last conference date, or at a later time agreed to by all parties, recognizing the 120 calendar day timeframes.

(7) Written summaries: The ALJ may request the parties to submit a written summary of all issues resolved at the pre-hearing conference.

(8) Pre-hearing order: The may, at their sole discretion, prepare or ask the parties to prepare a pre-hearing order. The pre-hearing order may contain:

(a) statements of any contested facts and issues;

(b) stipulation of matters not in dispute;

(c) list of witnesses to be called and the subject of their testimony;

(d) list of exhibits;

(e) discovery directives; or

(f) other matters relevant to the issues.

(9) Points of law: The ALJ may direct the parties to submit memoranda on points of law to inform the final decision, and may dictate the length and scope of the submissions.

G. Summary of evidence (SOE): A summary of evidence (SOE) is a document submitted by MAD that provides preliminary information concerning the basis of its or its selected claims and provider enrollment processing contractor's action. The SOE may be amended by MAD at any point prior to the pre-hearing if the ALJ and the provider, their authorized representative or legal counsel receives copies of the amended SOE at least two working days of the pre-hearing conference.

(1) The SOE must be provided at least 10 working days prior to the pre-hearing conference or if the pre-hearing conference is not held, within 10 working days prior to the scheduled provider administrative hearing date.

(2) The failure of MAD to timely provide the SOE may, at the ALJ's discretion, result in its exclusion or a continuance of the hearing.

(3) MAD staff or its designee is responsible for the preparation of the SOE and coordination of parties and witnesses. MAD is responsible for the submission of the SOE to all parties.

(4) The summary of evidence shall contain:

(a) the provider's name, telephone number and address and the status of any previous or concurrent appeal through the MAD or its selected claims and provider enrollment processing contractor;

(b) the action, proposed action or inaction being appealed;

(c) information on which the action or proposed action is based with supporting documentation and correspondence; and

(d) applicable federal and state law, regulations, statutes, rules or any combination of these.

H. Availability of provider evidence:

(1) The provider, their authorized representative or legal counsel will provide at least ten calendar days prior to the hearing to the FHB assigned ALJ any document to be introduced as evidence at the pre-hearing conference. The SOE may be amended by the provider, their authorized representative or legal counsel at any point prior to the pre-hearing if the ALJ and MAD receive copies of the amended SOE at least within two working days of the pre-hearing conference. The FHB will forward to the MAD administrative hearings unit copies

of such evidence. MAD will then make these available to its selected claims and provider enrollment processing contractor.

(2) Failure of the provider, their authorized representative or legal counsel to timely provide the documentary evidence may result in its exclusion or a continuance of the provider administrative hearing at the discretion of the ALJ.

I. **Availability of information:** MAD must:

(1) provide, on request, in a timely manner and without charge, any documents in its possession concerning the underlying action, that are not already in the provider's possession, and that are necessary for a provider to decide whether to request a hearing or to prepare for a provider administrative hearing; and

(2) allow the provider, their authorized representative or legal counsel to examine all documents to be used at the provider administrative hearing at a reasonable time before the date of the provider administrative hearing and during such hearings; documents or records which the provider would not otherwise have an opportunity to challenge or contest, may not be introduced at the provider administrative hearing or be taken into consideration by the ALJ.

[8.352.3.11 NMAC - N, 1/1/2014]

8.353.3.12 HEARING STANDARDS:

A. **Rights at hearing:** The parties are given an opportunity to:

(1) present their case or have it presented by their authorized representative or legal counsel;

(2) bring witnesses to present information relevant to the case;

(3) submit evidence to establish all pertinent facts and circumstances in the case;

(4) advance arguments without undue interference; and

(5) question or contradict any testimony or evidence, including an opportunity to confront and cross-examine opposing witnesses.

B. **ALJ:** Hearings are conducted by an impartial official, the ALJ, who:

(1) does not have any personal stake or involvement in the case; and

(2) was not involved in the determination or the action which is being contested; if the ALJ had any involvement with the action in question, including giving advice or consultation on the points at issue, or is personally related in any relevant degree to the parties, the ALJ must disqualify themselves as the ALJ for that specific case.

(3) **Authority and duties of the ALJ:** The ALJ must:

(a) explain how the provider administrative hearing will be conducted to participants at the start of the hearing, before administering oaths;

(b) administer oaths and affirmations;

(c) request, receive, and make part of the record all evidence considered necessary to decide the issues raised;

(d) regulate the conduct and the course of the provider administrative hearing and any pre-hearing conference to ensure an orderly hearing;

(e) request, if appropriate, an independent medical assessment or professional evaluation from a source mutually satisfactory to the parties; and

(f) produce the provider administrative hearing report and recommendation for review and final decision by the MAD director or designee.

(4) **Appointment of ALJ:** The ALJ is appointed by the HCA FHB chief upon receipt of the request for hearing. All communications are to be addressed to the assigned ALJ.

C. **Evidence and procedure:** Formal rules of evidence and civil procedure do not apply. A free, orderly exchange of relevant information is necessary for the decision-making process.

(1) **Admissibility:** All evidence is admissible subject to the ALJ's authority to limit irrelevant, repetitive or unduly cumulative evidence and their ability to conduct an orderly hearing. The ALJ must admit evidence that is relevant to those allegations against the provider included in the notice of recovery of overpayment, sanction or other remedy, application denial, or application termination.

(2) **Confidentiality:** The confidentiality of records is to be maintained. Information which is not presented during the provider administrative hearing in the presence of the provider, their authorized representative or legal counsel, and the MAD representative may not be used by the ALJ in making the provider administrative hearing recommendation except as allowed by Subsection E of Section 13 of this part.

(3) **Administrative notice:** The ALJ may take administrative notice of any matter in which courts of this state may take judicial notice.

(4) **Privilege:** The rules of privilege apply to the extent that they are required to be recognized in civil actions in the district courts of New Mexico.

(5) **Medical issues:** In a case involving medical and behavioral health issues, the parties may submit expert testimony, reports, affidavits or medical and behavioral health records into record as necessary. Admission of this evidence is at the discretion of the ALJ. All parties to the provider administrative hearing have the right to examine any documents which may influence the decision.

D. **Burden of proof:** MAD has the burden of proving the basis to support its proposed action by a preponderance of the evidence. In cases involving the imposition of civil money penalties against a NF provider, MAD's conclusion about the NF's level of noncompliance must be upheld unless clearly erroneous.

E. **Record of the provider administrative hearing:** A hearing is electronically recorded. The recording is placed on file at the FHB and is available to the parties for 60 calendar days following the decision. In addition to the recorded proceedings, the record of the provider administrative hearing includes any pleadings, documents, or other exhibits admitted into evidence. Any of the parties to the provider administrative hearing may request one digital copy of the recordings without charge. Subsequent copies will be charged at a rate HCA sets for any other digital request.

[8.352.3.12 NMAC - N, 1/1/2014]

8.352.3.13 **CONDUCTING THE HEARING:** A provider administrative hearing is conducted in an orderly manner and in an informal atmosphere. The provider administrative hearing is conducted in person or telephonically and is not open to the public. The ALJ has the authority to limit the number of persons in attendance if space or other considerations dictate.

A. **Opening the provider administrative hearing:** The hearing is opened by the ALJ. Individuals present must identify themselves for the record. The ALJ explains their role in the proceedings, and that the final decision on the appeal will be made by the MAD director after review of the proceedings and the ALJ's recommendation. The order of testimony is described, and the oath is administered to all who will testify at the hearing.

B. **Order of testimony:** The order of testimony at the provider administrative hearing is as follows:

(1) opening statements of parties or their representatives;

(2) presentation of MAD's case; if witnesses are called, the order of examination of each witness is:

(a) examination by the MAD representative;

(b) cross examination by the provider, their authorized representative or legal counsel; and

(c) opportunity to redirect the witness;

(3) presentation of the provider's case; if witnesses are called, the order of examination of each witness is:

(a) examination by provider, their authorized representative or legal counsel;

(b) cross examination by MAD or its selected claims and provider enrollment processing contractor; and

(c) opportunity to redirect the witness;

(4) presentation of rebuttal evidence by MAD and provider, respectively;

(5) the ALJ may direct further questions to the MAD representative, the provider, or any witnesses to clarify inconsistencies or obtain an adequate evidentiary record; and

(6) the ALJ may ask parties to summarize and present closing arguments.

C. **Written closing argument:** At the discretion of the ALJ, the parties may be directed to make closing arguments, or submit written memoranda on points of law.

D. **Continuance:** The ALJ may continue the provider administrative hearing upon the request of either party or on their own motion, for admission of additional testimony or evidence. The granting of a continuance is at the discretion of the ALJ and can only be allowed when the timeliness of a decision is not jeopardized by the continuance or the parties have agreed to an extension of the decision time frame. The reasons for the continuance must be stated for the record. Written notice of the date, time, and place of the continued hearing is sent to the parties if these are not set at the time of the continuance.

E. **Additional evidence:** If the ALJ needs additional evidence to further clarify documentary evidence presented during the hearing, he may close the hearing but keep the record open and direct the parties to submit such clarifying evidence. Each party receives a copy of the direction for further evidence and the

documentary evidence being submitted and is allowed an opportunity to respond to the submission, in writing, within 10 calendar days of its receipt. The additional evidence and responses become part of the hearing record.

F. Re-opening a hearing: The ALJ, at their discretion, may re-open a hearing when the evidentiary record fails to address an issue that is relevant to resolution of a provider administrative hearing request. The hearing can only be re-opened if the timeliness of the decision is not jeopardized or the parties have agreed to an extension of the decision timeframes. Written notice of the date, time and place of the re-opened hearing is sent by the FHB to the parties not less than 10 calendar days before the date of the re-opened provider administrative hearing.

[8.352.3.13 NMAC - N, 1/1/2014]

8.352.3.14 HEARING DECISION: The final HCA provider administrative hearing decision concerning the hearing is made by the MAD director or designee after review of the record and the ALJ's report and recommendation.

A. Decision based on the record: The ALJ's recommendation may be adopted or rejected in a final written decision by the MAD director or designee on issues that were the subject of the hearing. The MAD director or designee specifies the reasons for the decision and identifies the regulatory authority and the evidence supporting the decision, including the record created by the provider administrative hearing, applicable federal and state law, regulations and NMAC rules, policies and instructions or any combination of these. No person who participated in the original action under appeal or in the provider administrative hearing may participate in arriving at a final decision.

B. ALJ recommendation: The ALJ reviews the record of the provider administrative hearing and all applicable federal and state law, regulations and NMAC rules, policy and instructions or any combination of these, and evaluates the evidence submitted. The ALJ submits the complete record of the hearing, along with their written recommendation to the MAD director.

(1) Content of recommendation. The ALJ specifies the reasons for their conclusions, identifies the supporting evidence, references the applicable federal and state law, regulations and NMAC rules, policies and instructions or any combination of these, and responds to the arguments of the parties in a written report and recommendation.

(2) The ALJ recommends:

(a) in favor of the provider if MAD's action or proposed action is not supported by a preponderance of the evidence available as a result of the provider administrative hearing;

(b) in favor of MAD, if the preponderance of the evidence available supports the action or proposed action; or

(c) any other result supported by the record.

C. Review of recommendation: The provider administrative hearing file and recommendation are reviewed by the MAD director or designee to ensure conformity with applicable federal and state law, regulations and NMAC rules, policies and instructions or any combination of these.

D. Final decision: The ALJ's recommendation may be adopted or rejected in a final written decision by the MAD director or designee on issues that were the subject of the hearing. The MAD director specifies the reasons for the decision and identifies the regulatory authority and the evidence supporting the decision, including the record created by the provider administrative hearing, applicable federal and state law, rules and policies or any combination of these. No person who participated in the original action under appeal or in the hearing may participate in arriving at a final decision.

E. Notice to parties: The parties receive the written decision, including the effective date of sanctions, terms of sanctions, and amounts of overpayment to be recovered by MAD. When the provider is represented by legal counsel, counsel must receive the decision. The notice of the decision includes an explanation that the parties have exhausted all administrative remedies and may pursue judicial review of the decision. This explanation includes information on time limits, and where and how to pursue judicial review.

[8.352.3.14 NMAC - N, 1/1/2014]

8.352.3.15 IMPLEMENTATION OF DECISION: The final HCA provider administrative hearing decision is binding on all issues that were the subject of a hearing, as to the provider, unless stayed by court order pending appeal. The decision is implemented within the time frames specified below.

A. Decision favorable to HCA: Decisions favorable to MAD are implemented immediately, unless stayed by court order.

B. Decision favorable to provider: If the decision is in favor of the provider, MAD must immediately lift any sanctions in place and remit to the provider any funds being held pending the decision.
[8.352.3.15 NMAC - N, 1/1/2014]

8.352.3.16 JUDICIAL REVIEW:

A. Right of appeal: If the final HCA provider administrative hearing decision upholds MAD's original action or proposed action, the provider has the right to pursue judicial review of the decision and is so notified of that right in the decision.

B. Timeliness: The provider has 30 calendar days from the date of the provider administrative hearing decision to appeal that decision by filing an appropriate action for judicial review with the clerk of the first judicial district court and sending a copy of the notice of action to HCA and the ALJ.

C. Jurisdiction and standard: All appeals to the district court are based on a review of the record made at the hearing. The HCA office of general counsel files one copy of the hearing record with the clerk of the first judicial district court and furnishes one copy to the provider and their counsel within 20 calendar days after receipt of the notice of appeal.

D. Stay pending appeal: The district court decides, upon motion duly filed, whether the filing of the appeal will operate as a stay of the HCA final provider administrative hearing decision. If a stay is granted, the office of general counsel notifies appropriate staff concerning any necessary action.
[8.352.3.16 NMAC - N, 1/1/2014]

HISTORY OF 8.352.3 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 354 PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND PATIENT STATUS POLICIES
PART 2 PASRR AND PATIENT STATUS HEARINGS

8.354.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.354.2.1 NMAC - Rp, 8.354.2.1 NMAC, 8/1/2014; A, 7/1/2024]

8.354.2.2 SCOPE: The rule applies to the general public.
[8.354.2.2 NMAC - Rp, 8.354.2.2 NMAC, 8/1/2014]

8.354.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended, or by state statute. See Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.354.2.3 NMAC - Rp, 8.354.2.3 NMAC, 8/1/2014; A, 7/1/2024]

8.354.2.4 DURATION: Permanent.
[8.354.2.4 NMAC - Rp, 8.354.2.4 NMAC, 8/1/2014]

8.354.2.5 EFFECTIVE DATE: August 1, 2014, unless a later date is cited at the end of a section.
[8.354.2.5 NMAC - Rp, 8.354.2.5 NMAC, 8/1/2014]

8.354.2.6 OBJECTIVE: 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.
[8.354.2.6 NMAC - Rp, 8.354.2.6 NMAC, 8/1/2014]

8.354.2.7 DEFINITIONS:

A. "**Administrative law judge (ALJ)**" means the HCA fair hearings bureau's (FHB) appointed judge to oversee the claimant's administrative hearing process and render a recommendation to the medical assistance division (MAD) director.

B. "**Adverse action**"**:** means:

(1) the belief of a claimant or their authorized representative that their preadmission or annual resident review (PASRR) determination is erroneous; or

(2) the belief of a claimant or their authorized representative that the claimant's NF determination to transfer or discharge them is erroneous.

C. "**Authorized representative**" means the individual designated to represent and act on the claimant's behalf during the appeal process. The claimant or the claimant's authorized representative must provide formal 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 claimant.

D. "**Claimant**" means the individual requesting a HCA administrative hearing that is claiming to be affected by an adverse action or actions taken or intended to be taken by MAD, its utilization review (UR) contractor, the MCO or their designees.

E. "**Denial**" means the decision not to authorize the medical assistance program (MAP) eligible recipient or a MCO member's requested services, item, or level of care (LOC).

F. "**Designee**" means a state agency or an institution MAD has designated to be responsible for:

(1) conducting a PASRR level I screening to identify if a MAP eligible recipient or a MCO member has a mental illness or an intellectual disability; or

(2) conducting a PASRR level II evaluation.

G. "**DDSD**" means the developmental disabilities support division of the HCA, which conducts the PASRR level II evaluation for a MAP eligible recipient or a MCO member that has been identified through a PASRR level I screen.

H. "**HCA administrative hearing**" or "fair hearing" means an informal evidentiary hearing that is conducted by the FHB so that evidence may be presented as it relates to an adverse action taken, or intended to be taken, by MAD, it UR contractor, or the MCO, or their designees.

I. "**MAD**" means the medical assistance division, which administers medicaid and other medical assistance programs under HCA.

J. "**MAP**" means the medical assistance programs administered by MAD.

K. "**MCO**" means a member's HCA contracted managed care organization.

L. "**Member**" means a MAP eligible recipient enrolled in a HCA contracted MCO. Once a member requests a HCA administrative hearing, the member is referred to as a claimant.

M. "**Notice of action**" means the notice issued by MAD, its UR contractor, the MCO or their designees of their intent to take an adverse action against eligible recipient or a member in the form an adverse determination is made with regard to the preadmission or annual resident review requirements or a discharge or transfer from a NF.

N. "**Nursing facility (NF)**" means a MAD enrolled, and as appropriate, a MCO contracted, NF which meets the requirements as described in 8.312.2 NMAC and is designated by MAD, its UR contractor, or the MCO to complete a PASRR level I screen for a MAP eligible recipient or a MCO member.

O. "**Parties to the hearing**" are MAD, its UR contractor, the MCO or their designees and the claimant or their authorized representative.

[8.354.2.7 NMAC - Rp, 8.354.2.7 NMAC, 8/1/2014]

8.354.2.8 MISSION STATEMENT: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.

[8.354.2.8 NMAC - Rp, 8.354.2.8 NMAC, 8/1/2014]

8.354.2.9 CLAIMANT OR THE CLAIMANT'S AUTHORIZED REPRESENTATIVE AND HCA ADMINISTRATIVE HEARING PROCESS: HCA has established a hearing process for a MAP eligible recipient or a MCO member who is adversely affected by the preadmission screening and annual resident review (PASRR) or the transfer or discharge from a NF as required by Section 1919(e)(7) of the Social Security Act.

A. Claimant:

(1) When an adverse action (see Subsection B of 8.354.2.7 NMAC) is intended or taken against a MAP eligible recipient by MAD, its UR contractor or their designee, the MAP eligible recipient may file as a claimant to request a HCA administrative hearing.

(2) When an adverse action (see Subsection B of 8.354.2.7 NMAC) is intended or taken against a member by their MCO or its designee, the member may file as a claimant to request a HCA administrative hearing. A member is not required to first exhaust their MCO appeal process prior to filing for a HCA administrative hearing when affected by an adverse action listed in 8.354.2.7 NMAC. Upon requesting a HCA administrative hearing, the member is referred to as the claimant and is governed by the remaining sections of this rule.

(3) A claimant must request a HCA administrative hearing within 90 calendar days of the mailing of either the notice of action or the denial for new service.

B. A claimant or the claimant's authorized representative may have legal counsel assist them during the HCA administrative hearing process. If a claimant or the claimant's authorized representative, MAD, its UR contractor, the MCO or their designees retains legal counsel, that legal counsel must submit a notice of appearance to the assigned ALJ. The ALJ will forward this notice to the MAD administrative hearings unit (MAD AHU).

C. The claimant or claimant's authorized representative may also chose a relative, friend or other spokesperson (spokesperson) to represent or assist them in the HCA administrative hearing process.

[8.354.2.9 NMAC - Rp, 8.354.2.9 NMAC, 8/1/2014]

8.354.2.10 RIGHT TO A PASRR AND NURSING FACILITY TRANSFER OR DISCHARGE HCA ADMINISTRATIVE HEARING: This specific type of a HCA administrative hearing is an informal evidentiary hearing that is conducted by the FHB so that evidence may be presented as it relates to an adverse action taken or intended to be taken, against an individual by MAD, it UR contractor, the MCO and their designees. MAD or the MCO must grant an individual or the individual's authorized representative the opportunity for a HCA

administrative hearing under specific circumstances pursuant to 42 CFR Section 431.220(a) and 27-3-3 NMSA 1978. A HCA administrative hearing occurs telephonically between the parties to the HCA administrative hearing and the assigned FHB ALJ.

A. An individual or the individual's authorized representative may request a HCA administrative hearing based on their belief that MAD, its UR contractor, the MCO or their designees intends to take, or has taken, an adverse action.

B. MAD, its UR contractor, the MCO or their designees will not be responsible for any fees or costs, incurred by the individual or their authorized representative as a result of a HCA administrative hearing, or if they file an appeal of the HCA administrative hearing final decision to a New Mexico district court.

[8.354.2.10 NMAC - Rp, 8.354.2.10 NMAC, 8/1/2014]

8.354.2.11 NOTICE, TIME LIMITS, POSTPONEMENT, OR THE DISMISSAL OF A HCA ADMINISTRATIVE HEARING REQUEST:

A. Notice:

(1) In cases involving a PASRR determination or the determination to transfer or discharge the claimant from a NF, the notice of action is submitted by MAD, it UR contractor, the MCO or their designees. MAD, its UR contractor, the MCO or their designees shall issue a "notice of action" to an individual when it intends to take an adverse action against the individual. When the notice of action is concerning the LOC determination the MAP eligible recipient or the member currently has, the notice of action shall be sent not less than 10 calendar days prior to the date of MAD, its UR contractor, the MCO or their designee's intended adverse action.

B. Exceptions to a notice of action: Notwithstanding the notice requirement set forth in the preceding Subsection, MAD, its UR contractor, the MCO or their designees may mail a notice of action to the individual or the individual's authorized representative or estate (in the event of an individual's death) no later than the actual date of the intended adverse action when:

(1) MAD, its UR contractor, the MCO or their designees has confirmed the death of the individual;

(2) MAD, its UR contractor, the MCO or their designees has received a clear written statement signed by the individual or the individual's authorized representative that all or a portion of an authorized service is no longer wanted;

(3) the individual or the individual's authorized representative provides information to MAD, its UR contractor, the MCO or their designees that indicates their understanding that such information may require MAD, its UR contractor, the MCO or their designees to take the adverse action;

(4) MAD, its UR contractor, the MCO or their designees learns the individual is residing in an institution, which renders the individual ineligible for MAP enrollment and MAD services;

(5) MAD, its UR contractor, the MCO or their designees cannot determine the physical location of either the individual, or if designated, their authorized representative;

(6) MAD, its UR contractor, the MCO or their designees have established that the individual has been accepted for medicaid services outside of the state; or

(7) the primary care provider for the individual has prescribed a change in their LOC.

C. Time limits: an individual or their authorized representative must adhere to the time limits for requesting for a continuation of a benefit and for requesting a HCA administrative hearing.

(1) Requesting a HCA administrative hearing: An individual has 90 calendar days from the date of the notice of action to request a HCA administrative hearing. To be considered timely, the request must be received by one of the following: FHB, the individual's local income support division (ISD) office, offices of DOH-DDSS, the NF the individual resides at, or the MAD's director's office no later than the close of business on the 90th calendar day immediately following the date of the notice of action. If the request for a HCA administrative hearing is mailed by the individual, the request must be postmarked by the 90th calendar day from the date of the notice of action.

(2) Continuation of a benefit:

(a) A claimant may request the current benefit that is the subject of an adverse action continue while their HCA administrative hearing proceeds. A request for a continuation of a benefit shall be accorded to any claimant who requests the continuation within 10 calendar days of the mailing of the notice of action by MAD, its UR contractor, the MCO or their designees. The continuation of the benefit will be the same as the claimant's current benefit or LOC. MAD, its UR contractor, the MCO or their designees must provide information in its notice of action of a claimant rights and limitations to continue a benefit during their HCA administrative hearing process.

(b) A continuation of the benefit in a NF is not approved for a claimant:

(i) when the health or safety of other residents in the NF would be endangered by the claimant's continued presence;

(ii) the claimant's health improves sufficiently to allow a more immediate transfer or discharge;

(iii) an immediate transfer or discharge is required by the claimant's urgent medical needs; or

(iv) the claimant has not resided in the NF for 30 consecutive calendar days or more.

(4) The HCA administrative hearing is concluded within 90 calendar days from the date the claimant or the claimant's authorized representative requests a HCA administrative hearing unless the claimant or the claimant's authorized representative agrees to extend the HCA administrative hearing time frame in order to facilitate the process.

D. Dismissal of a hearings request: HCA authorizes FHB to issue a dismissal of a claimant's request for a HCA administrative hearing when:

(1) the request is not received within the time periods specified in the rules and notice of action;

(2) the request is withdrawn or cancelled in writing by the claimant or the claimant's authorized representative;

(3) the sole issue presented concerns a federal or state statue, regulation or rule requiring an adjustment of benefits for all or certain classes of individuals, including, but not limited to, a termination, modification, reduction, or suspension of a service;

(4) the same issue involving the claimant has already been subject to a final decision by the MAD director following a HCA administrative hearing;

(5) the sole issue presented is regarding a New Mexico administrative code (NMAC) rule rather than the application of the rule to the claimant; or

(6) the claimant or the claimant's authorized representative fails to appear at a scheduled hearing without good cause; the claimant or the claimant's authorized representative request for a HCA administrative hearing may be considered abandoned and therefore dismissed if the claimant or the claimant's authorized representative fails to appear telephonically or in person (if the claimant or the claimant's authorized representative has elected to participate in this manner) at the time of the hearing; however, if the claimant or the claimant's authorized representative presents to the ALJ good cause for failure to appear within 10 calendar days after the date of the HCA administrative hearing, the HCA administrative hearing may be rescheduled; good cause includes a death in the family, a disabling personal illness or another significant emergency, or at the discretion of the ALJ, as appropriate, for another exceptional circumstance; if the ALJ agrees the claimant or the claimant's authorized representative showed good cause, the HCA administrative hearing will be reschedule.

[8.354.2.11 NMAC - Rp, 8.354.2.10 and 8.354.11 NMAC, 8/1/2014]

8.354.2.12 SCHEDULING OF A HCA ADMINISTRATIVE HEARING:

A. Scheduling: The ALJ will assign a date for a HCA administrative hearing that affords the MAD director the opportunity to render their HCA administrative hearing final decision within the 90 calendar day time limit. The claimant or the claimant's authorized representative must agree via a recorded message to the assigned ALJ or in writing to the assigned ALJ to extend the 90 calendar day time limit up to an additional 30 calendar days to provide the necessary time for the HCA administrative hearing to be conducted and a final decision rendered. The ALJ has the authority on a case-by-case basis to extent the 90-calendar day time limit to more than 30-calendar days when the claimant or the claimant's authorized representative requests such an extension in writing. If an accommodation is necessary for a disability, the claimant or the claimant's authorized representative must notify FHB at least 10 calendar days prior to the HCA administrative hearing.

B. Rescheduling: Any party to a HCA administrative hearing may request, and is entitled to receive, one postponement of a HCA administrative hearing, as long as it does not interfere with the HCA administrative hearing final decision time frames.

(1) A request for more than one postponement is at the ALJ's discretion on a case-by-case basis.

(2) The claimant or the claimant's authorized representative must agree to allow the ALJ to extend the 90 calendar day time limit up to an additional 30 calendar days to provide the necessary time for the HCA administrative hearing to be conducted and a final decision rendered.

C. Expedited HCA administrative hearing: Any party may request an expedited HCA administrative hearing in cases involving a claimant's health, safety, or service availability issues. The request must be made in writing to the claimant's assigned ALJ. The request must state in detail the reasons why an expedited HCA administrative hearing is necessary. The granting of an expedited HCA administrative hearing is at the discretion of the ALJ.
[8.354.2.12 NMAC - Rp, 8.354.2.11 NMAC, 8/1/2014]

8.354.2.13 SUMMARY OF EVIDENCE (SOE):

A. Summary of evidence.

(1) At a HCA administrative hearing, MAD has the burden to prove through the preponderance of the evidence that an adverse action against a claimant is correct. A summary of evidence (SOE) provides information concerning the basis of MAD, its UR contractor, the MCO or their designee's adverse action. MAD may have its UR contractor, HCA MCO or its designee complete an SOE for final review by MAD; however, MAD is ultimately responsible for the submission of its SOE. An SOE is submitted by MAD to the ALJ and claimant or the claimant's authorized representative within specified time-frames.

(2) A claimant or the claimant's authorized representative may submit a SOE to provide the ALJ with information to refute MAD's SOE. A claimant or the claimant's authorized representative is not required to provide a SOE as the burden of proof falls on MAD.

(3) The MAD SOE shall, at a minimum, contain:

(a) the claimant's name, and as applicable, their authorized representative's or legal counsel's telephone number and address, and the status of any previous or concurrent appeal through their MCO or MAD UR contractor;

(b) the adverse action against the claimant;

(c) the documentation supporting MAD, its UR contractor, the MCO or their designee basis for the intended or taken adverse action; and

(d) any applicable federal or state statutes, regulations, rules or any combination of these; however, that a failure by MAD, the UR contractor, the MCO or their designee to submit an applicable statute, regulation or rule shall not constitute per se grounds for the ALJ to find that MAD, the UR contractor, the MCO or their designee failed to meet its burden of proof.

B. Timeframes.

(1) The HCA administrative hearing.

(a) MAD's SOE shall be delivered to the ALJ and the parties to the HCA administrative hearing at least 10 working days prior to the HCA administrative hearing.

(b) MAD's SOE may be amended by MAD at any point prior to the HCA administrative hearing if the ALJ and the claimant or the claimant's authorized representative is delivered copies of the amended SOE at least two working days prior to the HCA administrative hearing. MAD is responsible for providing its UR contractor, the MCO or their designee the amended SOE.

(c) If the claimant or their authorized representative has a SOE that they want entered into evidence for the HCA administrative hearing, they must provide the ALJ the SOE not less than three working days prior to the HCA administrative hearing. The ALJ will provide MAD AHU with a copy of the claimant's SOE within one working day of its receipt. The MAD AHU will provide a copy of the SOE to one or more as appropriate: its UR contractor, the MCO or their designee within one working day of its receipt.

(d) If the claimant or the claimant's authorized representative has an amendment to their SOE, they shall follow the process in Subparagraph (c) of Paragraph (1) of Subsection B of this section.

(2) The failure of MAD to provide its SOE in a timely manner may, at the ALJ's discretion result in its exclusion or a postponement of the HCA administrative hearing charged against MAD.

(3) If the claimant or the claimant's authorized representative fails to provide the assigned ALJ a SOE or any amendments to the SOE within the specified time-frames, and the claimant or the claimant's authorized representative wishes to submit such documents for consideration at the HCA administrative hearing, the claimant or the claimant's authorized representative will utilize their one allowed postponement opportunity in which to submit the SOE or any amendments to the ALJ. The ALJ will follow the process in Subparagraph (b) of Paragraph (1) of Subsection B of this section for the disbursement of the amended SOE.

C. Availability of information to the claimant or the claimant's representative: MAD, its UR contractor, the MCO or their designee shall:

(1) provide upon request to the claimant or their authorized representative, any document in its possession concerning its adverse action against the claimant that is not already in its SOE;

(2) provide the claimant or the claimant's authorized representative the requested documents and such documents will be provided by MAD, its UR contractor, the MCO or their designee to the claimant or the claimant's authorized representative in a timely manner and without charge.

D. No party to a HCA administrative hearing may present into evidence, as part of an amended SOE, any document or record that any other party of the hearing has not received at least two working days prior to the HCA administrative hearing. The ALJ will not take such information into consideration when reaching their recommendation.

[8.354.2.13 NMAC - Rp, 8.354.2.11 NMAC, 8/1/2014]

8.354.2.14 ADMINISTRATIVE HEARING STANDARDS:

A. Administrative law judge.

(1) A HCA administrative hearing is conducted by an impartial official who:

(a) does not have any personal stake or involvement in the case; and

(b) was not involved in the determination or the action which is being contested; if the ALJ had any involvement with the action in question, including giving advice or consultation on the points at issue, or is personally related in any relevant degree to the parties, the ALJ must disqualify theirself as the assigned ALJ for that case.

(2) In conducting a HCA administrative hearing, the ALJ must:

(a) explain how the HCA administrative hearing will be conducted to participants at the start of the hearing, before administering oaths;

(b) administer oaths and affirmations;

(c) request, receive, and make part of the record all evidence that has been provided to each party within the required time-frames that the ALJ considers necessary to decide the issues raised;

(d) regulate the conduct and the course of the HCA administrative hearing to ensure an orderly HCA administrative hearing;

(e) request, if appropriate, an independent physical or behavioral health assessment or a professional evaluation from a source mutually satisfactory to the parties at no cost to the claimant; and

(f) produce the ALJ HCA administrative hearing report that includes findings of fact and recommendations for the MAD director's consideration.

(3) Appointment of the ALJ: the ALJ is appointed by FHB upon receipt of the request for a HCA administrative hearing. The ALJ will be copied on all written communications between the parties to HCA administrative hearing to ensure all parties are free of undue influence and receive written notices and documents within the required time-frames.

B. Record of the hearing: A HCA administrative hearing is digitally recorded. The digital recording, findings of fact, SOEs and any amendments, pleadings, documents, NMAC rules, other relevant statutes or other exhibits admitted into evidence, as well as the ALJ's recommendations will be available to the parties for one calendar year following the HCA administrative hearing final decision. These items are referred to as the record of the HCA administrative hearing. Parties to the HCA administrative hearing may request one copy of the record without charge. Subsequent copies will be charged at a pre-determined rate set by HCA.

C. Rights at an administrative hearing: A claimant or the claimant's authorized representative will provide the assigned ALJ a signed release-of-information in order for a designated spokesperson to assist or represent the claimant or the claimant's authorized representative in presenting the claimant's case at a HCA administrative hearing. If a claimant or the claimant's authorized representative, MAD, its UR contractor, the MCO or their designee retains legal counsel, that legal counsel must submit a notice appearance to the assigned ALJ and the ALJ will forward this information to the MAD administrative hearings unit (MAD AHU). The parties are given an opportunity to:

(1) call witnesses to present information relevant to the case;

(2) submit evidence to establish all pertinent facts and circumstances in the case;

(3) advance arguments without undue interference; and

(4) question or contradict any testimony or evidence, including an opportunity to confront and cross-examine opposing witnesses.

D. Evidence and procedure: Formal rules of evidence and civil procedure do not apply to a HCA administrative hearing. A free, orderly exchange of relevant information is necessary for the decision-making process.

(1) Admissibility: all relevant evidence is admissible subject to the ALJ's authority to limit repetitive, scandalous or unduly cumulative evidence and their ability to conduct an orderly HCA administrative

hearing. The ALJ must admit evidence that is relevant to the intended or taken adverse action by MAD, its UR contractor, the MCO or their designees.

(2) Confidentiality: the confidentiality of records is to be maintained;

(3) Information not entered in the hearing record: information which is not presented during the HCA administrative hearing in the presence of the claimant or the claimant's authorized representative, MAD, its UR contractor, the MCO or their designees may not be used by the ALJ in making their record of fact finding and recommendation.

(4) Administrative notice: the ALJ may take administrative notice of any matter in which courts of this state may take judicial notice.

(5) Privilege: the rules of privilege apply to the extent that they are required to be recognized in civil actions in the district courts of New Mexico.

(6) Medical issues: in a case involving physical or behavioral health issues, the parties may submit expert testimony, reports, affidavits or health care records into evidence as necessary. Admission of this evidence is at the discretion of the ALJ and must meet the SOE time-frames for submission. All parties of the HCA administrative hearing have the right to examine any documents which may influence the HCA administrative hearing final decision.

[8.354.2.14 NMAC - Rp, 8.354.2.12 NMAC, 8/1/2014]

8.354.2.15 CONDUCTING THE HCA ADMINISTRATIVE HEARING: A HCA administrative hearing is conducted in an orderly manner and in an informal atmosphere. The HCA administrative hearing is normally conducted telephonically and is not open to the general public. The assigned ALJ has the authority to limit the number of persons in attendance as necessary for the ALJ to control the hearing.

A. Opening the hearing: The HCA administrative hearing is opened by the assigned ALJ. All individuals present at the hearing must identify themselves for the record, including when the claimant or the claimant's authorized representative has other representation or legal counsel to assist them during the HCA administrative hearing. The ALJ shall explain their role in conducting the HCA administrative hearing that they will submit the record of the HCA administrative hearing to the MAD director and that the final decision of the HCA administrative hearing will be made by the MAD director or designee after review of the record of the HCA administrative hearing.

B. Order of testimony: The order of testimony is described, and the oath is administered to all who will testify at the HCA administrative hearing. Because the burden of proof is with MAD, it is at the claimant or the claimant's authorized representative's discretion to call witnesses or to present evidence. The order of testimony at the HCA administrative hearing is as follows:

(1) opening statements of parties, authorized representatives, or designees, or if the claimant or the claimant's authorized representative through a signed statement has identified a designated spokesperson or legal counsel to assist them during the HCA administrative hearing process;

(2) presentation of MAD's case; if witnesses are called, the order of examination of each witness is:

(a) examination by MAD, its UR contractor, the MCO or their designees or other MAD designees;

(b) cross examination by the claimant, the claimant's authorized representative, designated spokesperson, or their legal counsel; and

(c) MAD's opportunity to redirect the witness;

(3) presentation of the claimant's case is at the claimant or the claimant's authorized representative discretion; if witnesses are called, the order of examination of each witness is:

(a) examination by claimant or the claimant's authorized representative, designated spokesperson or legal counsel;

(b) cross examination by MAD, its UR contractor, the MCO or their designees or another MAD designees and

(c) the claimant, claimant's authorized representative or designated spokesperson, or legal counsel's opportunity to redirect the witness;

(4) presentation of rebuttal evidence by MAD, its UR contractor, the MCO or their designees or another MAD designees and the claimant or the claimant's authorized representative, designated spokesperson or legal counsel respectively;

(5) the ALJ may direct further questions to any of the parties to the HCA administrative hearing to clarify inconsistencies or obtain an adequate evidentiary record; and

(6) the ALJ may ask specific parties to summarize and present closing arguments.

C. Points of law: The ALJ may direct the parties who have legal counsel to submit memoranda on points of law to assist the ALJ develop the HCA administrative hearing record and recommendation letter. The ALJ may dictate the length and scope of these submissions.

D. Written closing argument: At the discretion of the ALJ, the parties may be directed to make closing arguments, or submit written memoranda on points of law.

E. Continuance: The ALJ may, at their discretion, continue the HCA administrative hearing upon the request of the parties to the HCA administrative hearing or the ALJ's own motion, to allow for the admission of additional testimony or evidence. The reasons for the continuance must be clearly stated for the record. Written notice of the date, time, and place of the continued HCA administrative hearing shall be sent to the parties if they are not set at the time of the approval of the continuance.

F. Additional evidence: If the ALJ requires additional evidence to further clarify documentary evidence presented during the HCA administrative hearing, they may close the HCA administrative hearing but keep the record open and direct the parties to submit such clarifying evidence. The assigned ALJ shall provide each party to the HCA administrative hearing with a copy of the direction for further evidence and the documentary evidence to be submitted. Any party may respond to the ALJ's direction, in writing, within 10 calendar days of its receipt of the ALJ's notice. The ALJ will provide the other parties to the HCA administrative hearing a copy of any such submissions and the additional evidence and responses, subject to the ALJ's discretion and appropriate objections by any of the parties to the HCA administrative hearing, shall become part of the HCA administrative hearing record.

G. Re-opening a closed HCA administrative hearing: The ALJ may at their discretion, or subject to an order from a court of competent jurisdiction, or at the request of the MAD director may re-open a closed HCA administrative hearing when the evidentiary record fails to address an issue that is relevant to resolution of the HCA administrative hearing request. Written notice of the date, time and place of the re-opened HCA administrative hearing shall be sent by the ALJ to the parties not less than 10 calendar days before the re-opened HCA administrative hearing. Once the MAD director or designee has issued an HCA administrative final decision, the HCA administrative hearing cannot be re-opened absent an order from a court of competent jurisdiction. A claimant or the claimant's authorized representative may request a new HCA administrative hearing if additional material information becomes available that was not available at the time of the first HCA administrative hearing. The previously assigned ALJ has the discretion to determine if the additional information would necessitate a new HCA administrative hearing.

[8.354.2.15 NMAC - Rp, 8.354.2.13 NMAC, 8/1/2014]

8.354.2.16 HCA ADMINISTRATIVE HEARING FINAL DECISION: The final decision concerning the HCA administrative hearing is made by the MAD director or designee after the review of the HCA administrative hearing record and the ALJ's recommendation. If the ALJ had rendered a decision to dismiss a HCA administrative hearing request, that decision becomes the HCA administrative hearing final decision and the following process detailed in this section of the rule does not apply.

A. Decision based on the record: The ALJ's HCA administrative hearing recommendation must be based solely on the record of the HCA administrative hearing.

B. ALJ recommendation: The ALJ shall review the record of the HCA administrative hearing and submit a complete copy of the record to the MAD director.

(1) Content of the ALJ recommendation: the ALJ shall specify the reasons for their conclusions, identifies the supporting evidence, references the pertinent federal and state statutes, regulations, and NMAC rules, and responds to the arguments of the parties within their written report.

(2) The ALJ recommends:

(a) in favor of the claimant if MAD, its UR contractor, the MCO or their designee's intended or taken adverse action is not supported by a preponderance of the evidence submitted during the HCA administrative hearing; the ALJ will provide specific recommendations to each appealed adverse action;

(b) in favor of MAD, if the preponderance of evidence submitted during the HCA administrative hearing supports the intended or taken of adverse action or actions; or

(c) any other result supported by the record of the HCA administrative hearing which may be a combination of recommendations for and against the claimant or MAD; if the HCA administrative hearing covered a number of services or components of a service, the ALJ will provide specific recommendations to each intended or taken adverse action.

C. Review of the record: The record of the HCA administrative hearing and the report and recommendation of the ALJ is reviewed by the MAD director or designee to ensure conformity with applicable federal and state statutes, regulations, and rules.

D. Final decision: The ALJ's recommendation may be adopted or rejected in a final written decision by the MAD director or designee on issues that were the subject of the HCA administrative hearing. The MAD director's final decision letter shall specify the reasons for their decision and identify the regulatory authority and those portions of the record, applicable federal and state law, rules and policies or any combination of these that support the final decision. No person who participated during the HCA administrative hearing process may participate in arriving at a HCA administrative hearing final decision.

E. Notice to parties: MAD shall promptly provide all parties with a copy of the HCA administrative hearing final written decision. When the claimant is represented by legal counsel or an authorized representative, each must receive a copy of the final decision. The HCA administrative hearing final decision letter shall include an explanation that the parties have exhausted all HCA administrative remedies and a claimant or the claimant's authorized representative may pursue judicial review of this decision.

[8.354.2.156 NMAC - Rp, 8.354.2.14 NMAC, 8/1/2014]

8.354.2.17 CONTINUATION OF BENEFITS PURSUANT TO A TIMELY APPEAL AND A HCA ADMINISTRATIVE HEARING PROCEEDING: The HCA administrative hearing final decision is binding on all issues that have been the subject of the HCA administrative hearing as to the claimant unless stayed by either a court order or by the MAD director or designee. MAD is responsible for ensuring that the HCA administrative hearing final decision is fulfilled.

A. If the claimant is a member and they received a benefit under their approved continuation of the benefit and the decision is favorable to the MCO, the claimant's MCO will not take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the HCA administrative hearing process up to the date of the HCA administrative hearing final decision.

B. If the claimant is not enrolled in an MCO and the HCA administrative hearing final decision is favorable to MAD, MAD will not take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the HCA administrative hearing process up to the date of the HCA administrative hearing final decision.

C. When the HCA administrative hearing final decision is favorable to the claimant, MAD, its UR contractor, the MCO or their designees will authorize the benefit and coverage set forth in the HCA administrative hearing final decision.

[8.354.2.17 NMAC - Rp, 8.354.2.10 NMAC, 8/1/2014]

8**.354.2.18 IMPLEMENTATION OF THE HCA ADMINISTRATIVE FINAL DECISION:** The HCA administrative hearing final decision is binding on all issues that have been the subject of the HCA administrative hearing as to the claimant unless stayed by either a court order or by the MAD director or designee. MAD is responsible for ensuring that the HCA administrative hearing final decision is fulfilled.

A. If the claimant is a member and they received a benefit under their approved continuation of the benefit and the decision is favorable to the MCO, the claimant's MCO will not take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the MCO appeal and the HCA administrative hearing process up to the date of the HCA administrative hearing final decision.

B. If the claimant is not enrolled in an MCO and the HCA administrative hearing final decision is favorable to MAD, its UR contractor or designee, MAD will not take action to file a repayment claim to the claimant or the claimant's authorized representative for the services received during the HCA administrative hearing process up to the date of the HCA administrative hearing final decision.

C. When the HCA administrative hearing final decision is favorable to the claimant, MAD, its UR contractor, the MCO or their designee will authorize the benefit and coverage set forth in the HCA administrative hearing final decision.

[8.354.2.18 NMAC - Rp, 8.354.2.15 NMAC, 8/1/2014]

8.354.2.19 JUDICIAL APPEAL: If the HCA administrative hearing final decision upholds MAD, its UR contractor, the MCO or their designee's intended or taken adverse action, the claimant or the claimant's authorized representative has the right to pursue judicial review of the HCA administrative hearing final decision and is notified of that right in the HCA administrative final decision letter. Judicial appeals for the HCA administrative hearing

final decision are governed by New Mexico statutes and court rules. While the following subsections highlight applicable procedures, they should not be considered a substitute for examining the statutes and rules themselves.

A. Jurisdiction: Administrative appeals for a claimant are governed by the Section 39-3-1.1 NMSA 1978 and by Rule 1-074, Rules of Civil Procedures for the district courts.

B. Timeliness: Unless otherwise provided by law, a claimant or the claimant's authorized representative must appeal the HCA administrative hearing final decision within 30 calendar days of the date of the HCA administrative hearing final decision by filing a notice of appeal with the clerk of the appropriate New Mexico district court.

C. Jurisdiction and standard of review: All judicial appeals are based on the record made at the HCA administrative hearing, and in accordance with state statute and court rules. HCA files a copy of the HCA administrative hearing record with the court clerk and furnishes one copy to the claimant or the claimant's authorized representative and if applicable, their legal counsel within 30 calendar days after receipt of the notice of appeal. The court may set aside the HCA administrative hearing final decision if it finds the decision is:

(1) arbitrary, capricious, or an abuse of discretion;

(2) is not supported by substantial evidence in the record as a whole; or

(3) is otherwise not in accordance with the applicable law, statutes or rules.

D. Benefits pending state district court appeal: The filing of a notice of appeal shall not stay the enforcement of the HCA administrative hearing final decision. The claimant or the claimant's authorized representative may seek a stay upon a motion to the court or the claimant may request the MAD director or designee to stay the HCA administrative hearing final decision while the adverse action is on appeal in a New Mexico district court. If the court orders a stay, MAD, it UR contractor, the MCO or their designee will maintain the benefit at issue in accordance with the state district court's order. If the New Mexico district court's final decision is in favor of MAD, its UR contractor, the MCO or their designee and the claimant continued utilizing their benefit during the district court appeal process, see 8.352.2 NMAC for the repayment process.

[8.354.2.19 NMAC - Rp, 8.354.2.16 NMAC, 8/1/2014]

HISTORY OF 8.354.2 NMAC:

History of Repealed Material:

8.354.2 NMAC, PASRR and Patient Status Hearings, filed 02/17/2012 - Repealed effective 08/01/2014.