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**ATTACHMENT 2.2-A**

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

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MEDICAL ASSISTANCE PROGRAM

HCFA-AT-80-38 (BPP)
MAY 22, 1980
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*Forms Provided*
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* Supplement 4 - Consideration of Medicaid Qualifying Trusts--Undue Hardship

* Supplement 5 - More Liberal Methods of Treating Income under Section 1902(r)(2) of the Act

* Supplement 6 - More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

*Forms Provided

TN No. 91-19
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STATE New Mexico
DATE REC'D DEC 17 1991
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*Forms Provided

Supersedes Approval Date JAN 15 1992 Effective Date OCT 1 1991

HCFA ID: 7982E
1.4 State Medical Care Advisory Committee

There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.
State of NEW MEXICO

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

the New Mexico Department of Human Services is the single State agency responsible for:

/ / administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is: Section 3, Chapter 252, Laws 1977 and

Section 12-17-15, New Mexico Statutes Annotated, 1953 Compiliation (statutory citation)

/ / supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

(STATUTORY CITATION)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is

(STATUTORY CITATION)

DATE: 4/26/78

TONY ANAYA
Attorney General by

Signature

APPROVED by DHED/HCPA/MS
DATE: MAY 3, 1978

Assistant Attorney General
Title

TRANSMITTED NO. 78-7
State Plan for Medical Assistance  
under Title XIX, SSA  
New Mexico 

Attachment 1.2-A 

ORGANIZATION AND FUNCTION OF STATE AGENCY 

The Single State Agency designated to administer the Title XIX program in New Mexico is the Human Services Department. 

This attachment is organized in three sections. The first describes the department and lists the responsibilities of the administrative head of the agency. The second section contains brief descriptions of the major organizational units of the department. The third section is an organizational chart of the department. 

SECTION I 

The Human Services Department Act established a single, unified department to administer laws and exercise functions relating to human services. The department's mission is to assist individuals and families to achieve self-sufficiency by providing financial stability, child support, access to health services and opportunities for training, education, employment and child care, and to provide caring and compassionate services to vulnerable populations. 

The department establishes and maintains agreements with the New Mexico Department of Health, Department of Education, and Children, Youth and Families Department concerning programs and projects of mutual interest, including the use of Medicaid funding for eligible services provided by or through the other departments. 

Department Organization - The department is a cabinet level agency in the executive branch of New Mexico state government. It contains three operating divisions administering Medicaid, financial assistance, and child support enforcement, an Office of Inspector General and administrative and support sections. The department divisions and major offices are: 

A. the Medical Assistance Division; 
B. the Income Support Division; 
C. the Child Support Enforcement Division; 
D. the Office of Inspector General; 
E. the Administrative Services Division; and, 
F. the Office of General Counsel.
Secretary of Human Services - The administrative head of the human services department is the "secretary of human services," who is appointed by the governor with the consent of the senate and who serves in the executive cabinet. The appointed secretary shall serve and have all the duties, responsibilities and authority of that office during the period of time prior to final action by the senate confirming or rejecting his appointment.

Under state statute, the secretary's duties and powers include but are not limited to:

A. All operations of the department and administration and enforcement of laws with which the department is charged;
B. Every power expressly enumerated in the laws, whether granted to the secretary or the department or any division of the department, except where authority conferred upon any division is explicitly exempted from the secretary's authority by statute;
C. The authority to apply for and receive, with the governor's approval, in the name of the department any public or private funds, including but not limited to United States government funds, available to the department to carry out its programs, duties and services;
D. The authority to make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions, with the condition that no rule or regulation affecting any person or agency outside the department can be adopted without a public hearing:

SECTION II

Medical Assistance Division - The mission of the Medical Assistance Division is to ensure access to medically necessary health services for Medicaid eligible individuals. The Medical Assistance Division administers the Medicaid program. The division is responsible for the development, dissemination and on-going administration of both eligibility policy and amount, duration and scope of Medicaid coverage.

Income Support Division - The mission of the Income Support Division is to provide assistance benefits in a timely and accurate manner to eligible persons while fostering self-sufficiency. The division administers statewide programs for Aid to Families with Dependent Children, AFDC-Unemployed Parent, the state-funded General Assistance program for disabled adults, Food Stamps, Commodities, the Low-Income Home Energy Assistance Program and a variety of programs under Community Assistance, including grants to homeless programs, Community Service Block Grants, and water and sewer hook-up assistance. Workers in the ISD field offices determine eligibility for the Medicaid program, as well as for the income assistance programs.

Child Support Enforcement Division - The mission of the Child Support Enforcement Division is
to assist custodial parents to secure for their children the economic and medical support to which they are entitled. In order to establish and enforce child support orders, the division works with a wide range of federal, state and private agencies. The six major program services in the division are: absent parent location, establishment of paternity, establishment of financial and medical support orders, collection and distribution of support, support order enforcement and support order modification.

Office of the Inspector General - The mission of the Office of Inspector General is to maintain and promote public confidence in all Human Services Department programs and operations through the detection, prevention and deterrence of fraud, waste, abuse and inefficiency. The mission is accomplished through the coordination of audit, client disqualification, criminal investigation, internal investigation and restitution functions. The office conducts criminal, civil and internal affairs investigations as well as financial, program and compliance audits of department programs and contracts with outside contractors.

Administrative Services Division - The mission of the Administrative Services Division is to provide internal support for efficient operation of department programs. The division provides financial, accounting, information processing, automated systems planning, development and implementation planning, and personnel support services.

Office of General Counsel - The Office of General Counsel provides legal advice and intervention and litigation services. The office reports directly to the Cabinet Secretary. Other offices under the umbrella of the Office of the Secretary are the Hearings Bureau, which provides administrative arbitration services to clients who challenge department decisions; and the Public Information Office, which coordinates the department's response to media inquiries.
SECTION III

MEDICAL ASSISTANCE DIVISION

DIRECTOR

Deputy Director

Support

OFFICE OF MANAGED CARE

Primary Care Network

Third Party Liability Section

Surveillance and Utilization Review Section

PROGRAM SUPPORT BUREAU

Support

Budget and Evaluation Section

Eligibility Section

MEDICAL SERVICES BUREAU

Support

Program Development Section

Ambulatory Section

Institutional Section

NEW MEXICO HUMAN SERVICES

 superseded: TN. 89-65
State Plan for Medical Assistance
under Title XIX, SSA
New Mexico

Attachment 1.2-B

ORGANIZATION AND FUNCTION UNDER MEDICAL ASSISTANCE DIVISION

The unit responsible for administering the Title XIX program under the Single State Agency in New Mexico is the Medical Assistance Division.

This attachment is organized in two sections. The first provides a brief description of the responsibilities of the division director, the second briefly describes the bureaus and sections of the division and the third is an organizational chart of the division.

SECTION I

Division Director - The Medical Assistance Division Director directly supervises the bureau chiefs and represents the division in meetings with the Department Secretary, with provider groups, with officials of the federal Health Care Financing Administration, with the claims processing contractor, and with advisory groups. These meetings require 20 to 25 percent of the director's time, with 50 to 55 percent of his time going to division supervision. The remaining time is spent working with other private contractors and coordinating the division's efforts with those of other divisions in the Human Services Department and other state agencies involved in administration of the Medicaid program.

SECTION II

Program Support Bureau - The Program Support Bureau is responsible for support and programmatic functions within the division, including preparing and administering the budget; planning and evaluating programs; retrospectively reviewing the use of services by Medicaid recipients and bills from health care providers; and ensuring Medicaid is the payer of last resort. The four sections are: Budget and Evaluation; Eligibility; Surveillance and Utilization Review; and Third Party Liability.

A. Budget and Evaluation Section - The Budget and Evaluation Section develops and monitors the division's budget, prepares all fiscal documents, processes contracts, prepares federal reports, monitors inventory reporting, orders supplies and maintains account reports. Planning functions include development of long- and short-range

SUPERSEDES: TBD
policies, data analysis, program evaluation, preparation of reports and other technical support as required.

B. Eligibility Section - The Eligibility Section develops and implements Medicaid eligibility policy originating with federal statute and regulation and state statute and is the division's contact with the computerized eligibility system.

C. Surveillance and Utilization Review - The Surveillance and Utilization Review Section monitors the medical services provided by participating providers and the use of these services by recipients. The claims processing contractor provides SURES with individual medical profiles compiled from claims for comparison to established norms. Deviations are selected for analysis and, in the case of providers, may result in recoupment or referral to peer review, the Office of Inspector General or the Medicaid Fraud Unit. In the case of recipients, over-utilization may result in assignment to the Medical Management Program.

D. Third Party Liability Section - The Third Party Liability Section develops and implements methods of identifying third party medical resources for Medicaid recipients or liable third parties to ensure that Medicaid is the payor of last resort. This effort prevents the Medicaid program from paying for services when the recipient has other insurance; allows the program to collect reimbursement from appropriate insurance carriers in those cases in which payments were made prior to learning of the insurance coverage; and recover funds resulting from litigation and other settlements.

Medical Services Bureau - The Medical Services Bureau is responsible for the daily operation of the Medicaid Program. The bureau oversees processing of Medicaid claims and prior authorization of medical services through two separate contracts and coordinates the work of the contractors with other aspects of the program. The bureau is responsible for writing program policies and regulations relating to medical services; and communicating directly with providers of service and recipients regarding program coverage, payments, special requirements and billing instructions. The bureau also administers the health service aspects of the program, including helping assure patient access to services and promoting health screens for children. The three sections are: Institutional Care, Ambulatory and Program Development.

A. Institutional Care Section - The Institutional Care Section develops and implements policy for all institutional-based services. The staff oversees claims processing, develop utilization review systems, conduct provider training and review expenditures for these services. The services include hospitals, nursing homes, intermediate care facilities for the mentally retarded, home health agencies, hospices, transplants, inpatient and outpatient rehabilitation centers, independently certified physical and occupational therapists, accredited residential treatment centers and several EPSDT services.

B. Ambulatory Care Section - The Ambulatory Care Section is responsible for developing...
program guidelines, provider relations and claims payment monitoring for all ambulatory services. Ambulatory services include physicians, podiatrists, psychologists, laboratories, dentists, pharmacies and medical suppliers. The section's functions include provider training, fee schedules, service coordination with other department divisions, other state agencies and providers and the promotion of prevention services.

C. Program Development Section - The Program Development Section defines the direction for new Medicaid program services and supports the bureau in researching and implementing these services. The section researches federal regulations, studies Congressional and Legislative mandates and evaluates Medicaid services in other states to make recommendations to the division director. This office also works with other state agencies in the development and implementation of several programs including Case Management, Psychosocial Rehabilitation, Early Intervention, School-based services and Home- and Community-based waivers.

Office of Managed Care - The Office of Managed Care includes the Primary Care Network, a statewide primary care, case-management system which requires Medicaid recipients to enroll with primary physicians, clinics and pharmacies. These primary care providers serve as gatekeepers into the health care system and are responsible for monitoring the patient's use of health care services and eliminate the inefficient or inappropriate use of resources. The Office of Managed Care also oversees the division's transition from traditional fee-for-service Medicaid programs to managed Medicaid programs.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE: New Mexico

STATE PLAN DEFINITION OF HMO

An organization whose primary purpose is the provision of health care services and is licensed by the New Mexico Department of Insurance to manage, coordinate and assume financial risk on a capitated basis for the delivery of a specified set of services to enrolled members in a given geographic area. The HMO must establish and maintain a comprehensive provider network to ensure sufficient provision of an enhanced array of covered medically necessary services. It must make the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to nonenrolled Medicaid recipients within the area served by the HMO. It must meet all applicable State and Federal laws and regulations regarding solvency and risk, comply with networth requirements and maintain a fidelity bond which meets the maximum amount specified under the New Mexico Insurance Code. The HMO must deposit and maintain a cash reserve with an independent trustee during the duration of the contract plus ninety (90) days and assure that Medicaid enrollees will not be held liable for any of its debts if it becomes insolvent.

STATE NEW MEXICO
DATE REV: June 3, 1999
DATE APPR: September 3, 1997
DATE E.: July 1, 1994
NCFA 477

TN# Approval Date Effective Date
Supersedes
TN#

SUPERSEDES: TN -
The following groups are covered under this plan.

IV-A

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

42 CFR 435.110 1. Recipients of AFDC

The approved State AFDC plan includes:

[X] Families with an unemployed parent for the mandatory 6-month period and an optional extension of ___ months.

[X] Pregnant women with no other eligible children.

[X] AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement I of ATTACHMENT 2.6-A.

42 CFR 435.115 2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.

*Agency that determines eligibility for coverage.

TN No. 91-19 Approval Date JAN-15-1992 Effective Date OCT-1-1991
Supersedes ECFM ID: 7983E

TN No. 20-24

STATE NEW MEXICO
DATE RE: DEC 17-1991
DATE AGMT JAN 15-1992
DATE EFF: OCT 01-1991
HCFM 91-19
Agency* Citation(s) Groups Covered

IV-A A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

2. Deemed Recipients of AFDC.

1902(a)(10)(A)(i)(I) of the Act
b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.

402(a)(22)(A) of the Act
c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.

406(h) and 1902(a)(10)(A)(i)(I) of the Act
d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.

1902(a) of the Act
e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

3. Qualified Family Members

Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.

Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)
### Agency* Citation(s) Groups Covered

#### A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

**IV-A**

42 CFR 435.113

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:

   a. Families denied AFDC solely because of income and resources deemed to be available from--

      (1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;

      (2) Grandparents;

      (3) Legal guardians; and

   b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

   c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

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*Agency that determines eligibility for coverage.

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**HCFA ID: 7983E**
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

IV-A 42 CFR 435.114

6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

- Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

- Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

- Not applicable with respect to intermediate care facilities; State did or does not cover this service.

7. Qualified Pregnant Women and Children.

(a) 1902(a)(10)
(A)(i)(II)
and 1905(n) of the Act

a. A pregnant woman whose pregnancy has been medically verified who--

(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

*Agency that determines eligibility for coverage.

TN No. 0244 Approval Date MAR 10 1992 Supersedes TN No. 9119

Effective Date JAN 01 1992 HCFA ID: 7983E

STATE FEB 18 1992
DATE REC'D MAR 10 1992
DATE APP'ED JAN 01 1992
DATE EFF 01/02
HCFA 179
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency* Citation(s) Groups Covered

IV - A

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents? (A)

(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

1902(a)(10)(A) (I)(III) and 1905(n) of the Act

b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

Children born after

(specify optional earlier date)
who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

New Mexico

STATE DATE RECD DATE APPV'D DATE EFF
APR 03 1992 APR 29 1992 JAN 01 1992
HCFA 179 A

*Agency that determines eligibility for coverage.

TN No. Supersedes Approval Date Effective Date
81-19 APR 29 1992 JAN 01 1992
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

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<tr>
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<td>1902(a)(10)(A) (I)(IV) and 1902(l)(1)(A) and (B) of the Act</td>
<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(I)(IV) and 1902(l)(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>
|        | 1902(a)(10)(A) (I)(VI) 1902(l)(1)(C) of the Act 1902(a)(10)(A)(i) (VII) and 1902(l)(1)(D) of the Act | 9. Children: a. who have attained 1 year of age but have not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels. b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for these groups are specified in Supplement 1 to ATTACHMENT 2.6A.

STATE: New Mexico
DATE REC'D: APR 03 1992
DATE APP'D: APR 29 1992
DATE EFF: JAN 01 1992
HCFA 179

* Agency that determines eligibility for coverage.

TN No. 92-64
Supersede Approval Date APR 29 1992 Effective Date JAN 01 1992

TN No. 91-19
STATE PLAN UNDER TITLE XIX. OF THE SOCIAL SECURITY ACT
State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

10. Reserved

11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

STATE

APR 03 1992
APR 29 1992
JAN 01 1992
HCFA 179

Agency that determines eligibility for coverage.

Supersedes 91-19 Approval Date APR 29 1992 Effective Date JAN 01 1992
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State:** NEW MEXICO

#### COVERAGE AND CONDITIONS OF ELIGIBILITY

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<tr>
<td><strong>IV-A</strong></td>
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</tr>
<tr>
<td>A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (continued)</td>
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<tr>
<td>1902 (e) (4) of the Act</td>
<td></td>
</tr>
<tr>
<td>42 CFR.117</td>
<td>12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant.</td>
</tr>
<tr>
<td>42 CFR.435.120</td>
<td>13. Aged, Blind and Disabled Individuals Receiving Cash Assistance</td>
</tr>
</tbody>
</table>

**IV-A**

| X | 2. Individuals receiving SSI. |

This includes beneficiaries’ eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619 (e) of the Act or considered to be receiving SSI under section 1619 (b) of the Act.

| X | Aged |
| X | Blind |
| X | Disabled |

*Agency that determines eligibility for coverage.

**TN No:** 09-07  
**Approval Date:** 11/11/07  
**Effective Date:** 07/01/09
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

435.121

13. /✓/ b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

Aged
Blind
Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

TN No. 91-19 Approval Date JAN 1-5 1992 Effective Date OCT 1-1991
Supersedes HCPA ID: 7983E

TN No. 8718
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<th>Agency*</th>
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<tr>
<td>Social Security Administration</td>
<td>Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</td>
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</tr>
</tbody>
</table>

14. Qualified severely impaired blind and disabled individuals under age 65, who---

a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1615 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or

b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must---

1. Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;

2. Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;

3. Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

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*Agency that determines eligibility for coverage.

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<td>11-19</td>
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<td>8-218</td>
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<td>OCT 1, 1991</td>
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HCFA ID: 7983E
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<tr>
<td>Social Security Administration</td>
<td>A.</td>
<td>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
</tr>
</tbody>
</table>

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

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<th>TN No.</th>
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<td>81-17</td>
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HCFA ID: 7983E

STATE: NEW MEXICO

DATE REC'D: DEC 1 1992
DATE APP'D: JAN 15 1992
DATE EFF: OCT 1 1991
HCFA 179: 01-19
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1619(b)(3) of the Act

The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

TN No. 9712 Approval Date JAN 1 5 1992 Effective Date OCT 1 1991
Supersedes New Page

STATE NEW MEXICO
DATE REC'D DEC 1 1991
DATE ARR'D JAN 15 1992
DATE EFF OCT 01 1991
HCFA 1/7 91-10
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634(c) of the Act

15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--

   a. Are at least 18 years of age;

   b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

   c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

   d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.

IV-A

42 CFR 435.122 16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.

42 CFR 435.130 17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

TN No. 91-17 Approval Date JAN 15 1992 Effective Date OCT 1 1991
Supersedes
TN No. New Page

HCPA ID: 7983E

STATE NEW MEXICO
DATE REC'D DEC 17 1992
DATE APP'D JAN 15 1992
DATE EFF OCT 1 1991
HCPA 179 A-119
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131 18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

☐ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

☐ Aged ☐ Blind ☐ Disabled

☒ Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

OCT 1 1991

State: NEW MEXICO

HCFA ID: 7983E
A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.132 19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--

a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and

b. Remain institutionalized; and

c. Continue to need institutional care.

42 CFR 435.133 20. Blind and disabled individuals who--

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and

b. Were eligible for Medicaid in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

TN No. 91-19 Approval Date Jan 12 1982 Effective Date Oct 1 1991
Supersedes
TN No. New Page

HCFA ID: 7983E
Agency* Citation(s) Groups Covered

IV-A

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.134 21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

☐ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

☒ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

☐ Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

TN No. 91-17 Approval Date JAN 1 1992 Effective Date OCT 1 1991

HCFA ID: 7983E
A. Mandatory Coverage - Categorically Needy and Other
   Required Special Groups (Continued)

42 CFR 435.135 22. Individuals who --
   a. Are receiving OASDI and were receiving SSI/SSP
      but became ineligible for SSI/SSP after April
      1977; and

   b. Would still be eligible for SSI or SSP if
      cost-of-living increases in OASDI paid under
      section 215(i) of the Act received after the
      last month for which the individual was
      eligible for and received SSI/SSP and OASDI,
      concurrently, were deducted from income.

   ☐ Not applicable with respect to individuals
      receiving only SSP because the State either
      does not make such payments or does not
      provide Medicaid to SSP-only recipients.

   ☑ Not applicable because the State applies
      more restrictive eligibility requirements
      than those under SSI.

   ☐ The State applies more restrictive
      eligibility requirements than those under
      SSI and the amount of increase that caused
      SSI/SSP ineligibility and subsequent
      increases are deducted when determining the
      amount of countable income for categorically
      needy eligibility.

*Agency that determines eligibility for coverage.

TN No. 51-17 Approval Date JAN 15 1992 Effective Date OCT 1 1991
Supersedes
TN No. 88-09
HCFA ID: 7983E

STATE NEW MEXICO
DATE REL: DEC 17 1992
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<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
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<tr>
<td>1634 of the Act</td>
<td>23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.</td>
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<td>/X/ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.</td>
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<td>/ / The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.</td>
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*Agency that determines eligibility for coverage.

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HCFA ID: 7983E
24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

X

In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in § 1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.

In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

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<td>A</td>
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<tr>
<td>1902 (a) (10(E)(i)</td>
<td>25. Qualified Medicare beneficiaries--</td>
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<td>And 1905 (p)</td>
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<tr>
<td>1860 D-14 (a)(3)(d)</td>
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<td>of the Act</td>
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<tr>
<td>*HSD</td>
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<tr>
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<td>a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);</td>
</tr>
<tr>
<td></td>
<td>b. Whose income does not exceed 100 percent of the Federal poverty level, and</td>
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<td></td>
<td>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI).</td>
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<td>1902 (a)(10)(E) (ii),</td>
<td>26. Qualified disabled and working individuals—</td>
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<td>*HSD</td>
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<tr>
<td></td>
<td>a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;</td>
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<td>b. Whose income does not exceed 200 percent of the Federal poverty level; and</td>
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<tr>
<td></td>
<td>c. Whose resources do not exceed three times the maximum standard under SSI.</td>
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<tr>
<td></td>
<td>d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.</td>
</tr>
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<td>(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)</td>
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STATE New Mexico

DATE REC'D. 3-8-10
DATE APP'VD. 9-30-10
DATE EFF. 1-1-10
HCFA 179 10-03

TN No. 10-03 Approval Date 9-30-10 Effective Date 1-1-10
Supercedes TN No. 93-05

SUPERSEDES: TN- 93-05
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

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<td>A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (continued)</td>
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<tr>
<td>1902 (a) (10(E)(iii), 1905 (p)(3)(A)(ii) and 1860 D-14(a)(3)(D) of the Act</td>
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<tr>
<td>27. Specified low-income Medicare beneficiaries--</td>
<td></td>
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<tr>
<td>a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);</td>
<td></td>
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<tr>
<td>b. Whose income is at least 100 percent, but does not exceed 120 percent of the Federal poverty level.</td>
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<tr>
<td>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the Consumer Price Index (CPI).</td>
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<tr>
<td>(Medical assistance for this group is limited to Medicare Part A premiums under section 1839 of the Act.)</td>
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<tr>
<td>28. Qualifying Individuals</td>
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<tr>
<td>a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under 1818A of the Act);</td>
<td></td>
</tr>
<tr>
<td>Whose income is at least 120 percent, but does not exceed 135 percent of the Federal Poverty level;</td>
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<tr>
<td>Whose resources do not exceed three times the SSI resource limit, adjusted annually by the Consumer Price Index (CPI).</td>
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STATE: New Mexico
DATE REC'D: 8-8-10
DATE APP'ED: 8-20-10
DATE EFF: 1-1-10
HCFA A179: 10-03

TN No. 10-03 Approval Date 8-30-10 Effective Date 1-1-10
Supercedes TN No. 93-05

SUPERSEDES: TN-93-05
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency * Citation (s) | Groups Covered
--- | ---

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (continued)

1634 (e) of the Act

29. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611 (e)(3)(A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month.

b. The State applies more restrictive eligibility standards than those under SSI.

Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611 (e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State Plan, are eligible for Medicaid as categorically needy.

*Agency that determines eligibility for coverage.

Supercedes:

TN No. 10-03 Approval Date 8-30-10 Effective Date 1-1-10

SUPERSEDES: TN- 96-08
<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.L. 101-508 (Section 4601)</td>
<td>27. Children born after September 30, 1983, who have attained age 6 but have not attained age 19 in families with income up to 100 percent of the Federal poverty level, as specified in Supplement 1 to Attachment 2.6-A, for a family of the same size, including the children who meet the resource standards specified in Supplement 2 to Attachment 2.6-A.</td>
<td></td>
</tr>
</tbody>
</table>

* Agency that determines eligibility for coverage.

** TN NO. 91-19 **

Approval Date: JAN 1 5 1992  Effective Date: OCT 1 1991

Supersedes TN NO. New Page
### B. Optional Groups Other Than the Medically Needy

<table>
<thead>
<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42 CFR 435.210</td>
<td>1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.</td>
</tr>
<tr>
<td></td>
<td>1902(a) (10)(A)(ii) and 1905(a) of the Act</td>
<td>The plan covers all individuals as described above.</td>
</tr>
<tr>
<td></td>
<td>42 CFR 435.211</td>
<td>2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.</td>
</tr>
<tr>
<td></td>
<td>IV-A</td>
<td></td>
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</table>

*Agency that determines eligibility for coverage.*

<table>
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<tr>
<th>TN No.</th>
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<th>Effective Date</th>
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<tr>
<td>91-19</td>
<td>JAN 1 1992</td>
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**Supersedes**

<table>
<thead>
<tr>
<th>TN No.</th>
<th>HCFA ID: 7983E</th>
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<tr>
<td>87-19</td>
<td>91-19</td>
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**State:** NEW MEXICO

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<tr>
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<tr>
<td>DATE RAND</td>
<td>DEC 1 1992</td>
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<tr>
<td>DATE RAND</td>
<td>JAN 15 1992</td>
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<tr>
<td>DATE RAND</td>
<td>OCT 1 1991</td>
</tr>
<tr>
<td>HCFA 117</td>
<td>91-19</td>
</tr>
</tbody>
</table>
B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.212 & 1902(c)(2) of the Act, P.L. 99-272
(section 9517) P.L. 101-508 (section 4732)

[ ] 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

[ ] The State elects not to guarantee eligibility.

[ ] The State elects to guarantee eligibility. The minimum enrollment period is __ months (not to exceed six).

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

TN #: 03-03
Supersedes: TN #: 97-02
Effective Date: 7-1-03
Approval Date: 2-18-03
1932(a)(4) of Act

B. Optional Groups Other Than Medically Needy (continued)

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs; and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity’s service area or becomes ineligible.

X Disenrollment rights are restricted for a period of 12 months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

No restrictions upon disenrollment rights.

1903(m)(2)(H), 1902(a)(52) of the Act
P.L. 101-508
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

X The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

TN # 03-03

Effective Date 7-1-03

Approval Date 12-18-03
<table>
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<tr>
<th>Agency*</th>
<th>Citation(s)</th>
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<tr>
<td>IV-A</td>
<td>B. Optional Groups Other Than the Medically Needy (Continued)</td>
<td></td>
</tr>
<tr>
<td>42 CFR 435.217</td>
<td>X 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.</td>
<td></td>
</tr>
</tbody>
</table>

*Agency that determines eligibility for coverage.

TN No. 92-01 Approval Date 9/26/92 Effective Date 11/92
Supersedes
TN No. 91-19

HCFA ID: 7983E
B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(10) (A)(ii)(VII) of the Act

\[\text{5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.}\]

\[\text{☐} \]

\[\text{The State covers all individuals as described above.}\]

\[\text{☐} \]

\[\text{The State covers only the following group or groups of individuals:}\]

\[
\begin{align*}
\text{Aged} & \\
\text{Blind} & \\
\text{Disabled} & \\
\text{Individuals under the age of --} & \\
\quad 21 & \\
\quad 20 & \\
\quad 19 & \\
\quad 18 & \\
\text{Caretaker relatives} & \\
\text{Pregnant women} &
\end{align*}
\]

*Agency that determines eligibility for coverage.*

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<th>TN No.</th>
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<td>OCT 1 1991</td>
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<td></td>
</tr>
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HCFA ID: 7983E
B. Optional Groups Other Than the Medically Needy
(Continued)

6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

- The State covers all individuals as described above.

7. a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21 as indicated below.

<table>
<thead>
<tr>
<th>Age</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
</tr>
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TN No. 4119
Superseded Approval Date MAR 10 1992 Effective Date JAN 01 1992

HCFA ID: 7983E

STATE DATE REC'D MAR 10 1992 DATE APP'ED JAN 01 1992 DATE EFF JAN 01 1992
### Social Services and IV-A

#### B. Optional Groups Other Than the Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.222</td>
<td>Reasonable classifications of individuals described in (a) above, as follows:</td>
</tr>
<tr>
<td>(a)</td>
<td>X (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:</td>
</tr>
<tr>
<td>(b)</td>
<td>X In foster homes (and are under the age of 18).</td>
</tr>
<tr>
<td>(c)</td>
<td>X In private institutions (and are under the age of 18).</td>
</tr>
<tr>
<td>(d)</td>
<td>In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of 18).</td>
</tr>
<tr>
<td>(e)</td>
<td>(2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 18).</td>
</tr>
<tr>
<td>(f)</td>
<td>(3) Individuals in NFs (who are under the age of 18). NF services are provided under this plan.</td>
</tr>
<tr>
<td>(g)</td>
<td>(4) In addition to the group under b.(3), individuals in ICFs/MR (who are under the age of 18).</td>
</tr>
</tbody>
</table>

**TN No.** 27-12
**Supersedes** 87-02, page 12
**Approval Date** JAN 15 1992
**Effective Date** OCT 1 1999

**HCFA ID:** 7983E

**STATE: New Mexico**
**DATE REC'D:** DEC 17 1992
**DATE APPRO'D:** JAN 15 1992
**DATE CR:** OCT 0 1991
**HCFA ID:** 179
### B. Optional Groups Other Than the Medically Needy

(Continued)

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>(5)</td>
<td>Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of [____]). Inpatient psychiatric services for individuals under age 21 are provided under this plan.</td>
</tr>
<tr>
<td>*CYFD</td>
<td>Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.</td>
</tr>
</tbody>
</table>

**TN No.** 9813  
**Superseded TN No.** 9119  
**Approval Date** 01/04/95  
**Effective Date** 08/01/99  

**HCFA ID:** 7983E
B. Optional Groups Other Than the Medically Needy  
(Continued)

8. A child for whom there is in effect a 
State adoption assistance agreement 
(other than under title IV-E of the 
Act), who, as determined by the State 
adoption agency, cannot be placed for adoption 
without medical assistance because the child has 
special needs for medical or rehabilitative care, 
and who before execution of the agreement—

a. Was eligible for Medicaid under the State's 
approved Medicaid plan; or

b. Would have been eligible for Medicaid if the 
standards and methodologies of the title IV-E 
foster care program were applied rather than 
the AFDC standards and methodologies.

The State covers individuals under the age of—

____ 21
____ 20
____ 19
____ 18
B. Optional Groups Other Than the Medically Needy
(Continued)

9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:

- Individuals under the age of:
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women
B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230

10. States using SSI criteria with agreements under sections 1615 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is:

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

   (1) All aged individuals.
   (2) All blind individuals.
   (3) All disabled individuals.


<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42 CFR 435.230</td>
<td>(Continued)</td>
</tr>
<tr>
<td></td>
<td>(4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
<td></td>
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<tr>
<td></td>
<td>(5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(9) Individuals in additional classifications approved by the Secretary as follows:</td>
<td></td>
</tr>
</tbody>
</table>
### Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

- Yes.
- No.

The standards for optional State supplementary payments are listed in Supplement 8 of ATTACHMENT 2.8-A.
B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.230
435.121
1902(a)(10)
(A)(ii)(XI)
of the Act

☐ 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is:

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

(1) All aged individuals.

(2) All blind individuals.

(3) All disabled individuals.
<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Group Covered</th>
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</thead>
<tbody>
<tr>
<td>1902(a)(10)(A)(ii) (IX) and 1902(1) of the Act, P.L. 100-203 (Section 4101)</td>
<td>x 13</td>
<td>The following individuals who are not described in section 1902(a)(10)(A)(i) of the Act whose income level (established at an amount not more than 185 percent of the Federal poverty line) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:</td>
</tr>
</tbody>
</table>

Woman during pregnancy (and during the 60-day period beginning on the last day of pregnancy) and infants under one year of age.

Infants who are receiving inpatient services on the date they reach the maximum age for coverage under the approved plan will continued to be eligible for inpatient services until the end of the stay for which the inpatient services are furnished.

*Agency that determines eligibility for coverage.

TN No. 9115 Supersedes TN No. 9017

Approval Date OCT 2.3.1991 Effective Date JUL - 1 1999

<table>
<thead>
<tr>
<th>STATE</th>
<th>DATE REC'D</th>
<th>DATE APPVD</th>
<th>DATE EFF</th>
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</table>

HCFA 179 91-13
The payment levels under the approved State AFDC plan are no lower than the AFDC payment levels in effect under the approved AFDC plan on April 17, 1986.

Yes.

Not applicable. The State does not provide coverage of this optional categorically needy group.

14. In addition to individuals covered under item B.13, individuals—

(a) Who are 65 years of age or older or are disabled—

As determined under section 1614(a)(3) of the Act; or

As determined under more restrictive categorical eligibility criteria specified under item A.9(b) of this Attachment.

(b) Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal nonfarm income poverty line) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

(c) Whose resources do not exceed the maximum amount allowed—

Under SSI;

Under the State's more restrictive financial criteria; or

Under the State's medically needy program as specified in ATTACHMENT 2.6-A.

*Agency that determines eligibility for coverage.

TN No. 88-05
Supersedes 80-18

Approval Date 4-8-88
Effective Date 1-1-88

HCFA ID: 1036P/0015P
<table>
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<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV-A</td>
<td>1902(a)(47) and 1920 of the Act, P.L. 99-509 (Section 9407)</td>
<td>X 15. Pregnant women who meet the applicable income levels for the categorically needy specified in this plan under ATTACHMENT 2.6-A who are determined eligible by a qualified provider during a presumptive eligibility period in accordance with section 1920 of the Act.</td>
</tr>
</tbody>
</table>

C. Optional Coverage of the Medically Needy

435.301

This plan includes the medically needy.

X No.

Yes. This plan covers:

1. Pregnant women who, except for income and resources, would be eligible as categorically needy.

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*Agency that determines eligibility for coverage.*

<table>
<thead>
<tr>
<th>TN No.</th>
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HCFA ID: 1036P/0015P
### B. Optional Groups Other Than the Medically Needy (Continued)

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<td>(4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
<td></td>
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<tr>
<td></td>
<td>(5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
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<tr>
<td></td>
<td>(7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
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<tr>
<td></td>
<td>(8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
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<tr>
<td></td>
<td>(9) Individuals in additional classifications approved by the Secretary as follows:</td>
<td></td>
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</tbody>
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**TN No.** 91-17  
**Supersedes** 87-3  
**Approval Date** JAN 15 1992  
**Effective Date** OCT 1 1991  
**HCFA ID:** 7983E
B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes
___ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.2-A.
<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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<tr>
<td>IV-A</td>
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<td></td>
<td>B. Optional Groups Other Than the Medically Needy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Continued)</td>
</tr>
<tr>
<td>42 CFR 435.231</td>
<td>X</td>
<td>12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1902(a)(10)(A)(i)(V) of the Act</td>
<td></td>
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<td></td>
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<td>X</td>
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<tr>
<td>1902(a)(10)(A)(ii) and 1905(a) of the Act</td>
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TN No. 91-19
Supersedes
TN No. 87-17
Approval Date JAN 15 1992
Effective Date OCT 1 1991
HCFA ID: 7983E
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<tr>
<th>Agency*</th>
<th>Citation</th>
<th>Groups Covered</th>
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<tbody>
<tr>
<td>Section 4723 of P.L. 101-508 and Section 1903(f)(2)(B) of the Act</td>
<td>The State agency allows medically needy individuals and families to pay an amount to the State, which when combined with incurred medical costs in prior months, is sufficient when excluded from the family's income, to reduce such family's income below the applicable income limitation described in Section 1903(f)(1) of the Act.</td>
<td></td>
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* Agency that determines eligibility for coverage

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<td>DATE APPVD: 1-28-91</td>
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<td>DATE EFF: 11-5-90</td>
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<td>HCFA 179: 90-26</td>
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Effective Date: 11/5/90
Approval Date: 1/28/91
B. Optional Groups Other Than the Medically Needy
(Continued)

1902(e)(3) of the Act

13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in an institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act.

Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.

IV-A

1902(a)(10) (A)(ii)(IX) and 1902(l) of the Act

14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:

a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and

b. Infants under one year of age.

TN No. 92-22
Supersedes 91-19

Approval Date MAR 10 1992
Effective Date JAN 01 1992

HCFA ID: 7983E
<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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(RESERVED FOR FUTURE USE)

* Agency that determines eligibility for coverage.

TN NO. 91-19  Approval Date: JAN 15 1992  Effective Date: OCT 1-1992

Supersedes TN NO. 90-20

STATE: NEW MEXICO
DATE REC'D: DEC 17 1991
DATE APP'D: JAN 15 1992
DATE ENF: OCT 01 1991
HCFA 179 91-14
<table>
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<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
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</table>

**B. Optional Groups Other Than the Medically Needy (Continued)**

16. Individuals—

- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.

- b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

- c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.
<table>
<thead>
<tr>
<th>Agency</th>
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<tbody>
<tr>
<td>QUALIFIED P/E PROVIDERS</td>
<td>1902(a)(47) and 1920 of the Act</td>
<td>B. Optional Groups Other Than the Medically Needy (Continued)</td>
</tr>
</tbody>
</table>

X 17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.

*Agency that determines eligibility for coverage.*

<table>
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<tr>
<th>TN No.</th>
<th>Approval Date</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>92-04</td>
<td>APR 29 1992</td>
<td>JAN 01 1992</td>
</tr>
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</table>
B. Optional Groups Other Than the Medically Needy (Continued)

18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.

19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid extenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.
B. Optional Coverage Other Than the Medically Needy (Continued)

1902(a)(10)(A)
(ii)(XIV) of the Act

20. Optional Targeted Low Income Children who:

a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability);

b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on April 15, 1997 (other than because of the age expansion provided for in 1902(l)(2)(D));

c. are not covered under a group health plan or other group health insurance (as such terms are defined in 2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no Federal funds for the program;

d. have family income at or below:

200 percent of the Federal poverty level for the size family involved, as revised annually in the Federal Register; or

TN No. 04-04  Approval Date  Effective Date  10-1-09
Supersedes

TN No. 04-04

HCFA ID: 7982E

SUPERSEDES: TN- 04-04
ATTACHMENT 2.2-A
Page 23c

The State covers:

All children described above who are under age 12 (16, 19) with family income at or below 250 percent of the Federal poverty level.

The following reasonable classifications of children described above who are under age (16, 19) with family income at or below the percent of the Federal poverty level specified for the classification:

(ADD NARRATIVE DESCRIPTION(S) OF THE REASONABLE CLASSIFICATIONS AND PERCENT OF THE FEDERAL POVERTY LEVEL USED TO ESTABLISH ELIGIBILITY FOR EACH CLASSIFICATION)

1902(e)(12) of the Act

A child under age 19 (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of 12 months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.

1920A of the Act

Children under age 19 who are determined by a "qualified entity" (as defined in §1902A(b)(3)(A) based on preliminary information, to meet the highest applicable income criteria specified in this plan.

The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.

TN No. 04-04 Approval Date 11-16-09
Supersedes
TN No. 04-04

Effective Date 10-1-09
HCFA ID: 7982E
B. Optional Groups Other Than the Medically Needy (Continued)

<table>
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<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XIII) of the Act</td>
<td>[X] 23. BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A</td>
</tr>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act</td>
<td>[] 24. TVWWIIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.</td>
</tr>
<tr>
<td>1902(a)(10)(A) (ii)(XVI) of the Act</td>
<td>[] 25. TVWWIIA Medical Improvement Group - Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

NOTE: If the State elects to cover this group, it MUST also cover the Basic Coverage Group described in no. 24 above.
B. Optional Coverage Other Than the Medically Needy (Continued)

1902 (a) (10) (A) (ii) (XVIII) of the Act

[X] [26]. Women who:

a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;

b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and

d. have not attained age 65.

1920B of the Act

[X] [27]. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to breast and cervical cancer patients.

The presumptive period begins on the day that determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.
B. Optional Coverage Other Than the Medically Needy (Continued)

1902 (a) (10) (A) (ii) (XVIII) of the Act

[X] [26]. Women who:

a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;

b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and

d. have not attained age 65.

[10/19/02]

Women who are determined by a "qualified entity" (as defined in 19203 (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

Effective Date: 07-01-02
B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(XXI) 1902(ii)

X Individuals who are not pregnant and whose income does not exceed the State established income standard of 185% of the Federal Poverty Level. This amount does not exceed the highest income limit for pregnant women in this State Plan, which is 185% of the Federal Poverty Level.

☐ In determining eligibility for this group, the State considers only the income of the applicant or recipient.

Note: Services are limited to family planning services and family planning-related services as described in section 4.c(ii) of Attachment 3.1-A.

1920C

Presumptive Eligibility for Family Planning:

☐ The State provides a period of presumptive eligibility for family planning services to individuals determined by a qualified entity, based on preliminary information from the individual, described in the group the State has elected to make eligible under the above option. The period of presumptive eligibility ends on the earlier of the date a formal determination of Medicaid eligibility is made under 1902(a)(10)(A)(ii)(XXI), or, when no application has been filed, the last day of the month following the month during which the qualified entity determines the individual presumptively eligible.

TN No. 10-12 Approval Date 2-24-11 Effective Date 2-1-11

Supersedes TN No. SUPERSEDES. NONE - NEW PAGE
State/Territory New Mexico

<table>
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<tr>
<td>B.</td>
<td>Optional Groups Other Than the Medically Needy (Continued)</td>
</tr>
<tr>
<td>1902(a)(10)(A)(ii)(XXI)</td>
<td>X Individuals who are not pregnant and whose income does not exceed the State established income standard of 185% of the Federal Poverty Level. This amount does not exceed the highest income limit for pregnant women in this State Plan, which is 185% of the Federal Poverty Level.</td>
</tr>
<tr>
<td>1902(ii)</td>
<td>□ In determining eligibility for this group, the State considers only the income of the applicant or recipient.</td>
</tr>
<tr>
<td>Note: Services are limited to family planning services and family planning-related services as described in section 4.c(ii) of Attachment 3.1-A.</td>
<td></td>
</tr>
</tbody>
</table>

1920C

Presumptive Eligibility for Family Planning:

□ The State provides a period of presumptive eligibility for family planning services to individuals determined by a qualified entity, based on preliminary information from the individual, described in the group the State has elected to make eligible under the above option. The period of presumptive eligibility ends on the earlier of the date a formal determination of Medicaid eligibility is made under 1902(a)(10)(A)(ii)(XXI), or, when no application has been filed, the last day of the month following the month during which the qualified entity determines the individual presumptively eligible.
In addition to family planning services, the State covers family planning-related services to such individuals during the period of presumptive eligibility.

STATE: New Mexico
DATE RECD: 12-21-10
DATE APPV'D: 2-24-11
DATE EFF: 2-1-11
HCFA 179: 10-12

TN No.: 10-12  Approval Date: 2-24-11  Effective Date: 2-1-11

SUPERSEDES: NONE - NEW PAGE
C. Optional Coverage of the Medically Needy

42 CFR§35.301  This plan includes the medically needy.

[X] No.
[ ] Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan, for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.
C. Optional Coverage of Medically Needy (Continued)

4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.

5. (a. Financially eligible individuals who are not described in section C.3. above and who are under the age of—
   — 21
   — 20
   — 19
   — 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

☐ (b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:
   — (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:
     — (a) In foster homes (and are under the age of ___).
     — (b) In private institutions (and are under the age of ___).
C. Optional Coverage of Medically Needy (Continued)

- (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ____).

- (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ____).

- (3) Individuals in NFs (who are under the age of ____). NF services are provided under this plan.

- (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ____).

- (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

- (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.
C. Optional Coverage of Medically Needy (Continued)


and 435.330

and 435.330

and 435.330

42 CFR 435.326  10. Individuals who would be ineligible if they were
not enrolled in an HMO. Categorically needy
individuals are covered under 42 CFR 435.212 and
the same rules apply to medically needy
individuals.

435.340  11. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid
eligibility except the blindness or disability
criteria;

b. Were eligible as medically needy in December
1973 as blind or disabled; and

c. For each consecutive month after December 1973
continue to meet the December 1973 eligibility
criteria.
C. Optional Coverage of Medically Needy
(Continued)

1906 of the Act  

12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: __NEW MEXICO______________________________

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

<table>
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<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935(a) and 1902(a)(66)</td>
<td>The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.</td>
<td></td>
</tr>
<tr>
<td>42 CFR 423.774 and 423.904</td>
<td>1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.</td>
<td></td>
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TN No. O5-03 Approval Date 8-18-05 Effective Date July 1, 2005

Supersedes: NONE - NEW PAGE

STATE ___New Mexico____
DATE REC'D 7-18-05
DATE APP'ED 8-18-05
DATE EFF 7-1-05
HCFA 179 05-03
The New Mexico Medicaid program covers children for whom the State of New Mexico through the Children, Youth and Families Department (CYFD) has financial responsibility and who are in substitute care living arrangements but not under the care and control of a public institution. According to the terms of a Memorandum of Understanding between the secretaries of HSD and CYFD, CYFD is responsible for determining Medicaid eligibility and issuing identification cards to these children.

For purposes of this provision, "substitute care living arrangements" include placement in residential and non-residential treatment facilities in instances where medical treatment is required, placement in foster care, or adoption placement.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: NEW MEXICO

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home
C. Optional Coverage of the Medically Needy

42 CFR § 435.301 This plan includes the medically needy.

☐ No.

☐ Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.
C. Optional Coverage of Medically Needy (Continued)

4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.

5. a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--
   - 21
   - 20
   - 19
   - 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:
   - (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:
     - (a) In foster homes (and are under the age of ____).
     - (b) In private institutions (and are under the age of ____).
C. Optional Coverage of Medically Needy (Continued)

   (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___).

   (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ____).

   (3) Individuals in NFs (who are under the age of ____). NF services are provided under this plan.

   (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ____).

   (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

   (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.
C. Optional Coverage of Medically Needy (Continued)


42 CFR 435.320 7. Aged individuals:
and 435.330

42 CFR 435.322 8. Blind individuals:
and 435.330

42 CFR 435.324 9. Disabled individuals:
and 435.330

42 CFR 435.326 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.

435.340 11. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;

b. Were eligible as medically needy in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.
C. Optional Coverage of Medically Needy
(Continued)

12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

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<td>1935(a) and 1902(a)(66)</td>
<td>42 CFR 423.774 and 423.904</td>
<td>The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;</td>
</tr>
<tr>
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<td></td>
<td>3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.</td>
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TN No. 05-03 Approval Date 8-18-05 Effective Date July 1, 2005

Supersedes: NONE - NEW PAGE
The New Mexico Medicaid program covers children for whom the State of New Mexico through the Children, Youth and Families Department (CYFD) has financial responsibility and who are in substitute care living arrangements but not under the care and control of a public institution. According to the terms of a Memorandum of Understanding between the secretaries of HSD and CYFD, CYFD is responsible for determining Medicaid eligibility and issuing identification cards to these children.

For purposes of this provision, "substitute care living arrangements" include placement in residential and non-residential treatment facilities in instances where medical treatment is required, placement in foster care, or adoption placement.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

TN No. 91-17
Supersedes New Page
Approval Date JAN 15 1992
Effective Date OCT 1 1991
HCFA ID: 7983E

STATE New Mexico
DATE REL. D DEC 1 1992
DATE APPV D JAN 15 1992
DATE EFF OCT 01 1991
HCFA 179 A
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<td>2.6A pp. 92, 96</td>
<td>89-16</td>
<td>Catastrophic Coverage: Spousal impoverishment</td>
</tr>
<tr>
<td>Section</td>
<td>T.L.#</td>
<td>Subject</td>
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<tr>
<td>2.6A, p. 5</td>
<td>89-16</td>
<td>Catastr. Coverage: Spousal Impact</td>
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
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<tbody>
<tr>
<td></td>
<td>A. General Conditions of Eligibility</td>
</tr>
<tr>
<td></td>
<td>Each individual covered under the plan:</td>
</tr>
<tr>
<td>42 CFR Part 435, Subpart G</td>
<td>1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.</td>
</tr>
<tr>
<td></td>
<td>a. For the categorically needy:</td>
</tr>
<tr>
<td></td>
<td>(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.</td>
</tr>
<tr>
<td></td>
<td>(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.</td>
</tr>
<tr>
<td>1902(m) of the Act</td>
<td>(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.</td>
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STATE: New Mexico

DATE REC'D: APR 03 1992
DATE APP'ED: APR 29 1992
DATE EFF: JAN 01 1992

HCFA 179
State: NEW MEXICO
ELIGIBILITY CONDITIONS AND REQUIREMENTS

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<th>Citation(s)</th>
<th>Condition or Requirement</th>
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<tbody>
<tr>
<td>b. 1905(p) of the</td>
<td>For the medically needy, meets the nonfinancial eligibility conditions of 42 CFR Part 435.</td>
</tr>
<tr>
<td>c. 1905(s) of the</td>
<td>For financially eligible qualified Medicare Act beneficiaries covered under section 1902(a)(10)(E)(i) of The Act, meets the non-financial criteria of section 1905(p) of the Act.</td>
</tr>
<tr>
<td>d. 1905(s) of the</td>
<td>For financially eligible qualified disabled and Act working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).</td>
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SUPERSEDES: TN- 91-19

STATE: New Mexico
DATE REC'D: 10-5-09
DATE APPV'D: 12-23-09
DATE EFF: 10-1-09
HCFA 179 09-08

TN No: 09-08
Supersedes
TN No: 91-19

Approval Date: 12-28-09
Effective Date: 10-1-09
HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s) | Condition or Requirement
--- | ---

42 CFR 435.406 3. Is residing in the United States (U.S.), and—

a. Is a citizen or national of the United States;

b. Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA's eligibility is required by section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended;

c. Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;

d. Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;

e. Is a QA whose eligibility is authorized under section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended.

X State covers all authorized QAs.
___ State does not cover authorized QAs.

f. State elects CHIPRA option to provide full Medicaid coverage to otherwise eligible pregnant women or children as specified below who are aliens lawfully residing in the United States; including the following:

TN No: 09-08 Approval Date: 12-23-09 Effective Date: 10-1-09

HCFA ID: 7858

STATE New Mexico
DATE REC'D: 10-6-09
DATE APP'V'D: 12-23-09
DATE EFF: 10-1-09
HCFA 179: 09-08
(1) A "Qualified alien" otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;

(2) A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;

(3) An individual described in § CFR section 103.12(a)(4) who does not have a permanent residence in the country of their nationality and is in a status that permits the individual to remain in the U.S. for an indefinite period of time, pending adjustment of status. These individuals include:

(a) An individual currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);

(b) An individual currently under Temporary Protected Status pursuant to section 244 of the INA;

(c) A family Unity beneficiary pursuant to section 301 of Public Law 101-649 as amended by, as well as pursuant to, section 1504 of Public Law 106-554;

(d) An individual currently under Deferred Enforced Departure pursuant to a decision made by the President; and

(e) An individual who is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and

(4) An individual in non-immigrant classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including the following as specified in section 101(a)(15) of the INA:

- A parent or child of an individual with special immigrant status under section 101(a)(27) of the INA, as permitted under section 101(a)(15)(N) of the INA;

- A Fiancé of a citizen, as permitted under section 101(a)(15)(K) of the INA;

- A religious worker under section 101(a)(15)(R);

- An individual assisting the Department of Justice in a criminal investigation, as permitted under section 101(a)(15)(S) of the INA;

- A battered alien under section 101(a)(15)(U) (see also section 431 as amended by PRWORA); and

- An individual with a petition pending for 3 years or more, as permitted under section 101(a)(15)(V) of the INA.
g. The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA section 214 option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.
42 CFR 435.403 4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.

☐ State has interstate residency agreement with the following States:

☐ State has open agreement(s).
☐ Not applicable: no residency requirement.

SUPERSEDES: TN-91-19

STATE: New Mexico
DATE REC'D: 10-5-09
DATE APPVD: 12-23-09
DATE EFF: 10-1-09
HCFA 179: 09-08

TN No: 09-08
Supersedes TN No: 91-19

Approval Date: 12-23-09
Effective Date: 10-1-09

HCFA ID: 7985E
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.1008</td>
<td>5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.</td>
</tr>
<tr>
<td>42 CFR 435.1008</td>
<td>1905(a) of the Act</td>
</tr>
<tr>
<td>42 CFR 435.1008</td>
<td>1912 of the Act</td>
</tr>
<tr>
<td>42 CFR 433.145</td>
<td>6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)</td>
</tr>
</tbody>
</table>
An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(1)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

Assignment of rights is automatic because of State law.

42 CFR 435.910 7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).
Citation                  Condition or Requirement

1902(c)(2)  8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or
             receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to
             cover under sections 1902(a)(10)(A)(i)(IV) and

1902(e)(10)(A) and (B) of the Act  9. Is not required, as an individual child or pregnant
             woman, to meet requirements under section 402(a)(43)
             of the Act to be in certain living arrangements.
             (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency
determines if they are otherwise eligible under the State's Medicaid plan.)
1906 of the Act 10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).
B. Posteligibility Treatment of Institutionalized Individuals' Incomes

1. The following items are not considered in the posteligibility process:

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(o) of the Act</td>
<td>a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.</td>
</tr>
<tr>
<td>Bondi v Sullivan (SSI)</td>
<td>b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.</td>
</tr>
<tr>
<td>1902(r)(1) of the Act</td>
<td>c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).</td>
</tr>
<tr>
<td>1. (a) of P.L. 103-286</td>
<td>e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).</td>
</tr>
<tr>
<td>10405 of P.L. 101-239</td>
<td>f. Payments 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.).</td>
</tr>
<tr>
<td>6(h)(2) of P.L. 101-426</td>
<td>g. Radiation Exposure Compensation.</td>
</tr>
<tr>
<td>12005 of P.L. 103-66</td>
<td>h. VA pensions limited to $90 per month under 38 U.S.C. 5503.</td>
</tr>
</tbody>
</table>

TN No. 00-10
Supersedes 93-04

Approval Date 12-14-00
Effective Date 07-01-00
State NEW MEXICO

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1924 of the Act 435.725</td>
<td>2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutional care: Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons.</td>
</tr>
</tbody>
</table>
|                             | a. Aged, blind, disabled:  
|                             | Individuals $ 63  
|                             | Couples $ 126  
|                             | This amount is adjusted annually based on the CPI. |
|                             | b. AFDC related:  
|                             | Children $ 63  
|                             | Adults $ 63  
|                             | For the following individuals with greater need: Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the authority for approving that a criterion is met. |
|                             | c. Individuals under age 21 covered in this plan as specified in Item B.7 of ATTACHMENT 2.2-A. $ 63  

TN No: 09-01 Approval Date 5-31-09 Supersedes TN No. 08-02 Effective Date 7-1-09
For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

1924 of the Act

3. In addition to the amounts under item 2 , the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse’s income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.

   The poverty level component is calculated using the applicable percentage (see note §1924(d)(3)(B) of the Act) of the official poverty level.

   The poverty level component is calculated using a percentage greater than the applicable percentage, equal to % of the official poverty level (still subject to maximum maintenance needs standard).

   The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).

Except that, when applicable, the State will set the community spouse’s monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse’s income, or at the amount of any court-ordered support.
In determining any excess shelter allowance, utility expenses are calculated using:

- [x] the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or
- [ ] the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

- [x] one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B) ) exceeds the dependent family member's monthly income.
- [ ] a greater amount calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1):

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>435.725</td>
<td>d. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:</td>
</tr>
<tr>
<td>435.733</td>
<td>a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:</td>
</tr>
<tr>
<td>435.832</td>
<td>- AFDC level; or</td>
</tr>
<tr>
<td></td>
<td>- Medically needy level:</td>
</tr>
<tr>
<td></td>
<td>(Check one)</td>
</tr>
<tr>
<td></td>
<td>- AFDC levels in Supplement 1</td>
</tr>
<tr>
<td></td>
<td>- Medically needy level in Supplement 1</td>
</tr>
<tr>
<td></td>
<td>- Other:</td>
</tr>
<tr>
<td>435.725</td>
<td>b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:</td>
</tr>
<tr>
<td>435.733</td>
<td>(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.</td>
</tr>
<tr>
<td>435.832</td>
<td>(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A)</td>
</tr>
<tr>
<td>435.725</td>
<td>5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:</td>
</tr>
<tr>
<td>435.733</td>
<td>A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:</td>
</tr>
<tr>
<td>435.832</td>
<td>- No.</td>
</tr>
<tr>
<td></td>
<td>- Yes (the applicable amount is shown on page 5a.)</td>
</tr>
</tbody>
</table>
Amount for maintenance of home is:
$__________________

Amount for maintenance of home is the actual maintenance costs not to exceed $__________________

Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.

Amount for maintenance of home is not deductible when countable income is determined under §1924(d)(1) of the Act.

STATE: New Mexico

DATE REC'D: 12-24-00
DATE APPVD: 12-24-00
DATE EFF: 02-11-00

TN No. 00-10

Supersedes: NONE

Approval Date: 12-14-00
Effective Date: 09-01-00

Page 1 of 2

Revision: HCFA-PM-97-2
December 1997

ATTACHMENT 2.6-A
Page 5a
OMB No.: 0938-0673
ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s) | Condition or Requirement
---|---
42 CFR 435.711, 435.721, 435.831 | C. Financial Eligibility

For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.

For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.

Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.

Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.

Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.

Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.

Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(x)(2) of the Act.

Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(x)(2) of the Act.

Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(a)(1) of the Act.

<table>
<thead>
<tr>
<th>STATE</th>
<th>New Mexico</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE REC'D</td>
<td>11-29-95</td>
</tr>
<tr>
<td>DATE APP'ed</td>
<td>12-17-95</td>
</tr>
<tr>
<td>DATE EFF</td>
<td>10-01-95</td>
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<tr>
<td>HCFA 179</td>
<td></td>
</tr>
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</table>

TN No. 95-14
Superseded 91-19
Approval Date 12/14/95 Effective Date 10/01/95
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1902(r)(2) of the Act</strong></td>
<td>1. Methods of Determining Income</td>
</tr>
<tr>
<td></td>
<td>a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</td>
</tr>
<tr>
<td></td>
<td>(1) In determining countable income for AFDC-related individuals, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>(a) The methods under the State's approved AFDC plan only; or</td>
</tr>
<tr>
<td></td>
<td>X (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td><strong>1902(e)(6) the Act</strong></td>
<td>(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</td>
</tr>
<tr>
<td></td>
<td>(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TN No:</th>
<th>Approval Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supersedes</td>
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<tr>
<td>TN No.</td>
<td></td>
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</tr>
</tbody>
</table>

**SUPERSEDES: TN-92-04**
ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.721, and 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act</td>
<td>b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(4) of the Act, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>X The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>☐</td>
<td>For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>☐</td>
<td>For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
<tr>
<td>☐</td>
<td>For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>☐</td>
<td>For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements—</td>
</tr>
<tr>
<td>SSI methods only.</td>
<td></td>
</tr>
<tr>
<td>SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
<td></td>
</tr>
<tr>
<td>Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.</td>
<td></td>
</tr>
</tbody>
</table>

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(z)(2) of the Act</td>
<td>c. Blind individuals. In determining countable income for blind individuals, the following methods are used:</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td>The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
<tr>
<td></td>
<td>For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1615 or 1634 agreements—</td>
</tr>
<tr>
<td></td>
<td>SSI methods only.</td>
</tr>
<tr>
<td></td>
<td>SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>
7. Maintenance standards for community spouses and other dependent family members used to calculate monthly income allowances under Section 1924 of the Act.

a. Community spouses

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A standard based on the formula contained in Section 1924(d) is used.</td>
</tr>
<tr>
<td>2</td>
<td>The maximum standard contained in Section 1924(d)(3)(C).</td>
</tr>
<tr>
<td>3</td>
<td>A fixed standard which is greater than the minimum standard described in Section 1924(d) plus actual shelter costs not to exceed the maximum standard contained in Section 1924(d)(3)(C). The standard used is $________.</td>
</tr>
</tbody>
</table>

b. Other family members who are dependent

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A standard based on the formula contained in Section 1924(d)(1)(C) is used.</td>
</tr>
<tr>
<td>2</td>
<td>A fixed standard greater than the amount which would be used if the formula described in Section 1924(d)(1)(C) were used. The standard used is $________.</td>
</tr>
</tbody>
</table>

c. The standards described above are used for individuals receiving home and community-based waiver services in lieu of services provided in a medical or remedial care institution.
d. Definition of dependency

The definition of dependency below is used to define dependent children, parents and siblings for purposes of deducting allowances under Section 1924:

Minor children of the couple under the age of 18, disabled adult children of the couple who meet the disability criteria of the Social Security Administration, and dependent siblings or parents of either member of the couple.

These other family members must reside with the community spouse.

The dependency requirements are met if either member of the couple could claim the individual as a dependent for tax purposes under the Internal Revenue Code.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</td>
<td></td>
</tr>
<tr>
<td>d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:</td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>The methods of the SSI program.</td>
</tr>
<tr>
<td>—</td>
<td>SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>—</td>
<td>For institutional couples: the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
<tr>
<td>—</td>
<td>For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>—</td>
<td>For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>
For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1615 or 1634 agreements—

SSI methods only.

SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
ELIGIBILITY CONDITIONS AND REQUIREMENTS

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<td>1902(1)(3)(E) and 1902(r)(2) of the Act</td>
<td>e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(i)(IX) of the Act—</td>
</tr>
</tbody>
</table>

(1) The following methods are used in determining countable income:

- The methods of the State's approved AFDC plan.
- The methods of the approved title IV-E plan.
- The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
- The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
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<tbody>
<tr>
<td>1902(e)(6) of the Act</td>
<td>(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</td>
</tr>
<tr>
<td>1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act</td>
<td>(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</td>
</tr>
<tr>
<td>f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used:</td>
<td></td>
</tr>
<tr>
<td>The methods of the SSI program only.</td>
<td></td>
</tr>
<tr>
<td>SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
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<tr>
<td>For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
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</tr>
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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State:** NEW MEXICO

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

**REVISION:** HCFA-PM-92-1 (MB)  
**July, 1995**

**ATTACHMENT 2.6-A**

**Page 12**

**Superseded by:** Approval Date 01/11/95 Effective Date 07/01/95

**EN No.:** 88-04

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**STATE:** New Mexico  
**DATE REC'D:** 02-16-95  
**DATE APP'D:** 01-11-95  
**DATE EFF:** 02-01-95  
**HCFA 179**
If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.

1905(a) of the Act

(1) Qualified disabled and working individuals.

In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(B)(ii) of the Act, the methods of the SSI program are used.

1905(p) of the Act

(2) Specified low-income Medicare beneficiaries.

In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.
1902(u) of the Act

(h) **COBRA Continuation Beneficiaries**

In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:

- The disregards of the SSI program;
- The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

**NOTE:** For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

(i) Following SSI methodology of determination of financial eligibility, and Medicaid Qualifying Trust law, New Mexico is finding eligible for Institutional Care Medicaid certain individuals who otherwise meet all eligibility criteria, but have gross monthly income in excess of the New Mexico Medicaid income standard, but less than the cost of nursing home care they require. Such individuals execute income-diversion trusts, with all or part of their income irrevocably assigned to the trust. The irrevocable trust has all of the following characteristics:

1. The Trust is set up to receive only the assigned income. No resources are put into the ownership of the trust.

2. The trustee has the discretion to distribute to the beneficiary each month an amount, which in combination with all other income, will amount to less than the current Institutional Care Medicaid income standard. No other monies for any other purposes can be distributed from the trust.

3. Upon the death of the beneficiary, the trust funds will revert to the Medicaid program administered by the State of New Mexico, or any other state where the individual resides at the time of death, so long as the state has paid for Institutional Care Medicaid benefits.
Working Individuals with Disabilities - BBA

In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied:

The methodologies of the SSI program.

The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A.

The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.
Payment of Premiums or Other Cost Sharing Charges

For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of Attachment 2.2-A:

X The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied are described below:

Cost-sharing will be in the form of co-payments to be collected by providers at the time of service as follows:

$7 per outpatient visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session or behavioral health session.

$7 per dental visit

$20 per emergency room visit

$30 per inpatient hospital admission

$5 per prescription, applies to prescription and nonprescription drug items

The state also has a maximum co-payment amount, after which the recipient will no longer have a co-payment requirement for the remainder of the calendar year. The co-payment maximum amounts are:

$600. for an individual with income under 100% of the Federal Poverty Income Guideline (FPL), and $1500. for an individual with income between 100% and 250% of the FPL.

TN No. 01-01
## Citation

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>
| 1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act (cont.) | For individuals eligible under the Basic Coverage Group described in No. 24 on page 23d of Attachment 2.2-A, and the Medical Improvement Group described in No. 25 on page 23d of Attachment 2.2-A: 

**NOTE:** Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds $75,000 pay 100 percent of premiums.

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The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income.

The premiums or other cost-sharing charges, and how they are applied, are described on page 12o.
Citation: Sections 1902(a)(10)(A), (ii)(XV), (XVI), and 1916(g) of the Act (cont.)

Condition or Requirement: Premiums and Other Cost-Sharing Charges

X For the Basic Coverage Group and the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described below.

Cost-sharing will be in the form of copayments to be collected by providers at the time of service as follows:
- $5 per outpatient visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session or behavioral health session.
- $5 per dental visit
- $15 per emergency room visit
- $25 per inpatient hospital admission
- $2 per prescription, applies to prescription and nonprescription drug items

Native American are exempt from copayments.

TN No. 01-01
Supersedes  
TN No.  
SUPERSEDES: NONE - NEW PAGE
2. Medicaid Qualifying Trusts

In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.

☐ The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.

3. Medically needy income levels (MNILs) are based on family size.

Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.
42 CFR 435.732, 435.831 4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only

a. Medically Needy

(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either ___ or ___ month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.

(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:

(a) Health insurance premiums, deductibles and coinsurance charges.

(b) Expenses for necessary medical and remedial care not included in the plan.

(c) Expenses for necessary medical and remedial care included in the plan.

Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.

1902(a)(17) of the Act

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1903(f)(2) of the Act</td>
<td>(3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.</td>
</tr>
</tbody>
</table>

**TN No.** 91-19  
**Approval Date** JAN 15 1992  
**Effective Date** OCT 1 1992  
**HCFA ID:** 7985E/
### Citation

<table>
<thead>
<tr>
<th>Condition or Requirement</th>
</tr>
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<tbody>
<tr>
<td><strong>b. Categorically Needy – Section 1902 (f) States</strong></td>
</tr>
</tbody>
</table>

#### 42 CFR

- **435.732**

  The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:

  1. Any SSI benefit received.

  2. Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.

  3. Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.

  4. Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4.

  5. Incurred expenses for necessary medical and remedial services recognized under State law.

#### 1902(a)(17) of the Act, P.L. 100-203

In incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

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**TH No. 91-19**

<table>
<thead>
<tr>
<th>Supersedes</th>
<th>Approval Date</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>87-17 page 11</td>
<td>JAN 15 1992</td>
<td>OCT 1 1993</td>
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<tr>
<td>87-18 page 12</td>
<td>JAN 15 1992</td>
<td>OCT 1 1993</td>
</tr>
</tbody>
</table>

**HCFA ID:** 7985E
4.b. Categorically Needy - Section 1902(f) States
Continued

1903(f)(2) of the Act

(6) Spenddown payments made to the State by the individual.

NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

TN No. 9119  Approval Date JAN 15 1992  Effective Date OCT 1 1992
Supersedes
TN No.  / Page

HCFA ID: 7985E/
<table>
<thead>
<tr>
<th>Section</th>
<th>T.L.#</th>
<th>Subject</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supp. 1 to AD 26-A, p. 1</td>
<td>90-05</td>
<td>Change in the N.M. Institutional Care Program</td>
<td></td>
</tr>
</tbody>
</table>
5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

   (a) The methods under the State's approved AFDC plan; and

   (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
5. Methods for Determining Resources

1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act

b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(11)(X) of the Act, the agency used the following methods for treatment of resources:

- The methods of the SSI program.
- SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
- Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.
In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.

1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act

c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources:

- The methods of the SSI program.
- SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
- Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
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<tbody>
<tr>
<td>1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act</td>
<td>d. <strong>Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act.</strong> The agency uses the following methods for the treatment of resources:</td>
</tr>
<tr>
<td></td>
<td>X The methods of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
<td>e. <strong>Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act.</strong></td>
</tr>
<tr>
<td></td>
<td>The agency uses the following methods in the treatment of resources.</td>
</tr>
<tr>
<td></td>
<td>X The methods of the SSI program only.</td>
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<td>The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</td>
<td></td>
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<tr>
<td>X</td>
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<td>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</td>
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<tr>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
<td>Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.</td>
</tr>
<tr>
<td>The agency uses the following methods for the treatment of resources:</td>
<td></td>
</tr>
<tr>
<td>The methods of the State's approved AFDC plan.</td>
<td></td>
</tr>
<tr>
<td>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.</td>
<td></td>
</tr>
<tr>
<td>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</td>
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<tr>
<td></td>
<td>The agency uses the following methods for the treatment of resources:</td>
</tr>
<tr>
<td></td>
<td>- The methods of the State's approved AFDC plan.</td>
</tr>
<tr>
<td>1902(1)(3)(C) of the Act</td>
<td>- Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1902(r)(2) of the Act</td>
<td>- Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A.</td>
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<td>- Not applicable. The agency does not consider resources in determining eligibility.</td>
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<td>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</td>
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</table>

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State: **NEW MEXICO**

TN No. **91-19**

Approval Date **APR 29 1992**

Effective Date **JAN 01 1992**

Supersedes **92-04**

**DATE REC'D** **APR 03 1992**

**DATE APV'D** **APR 29 1992**

**DATE EFF** **JAN 01 1992**

**HCFA 179**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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<tbody>
<tr>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
<td>2. Poverty level children under section 1902(a)(10)(A)(1)(VII)</td>
</tr>
</tbody>
</table>

The agency uses the following methods for the treatment of resources:

- The methods of the State's approved AFDC plan.
- Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 8a of ATTACHMENT 2.6-A.
- Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8a to ATTACHMENT 2.6-A.

Not applicable. The agency does not consider resources in determining eligibility.

In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

STATE: New Mexico
DATE REC'D: APR 03 1992
DATE APPV'D: APR 29 1992
DATE EFF: JAN 01 1992
HCFA 179

TN No. 92-04
Supersedes 91-19
Approval Date APR 29 1992
Effective Date JAN 01 1992
<table>
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<tr>
<th>Citation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1905(p)(1) (C) and (D) and</td>
<td>X For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources:</td>
</tr>
<tr>
<td>1902(r)(2) of the Act</td>
<td>The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.</td>
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<td>1905(s) of the Act</td>
<td>i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.</td>
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<td>1902(u) of the Act</td>
<td>j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources:</td>
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<td></td>
<td>The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.</td>
</tr>
</tbody>
</table>
k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act

The agency uses the same method as in 5.h. of Attachment 2.6-A.

6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

   - Same as SSI resource standards.
   - More restrictive.

   The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

   The resource standards are the same as those in the related cash assistance program.

   Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.
<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3)(A), (B) and (C) of the Act</td>
<td>c. For pregnant women covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard. Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard under the SSI program:</td>
</tr>
<tr>
<td></td>
<td>X No. The agency does not apply a resource standard to these individuals.</td>
</tr>
<tr>
<td>For infants covered under the provisions of section 1902(a)(10)(A)(i)(IV)</td>
<td>Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State’s approved AFDC plan.</td>
</tr>
<tr>
<td>and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard.</td>
<td>X No. The agency does not apply a resource standard to these individuals.</td>
</tr>
<tr>
<td>1902(1)(3)(A) and (C) of the Act</td>
<td>d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard.</td>
</tr>
<tr>
<td></td>
<td>Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State’s approved AFDC plan.</td>
</tr>
<tr>
<td></td>
<td>X No. The agency does not apply a resource standard to these individuals.</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1902(1)(3)(A) and (C) of the Act</td>
<td>e. For children covered under the provisions of section 1902(a)(10)(A)(i)(VII) of the Act, the agency applies a resource standard.</td>
</tr>
<tr>
<td></td>
<td>Yes: Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</td>
</tr>
<tr>
<td></td>
<td>No. The agency does not apply a resource standard to these individuals.</td>
</tr>
<tr>
<td>1902(m)(1)(C) and (m)(2)(B) of the Act</td>
<td>f. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(i)(II)(X) of the Act, the resource standard is:</td>
</tr>
<tr>
<td></td>
<td>Same as SSI resource standards.</td>
</tr>
<tr>
<td></td>
<td>Same as the medically needy resource standards which are higher than the SSI resource standards (if the State covers the medically needy).</td>
</tr>
<tr>
<td></td>
<td>Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.</td>
</tr>
</tbody>
</table>
7. Resource Standard - Medically Needy
   
   a. Resource standards are based on family size.
   
   b. A single standard is employed in determining resource eligibility for all groups.
   
   c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for—
      
      — Aged
      — Blind
      — Disabled

   Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 so indicates.

8. Resource Standard - Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries
   
   For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act and specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, the resource standard is twice the SSI standard.

9. Resource Standard - Qualified Disabled and Working Individuals
   
   For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.
State: New Mexico

Citation | Condition or Requirement
--- | ---
7. Resource Standard - Medically Needy

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
a. Resource standards are based on family size.
b. A single standard is employed in determining resource eligibility for all groups.
c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for-

- Aged
- Blind
- Disabled

Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.

8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals

For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI).

TN No: 10-03 Approval Date 8-80-10 Effective Date 1-1-10

SUPERSEDES: TN- 91-19
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>
For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is |
| 1902(u) of the Act | 10. For COBRA continuation beneficiaries, the resource standard is:  
- Twice the SSI resource standard for an individual.  
- More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A. |

**STATE** New Mexico  
**DATE REC'D** 3-3-90  
**DATE APPVD** 5-30-90  
**DATE EFF** 1-1-91  
**HC.TA 179** 10-03  

**TN No:** 10-03  
**Approval Date:** 7-30-91  
**Effective Date:** 1-1-91  
**SUPERSEDES:** TN-91-19
1902(u) of the Act  

10. Excess Resources

a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

Any excess resources make the individual ineligible.

b. Categorically Needy Only

X This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

Any excess resources make the individual ineligible.
10. Excess Resources
   
a. Categorically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals

   Any excess resources make the individual ineligible.

b. Categorically Needy Only

   [X] This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

   Any excess resources make the individual ineligible.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.914</td>
<td>11. Effective Date of Eligibility</td>
</tr>
<tr>
<td></td>
<td>a. Groups Other Than Qualified Medicare Beneficiaries</td>
</tr>
<tr>
<td></td>
<td>(1) For the prospective period.</td>
</tr>
<tr>
<td></td>
<td>Coverage is available for the full month if the following individuals are eligible at any time during the month.</td>
</tr>
<tr>
<td></td>
<td>X Aged, blind, disabled.</td>
</tr>
<tr>
<td></td>
<td>X AFDC-related.</td>
</tr>
<tr>
<td></td>
<td>Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.</td>
</tr>
<tr>
<td></td>
<td>___ Aged, blind, disabled.</td>
</tr>
<tr>
<td></td>
<td>___ AFDC-related.</td>
</tr>
<tr>
<td></td>
<td>(2) For the retroactive period.</td>
</tr>
<tr>
<td></td>
<td>Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:</td>
</tr>
<tr>
<td></td>
<td>___ Aged, blind, disabled.</td>
</tr>
<tr>
<td></td>
<td>___ AFDC-related.</td>
</tr>
<tr>
<td></td>
<td>Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.</td>
</tr>
<tr>
<td></td>
<td>X Aged, blind, disabled.</td>
</tr>
<tr>
<td></td>
<td>X AFDC-related.</td>
</tr>
<tr>
<td>Citation(s)</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>1920(b)(1) of the Act</td>
<td>(3) For a presumptive eligibility period for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.</td>
</tr>
<tr>
<td>1902(e)(8) and 1905(a) of the Act</td>
<td>b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for:</td>
</tr>
<tr>
<td></td>
<td>(3) 12 months</td>
</tr>
<tr>
<td></td>
<td>(2) 6 months</td>
</tr>
<tr>
<td></td>
<td>(4) months (no less than 6 months and no more than 12 months)</td>
</tr>
</tbody>
</table>
12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals

The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.

Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.

13. Transfer of Assets - All eligibility groups

The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.

Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.

14. Treatment of Trusts - All eligibility groups

The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.

The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts;

The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of Miller trusts.

The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 9 to ATTACHMENT 2.6-A.

STATE: APR 0 3 1995
DATE REC'D: APR 1 8 1995
DATE APPR'D: MAR 0 1 1995
DATE EFF: MAR 0 1 1995
HCFA 179
15. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.

When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:

- the maximum standard permitted by law;
- the minimum standard permitted by law; or
- a standard that is an amount between the minimum and the maximum.
<table>
<thead>
<tr>
<th>CONDITION OR REQUIREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>The agency complies with the spousal impoverishment provisions as set forth in Section 1924 (a) of the Act.</td>
</tr>
<tr>
<td>The agency applies the spousal impoverishment policies to persons receiving services under a Section 1915(c) home and community based waiver.</td>
</tr>
<tr>
<td>Applies to all 1915(c) home and community based waivers.</td>
</tr>
<tr>
<td>Applies only to the following 1915(c) waivers:</td>
</tr>
</tbody>
</table>

---

**STATE:** NEW MEXICO

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**In No. 91-19**

**Supersedes 89-13**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Need Standard</th>
<th>Payment Standard</th>
<th>Maximum Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$ 427.35</td>
<td>$231</td>
<td>$231</td>
</tr>
<tr>
<td>2</td>
<td>573.50</td>
<td>310</td>
<td>310</td>
</tr>
<tr>
<td>3</td>
<td>719.65</td>
<td>389</td>
<td>389</td>
</tr>
<tr>
<td>4</td>
<td>867.65</td>
<td>469</td>
<td>469</td>
</tr>
<tr>
<td>5</td>
<td>1013.80</td>
<td>548</td>
<td>548</td>
</tr>
<tr>
<td>6</td>
<td>1159.95</td>
<td>627</td>
<td>627</td>
</tr>
<tr>
<td>7</td>
<td>1306.10</td>
<td>706</td>
<td>706</td>
</tr>
</tbody>
</table>

2. Pregnant Women and Infants under Section 1902(a)(10)(i)(IV) of the Act:

Effective April 1, 1990 based on the following percent of the official federal income poverty level--

\[ \times \] 133 percent / / ______ percent (no more than 185%) (specify)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

A. INCOME ELIGIBILITY LEVELS - CATEGORICALLY NEEDY continued

Pregnant Women, Infants, and Children Under Age 6

The levels for determining income eligibility for groups of pregnant women, infants, and children under age 6 under the provisions of 1902(a)(10)(A)(i)(VI) of the Act are as follows:

Based on 133% percent of the official Federal income poverty line:

<table>
<thead>
<tr>
<th># Of Persons in Assistance Unit</th>
<th>133% of FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$755</td>
</tr>
<tr>
<td>2</td>
<td>1019</td>
</tr>
<tr>
<td>3</td>
<td>1283</td>
</tr>
<tr>
<td>4</td>
<td>1547</td>
</tr>
<tr>
<td>5</td>
<td>1810</td>
</tr>
<tr>
<td>6</td>
<td>2074</td>
</tr>
<tr>
<td>7</td>
<td>2338</td>
</tr>
</tbody>
</table>

Add $264 for each additional household member.
A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 15), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.
INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(1)(A)(11)(IX) and 1902(1)(2) of the Act are as follows:

Based on 185 percent of the official Federal income poverty level (no less than 133 percent and no more than 185 percent).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW MEXICO

OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO THE SUPPLEMENTAL SECURITY INCOME (SSI) FEDERAL BENEFIT RATE

1. Individuals in institutions who are eligible under a special income level (42 CFR 435.231)
   - The State allows eligibility for individuals with income that does not exceed 300 percent of the SSI Federal benefit rate.
   - The State has elected to allow eligibility for individuals with income at an amount lower than 300 percent of the SSI Federal benefit rate.

STATE: New Mexico
DATE REC'D: 6-9-98
DATE APPRV'D: 8-12-98
DATE ENR: 4-1-99
HCFA 179: 99-03

TN No. 9385 Approval Date 8-12-98 Effective Date 4-1-99
Supersedes
TN No. 98-10
C. INCOME ELIGIBILITY LEVELS - OPTIONAL GROUP OF QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES UP TO FEDERAL POVERTY LINE

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

Based on 100 percent of the official Federal nonfarm income poverty line:

$552 for an individual
$740 for couple.
INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(4) of the Act are as follows:

Based on ___ percent of the official Federal income poverty line.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$_______</td>
</tr>
<tr>
<td>2</td>
<td>$_______</td>
</tr>
<tr>
<td>3</td>
<td>$_______</td>
</tr>
<tr>
<td>4</td>
<td>$_______</td>
</tr>
<tr>
<td>5</td>
<td>$_______</td>
</tr>
</tbody>
</table>

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOME RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989: \( \frac{\text{Income}}{\text{Percent}} \) 85 percent (no more than 10
Eff. Jan. 1, 1990: \( \frac{\text{Income}}{\text{Percent}} \) 90 percent (no more than 10
Eff. Jan. 1, 1991: 100 percent
Eff. Jan. 1, 1992: 100 percent

CA. QUALIFIED DISABLED WORKING INDIVIDUALS WITH INCOME RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified disabled working individuals under the provisions of section 1905(s) of the Act are as follows: 200% of the federal income poverty levels effective July 1, 1990.

Income levels for QMB's & QD's will be revised each April 1 to reflect the updated FPL figures for that year; i.e., April 1, 1993 for 1993; April 1, 1994 for 1994, etc.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1989 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

   Eff. Jan. 1, 1989: □ 80 percent □ _____ percent (no more than 100)
   Eff. Jan. 1, 1990: □ 85 percent □ _____ percent (no more than 100)
   Eff. Jan. 1, 1991: □ 95 percent □ _____ percent (no more than 100)
   Eff. Jan. 1, 1992: 100 percent

b. Levels:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$___________</td>
</tr>
<tr>
<td>2</td>
<td>$___________</td>
</tr>
</tbody>
</table>

TN No. 97-19 Supersedes Approval Date JAN 1 1992 Effective Date OCT 1 1991
HCFA ID: 7985E

STATE NEW MEXICO
DATE REC'D DEC 17 1991
DATE APPROVD JAN 15 1992
DATE EFF OCT 1 1991
HCFA 179 A
**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State: **NEW MEXICO**

**INCOME LEVELS (Continued)**

___ Applicable to all groups. ___ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net income level protected for maintenance for months</th>
<th>Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007(^1)</th>
<th>Net income level for persons living in rural areas for months</th>
<th>Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$ $</td>
<td>$ $</td>
<td>$ $</td>
<td>$ $</td>
</tr>
<tr>
<td>2</td>
<td>$ $</td>
<td>$ $</td>
<td>$ $</td>
<td>$ $</td>
</tr>
<tr>
<td>3</td>
<td>$ $</td>
<td>$ $</td>
<td>$ $</td>
<td>$ $</td>
</tr>
<tr>
<td>4</td>
<td>$ $</td>
<td>$ $</td>
<td>$ $</td>
<td>$ $</td>
</tr>
</tbody>
</table>

For each additional person, add: $ $ $ $ $ $.

\(^1\) The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net income level protected for maintenance for months</th>
<th>Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007½</th>
<th>Net income level for persons living in rural areas for months</th>
<th>Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007½</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>6</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>7</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>8</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>9</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>10</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

For each additional person, add: $                                                    $                                                                          $                                                               $                                                               

¹ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

TN No. 91-19
Supersedes Approval Date JAN 15 1992
Effective Date Oct 1 1991

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women
   a. Mandatory Groups
      □ Same as SSI resources levels.
      □ Less restrictive than SSI resource levels and is as follows:

         | Family Size | Resource Level |
         |-------------|---------------|
         | 1           | no resource limit |
         | 2           |               |

   b. Optional Groups
      □ Same as SSI resources levels.
      □ Less restrictive than SSI resource levels and is as follows:

         | Family Size | Resource Level |
         |-------------|---------------|
         | 1           | no resource limit |
         | 2           |               |

TN No. 91-19  Approval Date JAN 15 1992  Effective Date OCT 1 1991
Supersedes TN No. 88-15

HCFA ID: 7985E

STATE NEW MEXICO
DATE FILED DEC 17 1991
DATE APPROVED JAN 15 1992
DATE EFF OCT 1 1991
2. Infants

a. Mandatory Group of Infants

- Same as resource levels in the State's approved AFDC plan.
- Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
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<tbody>
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<td>10</td>
<td>no resource standards applied</td>
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TN No. 91-19
Supersedes TN No. 88-25

Approval Date JAN 1 5 1992
Effective Date OCT 1 1991

HCFA ID: 7985E
## Optional Group of Infants

- Same as resource levels in the State's approved AFDC plan.
- Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
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**Supersedes:** 91-19  
**Approval Date:** JAN 15 1992  
**Effective Date:** OCT 1 1991  
**HCFA ID:** 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

3. Children
   a. Mandatory Group of Children under Section 1902(a)(10)(I)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

   ___ Same as resource levels in the State's approved AFDC plan.
   X Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
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<tbody>
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STATE: New Mexico
DATE REC'D: APR 03 1992
DATE APPV'D: APR 29 1992
DATE EFF: JAN 01 1992
HCFA 179

TN NO. 92-04
Superseded Approval Date APR 29 1992 Effective Date JAN 01 1992
TN NO. 92-04
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

Mandatory Group of Children under Section 1902(a)(10)(A)(Y)(70) of the Act (children who were born after 4-30-83 and have attained age 6 but have not attained age 18) have same as resource levels in the State's approved AFDC plan.

Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
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Supersede: 91-19
TN No. 22-04
Approval Date APR 29 1992 Effective Date JAN 01 1992
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
NEW MEXICO

State: ____________________________

4. Aged and Disabled Individuals

☐ Same as SSI resource levels.
☐ More restrictive than SSI levels and are as follows:

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<thead>
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<th>Resource Level</th>
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<tbody>
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</table>

☐ Same as medically needy resource levels (applicable only if State has a medically needy program)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

☐ Except those specified below under the provisions of section 1902(f) of the Act.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
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For each additional person

TN No. 91-19
Supersedes Approval Date JAN 15 1992 Effective Date OCT 1 1991

HCFA ID: 7985E
- ADDENDUM TO SECTION 4.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM
STATE PLAN TEMPLATE

Section 4. Eligibility Standards and Methodology (section 2102(b))

4.1.3. X Income: Disregards

X All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

In determining the amount of the medical care credit for recipients of the Medical Assistance for persons requiring Institutional Care Program, $30 for personal needs is an allowable deduction from the individual's income. In addition, an amount equal to the current Medicare Part B Premium is allowed for medical bills incurred prior to Medicaid eligibility; an amount equal to the current Part B Premium is allowed for noncovered drugs; an amount equal to the current Part B Premium is allowed for noncovered physician services; an amount equal to the current Part B Premium will be allowed for noncovered equipment and medical supplies and an amount equal to the current Part B Premium will be allowed for other practitioners licensed under state law but not included as a covered benefit under the New Mexico Medicaid Program.

If the institutionalized individual has medical or health insurance and is responsible for paying the premium(s), the full amount of the premium payment(s) are an allowable deduction from the individual's income when calculating the medical care credit.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW MEXICO

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)
MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

TN No. 91-17 Supersedes JAN 1 5 1992 Effective Date OCT 1 1992
TN No. X X X X Approval Date 7985E

STATE NEW MEXICO DEC 1 7 1991
DATE ZED JAN 1 5 1992
DATE A prob OCT 0 1 1992
DATE : 91-19
HCFA ID:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

NEW MEXICO

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

TN No. 91-19
Supersedes
TN No. 85-7
Approval Date JAN 15 1992
Effective Date OCT 1 1991

HCFA ID: 7985E

STATE NEW MEXICO
DATE EN B DEC 17 1991
DATE ACT. JAN 15 1992
DATE EN B OCT 01 1991
HCFA ID 91-19
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

TN No. 92-27
Supersedes
TN No. 85-7

Approval Date JAN 15 1992
Effective Date OCT 1 1999

HCFA ID: 7985E

STATE: New Mexico
DATE RECEIVED: DEC 17 1991
DATE COPY: JAN 15 1992
DATE AMT: OCT 01 1991
HCFA 179: 91-19
State Plan Under Title XIX of the Social Security Act

State: New Mexico

LESS RESTRICTIVE METHODS OF TREATING INCOME UNDER SECTION 1902(t)(2) OF THE ACT

X  For all eligibility groups not subject to the limitations on payment explained in section 1903(f) of the Act*: All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

* Less restrictive methods may not result in exceeding gross income limitations under section 1903(f).
MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(f)(2) OF THE ACT*

☐ Section 1902(f) State ☐ Non-Section 1902(f) State

For individuals in institutions, who are eligible under a special income cap, the state uses the following more liberal income policy.

For married individuals, there is a rebuttable presumption that the total monthly income received by spouses is community property income. One half of the total community income will be attributed to the spouse at home. If the spouse at home receives more than one half of the total community income in his or her name, only the institutionalized spouse's income in his/her name will be considered for eligibility purposes. Community property principles are applicable only for purposes of establishing eligibility.

This policy will not apply in any situation where use of the rule would result in an individual not being eligible for Medicaid where he would have been eligible using name-on-the-check methodology.

Anyone whose income exceeds the FPP limits of 300% of FPL or SSI FRR will be made eligible by use of this more liberal income eligibility methodology. For married individuals institutionalized individuals with same income in their own home than the spouse at home, this test will be done using their community property share (1/2) of the total community income.

*More liberal methods may not result in exceeding gross income limitations under section 1903(f).
MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(f)(2) OF THE ACT*

☐ Section 1902(f) State    ☒ Non-Section 1902(f) State

For individuals in institutions, who are eligible under a special income
cap, the state uses the following more liberal income policy.

For married individuals, there is a rebuttable presumption that the total
monthly income received by spouses is community property income. One half
of the total community income will be attributed to the spouse at home. If
the spouse at home receives more than one half of the total community income
in his or her name, only the institutionalized spouse's income in his/her
name will be considered for eligibility purposes. Community property prin-
ciples are applicable only for purposes of establishing eligibility.

This policy will not apply in any situation where use of the rule would
result in an individual not being eligible for Medicaid where he would
have been eligible using name-on-the-check methodology.

No one whose income exceeds the FFP limits of 300% of the current SSI FBR
will be made eligible by use of this more liberal income eligibility
methodology. For married institutionalized individuals with more income
in their own name than the spouse at home, this test will be done using
their community property share (1/2) of the total community income.

*More liberal methods may not result in exceeding gross income limitations
under section 1903(f).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902 (r)(2) OF THE ACT*

☐ Section 1902(f) State ☒ Non-Section 1902(f) State

For a married individual applying for the Qualified Medicare Beneficiaries program who lives in the same household as his/her ineligible spouse, the state will disregard from the applicant's own total gross monthly income an amount up to the difference between the federal income poverty level (FPL) for the size of the family involved (i.e., two) and the FPL for an individual. The resulting figure will then be compared to the FPL for an individual. If that figure is below the FPL for an individual, the state will proceed to determine the ineligible spouse's total gross income (both earned and unearned) and subtract appropriate living allowances for any ineligible minor dependent children of either member of the couple who live in the home. The resulting combined countable income of the applicant and the ineligible spouse, minus appropriate disregards for unearned and earned income, is then compared to the FPL for two persons. If the combined income is less than the FPL for two persons, the applicant is eligible on the factor of income.

* More liberal methods may not result in exceeding gross income limitations under Section 1903(f).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT*

// Section 1902(f) State /X/ Non-Section 1902(f) State

1. For children identified under provisions of 1902 (a)(10)(A)(i)(VI), 1902 (1)(1)(C) of the Act, disregard from the countable income of the assistance unit the difference between 185% of the federal poverty guidelines, as revised annually in the Federal Register, and 133% of the federal poverty guidelines for the size of the assistance unit involved.

2. For children born after September 30, 1983, as described in 1902 (a)(10)(A)(i)(VII), 1902 (1)(1)(D) disregard from the countable income of the assistance unit the difference between 185% of the federal poverty guidelines, as revised annually in the Federal Register, and 100% of the federal poverty guidelines for the size of the assistance unit involved.

3. For dependent children identified under provisions of 1902(a)(10)(A)(i)(VI) 1902(1)(1)(C), and children born after September 30, 1983, as described in 1902(a)(10)(A)(i)(VII) and 1902(1)(1)(D), the state will disregard all earned income from the countable income calculations.

*More liberal methods may not result in exceeding gross income limitations under section 1903(f).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State NEW MEXICO

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

// Section 1902(f) state /X/ Non-section 1902(f) state

4) The following applies to infants described at sections 1902(a)(10)(A)(i)(IV) and 1902(1)(1)(B) and children ages 1 through 5 described at 1902(a)(10)(A)(i)(VI) and 1902(1)(1)(C) of the statute.

An earned income disregard of seven hundred-fifty dollars ($750) dollars will be applied to the gross earned income of the parent(s).

The dependent care deduction will be the greater of actual care costs or three hundred-seventy-five ($375) dollars per household whichever is greater.

5) For Working Disabled Individuals Medicaid group, an amount equal to the current SSI FBR is disregarded for purposes of the second step in the income eligibility determination process (i.e. the individual must meet SSI income criteria when the individual's earnings are disregarded).

6) For Working Disabled Individual Medicaid group, work-related expenses for the disabled and for the blind will be deducted after the "1/2 of the remainder of the earnings" deduction is applied.

7) The following applies to Pregnant Women and Infants covered under the provisions of section 1902(a)(10)(A)(ii)(IX) of the Act: An amount of income equal to the difference between 185% and 235% FPL for the appropriate household size will be disregarded from income calculations.


SUPERSEDES: TN-07-02

STATE New Mexico
DATE REC'D 4-9-08
DATE APP'D 6-3-08
DATE EFF 7-1-08
HCFA 179 03-01
Federal and State tax refunds and refundable tax credits are excluded as income for the following eligibility groups:

- Poverty level pregnant women and infants under 1902(a)(10)(A)(i)(IV).
- Poverty level children aged 1 up to age 6 under 1902(a)(10)(A)(i)(VI).
- Optional categorically needy groups under 1902(a)(10)(A)(ii) as listed below.

Working Disabled Individuals under 1902(a)(10)(A)(ii)(XIII)
Pregnant women and infants under 1902(a)(10)(A)(ii)(IX)

**NOTE:** The Special Income Level Group under 1902(a)(10)(A)(ii)(V), the Individuals Who Would be Eligible if in an Institution Group under 1902(a)(10)(A)(ii)(VI) and the Hospice Group under 1902(a)(10)(A)(ii)(VII) cannot be included in this disregard.

- All aged, blind or disabled groups in 209(b) states under 1902(f).
- QMBs, SLMBs and QIs under 1905(p),
Federal and State tax refunds and refundable tax credits are excluded as resources for the following eligibility groups:

- Poverty level pregnant women and infants under 1902(a)(10)(A)(i)(IV).
- Poverty level children aged 1 up to age 6 under 1902(a)(10)(A)(i)(VI).
- Optional categorically needy groups under 1902(a)(10)(A)(ii) as listed below.
- Working Disabled Individuals under 1902(a)(10)(A)(ii)(XIII)
- All aged, blind or disabled groups in 209(b) states under 1902(f).
- QMBs, SLMBs and QIs under 1905(p).
New Mexico Revision
December, 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New Mexico

b. No individual is ineligible by reasons of A.1. if:

i. The resource transferred was a home, and title to the home was transferred to:

(a) a child of the institutionalized individual who is under age 21 or who is blind or disabled (as determined by SSI);

(b) a son or daughter of the institutionalized individual who resided in the home for at least two years before the applicant was admitted to the medical institution or nursing facility, and who provided care which enabled the institutionalized individual to remain at home during that period; or

(c) a sibling of the institutionalized individual who has an equity interest in the home and was residing in the home for at least one year before the applicant was admitted to the medical institution or nursing facility.

TN No. 9823 Approval Date 1/25/94 Effective Date 10/1/93
Superseded TN No. 85-07

STATE: New Mexico
DATE RECEIVED 12-22-93
DATE APPEV'D 10-1-93
DATE EFF 10-1-93
HCFA 179
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

ii. A satisfactory showing is made that the individual intended to dispose of the resources at fair market value or for other valuable consideration, or that the resources were transferred exclusively for a purpose other than to qualify for medical assistance.

iii. It is determined that denial of eligibility would work an undue hardship. Undue hardship exists if each condition below is met:

(a) The transfer was made to someone other than a family member.

(b) The applicant can present convincing evidence that every effort was made to recover the transferred resource; and

(c) It is verified that the applicant is unable to obtain care in any long-term care facility in the state without Medicaid coverage including state-run facilities.
2. Effective October 1, 1993, the transfer of asset provisions are in accordance with OBRA 93 as follows:
   a. The lookback period will be 36 months (or 60 months in the case of transfers to trusts);
   b. There will be no cap on the period of ineligibility;
   c. There will be no overlapping of periods of ineligibility;
   d. The total value of all assets transferred will be divided by the average cost to a private patient of nursing facility services in the state to determine the number of months of ineligibility.
   e. The exceptions to the period of ineligibility will be applied in accordance with Section 13611 of Public Law 101-66 dated August 10, 1993.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

No individual is ineligible by reason of item A.2 if:

i. A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;

ii. Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;

iii. A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or

iv. The agency determines that denial of eligibility would work an undue hardship.

APPROVED BY DHHS/HCFA/DFO

DATE: JAN 30 1986

TRANSMITTAL NO: 85-7
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

3. 1902(f) States

Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is $12,000 or less:

   Specified elsewhere

2. If the uncompensated value of the transfer is more than $12,000:

   Specified elsewhere

APPROVED BY DHHS/HCFA/DPO
DATE: JAN 30 1986
TRANSMITTAL NO: 85-7
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

If the resource could have been excluded at the time of transfer, then it is not considered to be a transfer affecting eligibility.

APPROVED BY DHHS/HCFA/DPO
DATE:  JAN  30 1986
TRANSMITTAL NO:  85-7

TN No. 85-7
Supersedes 4093B/0002P
Approval Date  JAN  30 1986  Effective Date  OCT 1 1985

HCFA ID: 4093B/0002P
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

TRANSFER OF RESOURCES

C. The agency will comply with the mandatory provision under Section 1917 of the Social Security Act as amended by the Deficit Reduction Act of 2005.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by
reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid
services upon disposing of assets for less than fair market value
on or after the look-back date.

The agency withholds payment to institutionalized individuals for
the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a
medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

The agency applies these provisions to the following non-
institutionalized eligibility groups. These groups can be
no more restrictive than those set forth in section 1905(a)
of the Social Security Act:

The agency withholds payment to non-institutionalized individuals
for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled and
elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not
inpatients in certain medical institutions, as recognized
under agency law and specified in section 1905(a)(24).

The following other long-term care services for which
medical assistance is otherwise under the agency plan:

<table>
<thead>
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<td>APR 18 1995</td>
</tr>
<tr>
<td>DATE EFF</td>
<td>MAR 01 1995</td>
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Supersedes Approval Date APR 18 1995 Effective Date MAR 01 1995

SUPERSEDES: NONE - NEW PAGE
TRANSFER OF ASSETS

3. **Penalty Date**—The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

- X the first day of the month in which the asset was transferred;
- the first day of the month following the month of transfer.

4. **Penalty Period—Institutionalized Individuals**—In determining the penalty for an institutionalized individual, the agency uses:

- X the average monthly cost to a private patient of nursing facility services in the state;
- the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. **Penalty Period—Non-institutionalized Individuals**—The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

- imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

---

New Mexico

STATE

DATE REC'D APR 03 1995
DATE APPVD APR 18 1995
DATE EFF MAR 01 1995
HCFA 179 25-86
TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care:
   a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:
      
      \[\times\] does not impose a penalty;
      
      imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.
   b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:
      
      \[\times\] does not impose a penalty;
      
      imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap:
   The agency:
      
      \[\times\] totals the value of all assets transferred to produce a single penalty period;
      
      calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap:
   The agency:
      
      \[\times\] assigns each transfer its own penalty period;
      
      uses the method outlined below.
TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

Any existing penalty period is divided equally between the spouses if both are Medicaid eligible.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

For transfers of individual income payments, the agency will impose partial month penalty periods.

For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

The agency uses an alternate method to calculate penalty periods, as described below:

[Signature]

STATE New Mexico

DATE REC'D APR 03 1995
DATE APVD APR 08 1995
DATE EFF MAR 01 1995
HCFA 179

TN No. 95-86
Supersedes SUPERSEDES - NONE - NEW PAGE

Approval Date APR 18 1995
Effective Date MAR 01 1995
TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship—
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

When appropriate, recipients are notified of the existence of hardship provisions as contained in the state policy manual.

A decision to approve, deny or delay the disposition of the application must be made within thirty (30) days.

Client notices contain the statement that any adverse action may be appealed based upon notification to the Human Services Department's Hearings Bureau by the applicant/recipient or his/her representative.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

(1) The assets were transferred to someone other than a family member.

(2) The applicant can present convincing evidence that every effort was made to recover the transferred resource, and

(3) The applicant is unable to obtain care in any long-term care facility in the state without Medicaid coverage.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

TRANSFER OF ASSETS

12. The agency will comply with the mandatory provision under Section 1917 of the Social Security Act as amended by the Deficit Reduction Act of 2005.

STATE: New Mexico
DATE REC'D: 5-2-06
DATE APPROV.: 9-8-06
DATE EFF.: 4-1-06
HCFA 179 6-6-6

TN # O6-06 Approval Date 9-8-06 Effective Date 4-1-06
Supersedes
TN # SUPERCEDE NONE -NEW PAGE
DIDNT CORR!
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

Undue hardship is considered to exist if denial of medical assistance would deprive the individual of food, shelter or medical care.

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is N/A.
COST EFFECTIVENESS METHODOLOGY FOR
COBRA CONTINUATION BENEFICIARIES

1902(u) of the Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

- The methodology as described in SMM section 3598.
- Another cost-effective methodology as described below.

TN No. 91-19 Approval Date JAN 1 5 1992 Effective Date OCT 1 199

Supersedes TN No. 91-05

HCFA ID: 7985E
State Plan Under Title XIX of the Social Security Act

State: New Mexico

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

X The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW MEXICO
ELIGIBILITY—UNDER SECTION 1931 OF THE ACT

The state covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State Plan effective July 16, 1996:

X Pregnant women with no other children.
X AFDC children age 18 who are full-time students in a secondary school or the equivalent level of vocational or technical training.

In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 without modification.

X In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 with the following modifications:

The agency applies lower income standards, which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

SUPERSEDES: TN No. 00-02
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ___New Mexico_____

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

Up to the first $100. of income received by an institutionalized recipient in an ICF-MR from employment in a sheltered workshop or other work activity program may be allowed for personal needs, in addition to the $63 from unearned income.

TN No. 09-01
Supersedes TN No. 08-02

Approval Date 5-26-09 Effective Date 7-1-09
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW MEXICO
ELIGIBILITY—UNDER SECTION 1931 OF THE ACT

(Continued)

X The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

- The first $120 and 1/3 of the remainder is deducted from the earned income of each household member, with no time limits on the deductions.

- Resource determination methodology allows for exclusion of all resources.

- For purposes of determining countable income, the state disregards all of the earned income of all dependent children.

- The state disregards wages from the Census Bureau for temporary employment related to Census activities.

X The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

- Earned income disregards are the first $90 and an additional $30 and 1/3 of the remainder, if certain criteria are met, for a time-limited period of time.

- Excludable resources include the first $1,500 liquid resources, $2,000 in non-liquid resources, and total value of at least one vehicle, and in some parts of the state additional vehicles.

STATE New Mexico
DATE REC 7-4-08
DATE APPV'D 6-3-08
DATE EFF 7-1-08
HCFA 179 03-01

SUPERSEDES: TN—04-05

TN No. 08-01
Supersedes
TN No. 04-05

Approval Date 6-3-08 Effective Date 7-1-08
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

ELIGIBILITY--UNDER SECTION 1931 OF THE ACT

The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996 as follows:

Federal and State tax refunds and refundable tax credits are excluded as income and resources for individuals eligible under 1931 authority.

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

Certain Federal and State tax refunds and refundable tax credits were not excluded as income and resources for individuals eligible under 1931 authority.

SUPERSEDES: NONE - NEW PAGE
X The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

- All earned income is excluded in the second or third month for two months starting with the month a family exceeds 1931 income standards. This will allow Transitional Medicaid coverage for any family who loses eligibility for 1931 Medicaid due to earnings, and will give the family the necessary twelve months of post 1931 eligibility Transitional Medicaid coverage.

X The agency continues to apply the following waivers of provisions of part A of title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

Waiver of 402(a)(41) is as follows:

- The 100 hour rule for unemployed parents is waived. Thus, eligibility for 1931 Medicaid may exist regardless of the absence or presence of 'deprivation' criteria.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: NEW MEXICO

SECTION 1924 PROVISIONS

A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.

B. In the determination of resource eligibility the State resource standard is $ 2,000.

C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:

1). The excess resource must be a non-liquid asset with a fair market value of $30,000 or less, and

2). The client or representative must demonstrate that a bona fide effort to sell or liquidate the resource has been unsuccessful, and

3). The applicant or representative must continue to make a bona fide effort to sell the property for as long as eligibility continues, or the property is sold, and

4). It is verified that the applicant is unable to obtain care in any long-term care facility in the state without Medicaid coverage. The client is required to verify only that he/she cannot obtain admission to the state-run facilities.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

ASSET VERIFICATION SYSTEM

1940(a) of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

   A. The request and response system must be electronic:

      (1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).

      (2) The system cannot be based on mailing paper-based requests.

      (3) The system must have the capability to accept responses electronically.

   B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department’s National Institute of Standards and Technology, or NIST).

   C. The system must establish and maintain a database of FIs that participate in the agency’s AVS.

   D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant’s home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual’s eligibility.

   E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

ASSET VERIFICATION SYSTEM

2. System Development

   A. The agency itself will develop an AVS.

      In 3 below, provide any additional information the agency wants to include.

   X  B. The agency will hire a contractor to develop an AVS.

      In 3 below provide any additional information the agency wants to include.

   C. The agency will be joining a consortium to develop an AVS.

      In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

   D. The agency already has a system in place that meets the requirements for an acceptable AVS.

      In 3 below, describe how the existing system meets the requirements in Section 1.

   E. Other alternative not included in A. -- D. above.

      In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual’s home, when the individual’s equity interest in the home exceeds the following amount:

\[ \text{X} \times \$500,000 \text{ (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000)}. \]

An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is ________________.

____ This higher standard applies statewide.

____ This higher standard does not apply statewide. It only applies in the following areas of the State:

____ This higher standard applies to all eligibility groups.

____ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.
<table>
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<th>Section</th>
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<th>Subject</th>
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<td>Change in the N. M. Institutional Care Program</td>
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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAl CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
Provided: □ No limitations  □ With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

1905(a)(4)(C)

4.c.(i) Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Att. 2.2-A, B, if this eligibility option is elected by the State.
Provided: □ No limitations  □ With limitations*

4.c.(ii) Family planning-related services provided under the above State Eligibility Option

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.
Provided: □ No limitations  □ With limitations*

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).
Provided: □ No limitations  □ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.
Provided: □ No limitations  □ With limitations*

* Description provided on attachment.

STATE_ New Mexico
DATE REC'D_ 12-21-10
DATE APPVD_ 2-24-11
DATE EFF_ 2-1-11
HCFA 179_ 10-12

TN No. _10-12_ Approval Date_ 2-24-11_ Effective Date_ 2-1-11_

Supersedes TN No. _93-10_

SUPERSEDES: TN- _93-10_
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.
   Provided: □ No limitations  □ With limitations*

2.a. Outpatient hospital services.
   Provided: □ No limitations  □ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic and covered under the Plan.
   □ Provided: □ No limitations  □ With limitations*
   □ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
   Provided: □ No limitations  □ With limitations*

3. Other laboratory and x-ray services.
   Provided: □ No limitations  □ With limitations*

*Description provided on attachment.

TN No. 91-19
Supersedes Approval Date JAN 1 5 1992 Effective Date OCT 1 1991
TN No. 91-11 Page 1 States 1-3
HCFA ID: 7986E
State/Territory: New Mexico

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: _X_ No limitations _X_ With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: ___ No limitations _X_ With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ___ No limitations _X_ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations _X_ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: ___ No limitations _X_ With limitations*

* Description provided on attachment.

TN No. 93-10
Supersedes 93-D1
Approval Date JUL 20 1993
Effective Date MAY 01 1993
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.
   - X Provided: No limitations
   - X With limitations
   - Not provided.

c. Chiropractors' services.
   - Not provided.

7. Home health services.
   a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.
      - Provided: No limitations
      - X With limitations
   b. Home health aide services provided by a home health agency.
      - Provided: No limitations
      - X With limitations
   c. Medical supplies, equipment, and appliances suitable for use in the home.
      - Provided: No limitations
      - X With limitations

*Description provided on attachment.

TN No. 89-10
Supersedes Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. 88-10 page 2
88-8 page 5
HCFA ID: 7986E

STATE NEW MEXICO
DATE RFPD DEC 17 1991
DATE RCFD JAN 15 1992
DATE AFFD OCT 01 1991
HCFA 177 91-19
d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

[ ] Provided: [ ] No limitations [X] With limitations*
[ ] Not provided.

8. Private duty nursing services.

[ ] Provided: [ ] No limitations [X] With limitations*
[ ] Not provided.

*Description provided on attachment.
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.
   ☑ Provided: ☐ No limitations ☑ With limitations*
   ☐ Not provided.

10. Dental services.
    ☑ Provided: ☐ No limitations ☑ With limitations*
        ☐ Not provided.

11. Physical therapy and related services.
    
a. Physical therapy.
       ☑ Provided: ☐ No limitations ☑ With limitations*
           ☐ Not provided.

    b. Occupational therapy.
       ☑ Provided: ☐ No limitations ☑ With limitations*
           ☐ Not provided.

    c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).
       ☑ Provided: ☐ No limitations ☑ With limitations*
           ☐ Not provided.

*Description provided on attachment.
AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDED

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses
prescribed by a physician skilled in diseases of the eye or by an
optometrist.

a. Prescribed drugs.

[ ] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

b. Dentures.

[ ] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

c. Prosthetic devices.

[ ] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

d. Eyeglasses.

[ ] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services,
  i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

[ ] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

*Description provided on attachment.

APPROVED BY DHHS/HCFA/DPO
DATE: 1-30-86
TRANSMITTAL NO: 85-8

TW No. 85-8
Supersedes
TW No. 24-2
Approval Date 1-30-86
Effective Date 10-01-86

HCFA ID: 0069P/0002P
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.
   ☐ Provided: ☐ No limitations ☐ With limitations*
   ☑ Not provided.

c. Preventive services.
   ☐ Provided: ☐ No limitations ☐ With limitations*
   ☑ Not provided.

d. Rehabilitative services.
   ☐ Provided: ☐ No limitations ☑ With limitations*
   ☑ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.
   a. Inpatient hospital services.
      ☑ Provided: ☐ No limitations ☑ With limitations*
      ☑ Not provided.

   b. Nursing facility services.
      ☑ Provided: ☑ No limitations ☑ With limitations*
      ☑ Not provided.

*Description provided on attachment.

STATE: New Mexico
DATE REC'D: 6-9-73
DATE APPV'D: 10-22-73
DATE EFF: 4-1-74
HCFA 179

TW No. 93-08
Approval Date: 10/22/73 Effective Date: 04/01/73
15. Services in an intermediate care facility for the mentally retarded, as defined in section 1905(d), (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care.

[ ] Provided: [ ] No limitations [ ] With limitations*
[ ] Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[ ] Provided: [ ] No limitations [ ] With limitations*
[ ] Not provided.

17. Nurse-midwife services.

[ ] Provided: [ ] No limitations [ ] With limitations*
[ ] Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

[ ] Provided: [ ] No limitations [ ] With limitations*
[ ] Not provided.

*Description provided on attachment.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: New Mexico

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services
   a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).
      X Provided: X With limitations
      ___ Not provided.
   b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.
      ___ Provided: ___ With limitations
      ___ Not provided.

20. Extended services for pregnant women
   a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.
      ___ Additional coverage ++
   b. Services for any other medical conditions that may complicate pregnancy.
      X Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

STATE
DATE REC'D 7-20-94
DATE APPV'D 8-11-94
DATE EFF 7-1-94
HCFA 179

TN No. 94-08
Superseded Approval Date 8-11-94 Effective Date 7-1-94

TN No. 91-19
21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a provider (in accordance with section 1920 of the Act).

Provided: No limitations With limitations
Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

Provided: No limitations With limitations
Not provided.

23. Pediatric or family nurse practitioners' services.

Provided: No limitations With limitations

*Description provided on attachment.
24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
   a. Transportation.
      ☑ Provided: ☑ No limitations ☑ With limitations*
      □ Not provided.

   b. Services of Christian Science nurses.
      □ Provided: □ No limitations ☑ With limitations*
      ☑ Not provided.

   c. Care and services provided in Christian Science sanitoria.
      □ Provided: □ No limitations ☑ With limitations*
      ☑ Not provided.

   d. Nursing facility services for patients under 21 years of age.
      □ Provided: ☑ No limitations ☑ With limitations*
      □ Not provided.

   e. Emergency hospital services.
      ☑ Provided: □ No limitations ☑ With limitations*
      □ Not provided.

   f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person.
      ☑ Provided: □ No limitations ☑ With limitations*
      □ Not provided.

*Description provided on attachment.
STATE New Mexico

24. Pediatric or family nurse practitioners' services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of OBRA'89):

Provided: [ ] No Limitations [X] With Limitations*

*Description provided on attachment.

TN No. 9022   Approval Date 4/24/91   Effective Date 7/1/90

Supersedes

TN No. ______
Family Planning Benefits

1905(a)(4)(C) 4.c.(i) Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Att. 2.2-A, B, if this eligibility option is elected by the State.

Provided: □ No limitations X With limitations

Please describe any limitations:

Family planning services are limited to contraceptive management and related services. Non-covered services include procreative management, hysterectomy, and pregnancy termination.

4.c.(ii) Family planning-related services provided under the above State Eligibility Option

Services generally provided as part of, or as follow-up to, a family planning visit for contraceptive management, including but not limited to: screening and treatment of sexually transmitted disease; HPV vaccine; treatment of lower genital and urinary tract infections, treatment of complications of contraception; annual office visit for men (including physical, laboratory tests, and contraceptive counseling); services provided as part of, or as follow-up to, a sterilization procedure; mammogram (with prior authorization); ovarian cyst identification and treatment (with prior authorization).

TN No. 10-12 Approval Date 2-24-11 Effective Date 3-1-11

Supersedes TN No. SUPERSEDES: NONE - NEW PAGE
State of New Mexico
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

   X  Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

   No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

SUPERSEDES: TN-98-12

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<td>HCFA 179</td>
<td>04-01</td>
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</tbody>
</table>

A
25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

Provided:

\checkmark State Approved (Not Physician) Service Plan Allowed
\checkmark Services Outside the Home Also Allowed
\checkmark Limitations Described on Attachment

Not Provided.
State of New Mexico
PACE State Plan Amendment Pre-Print

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy
(Continued)

1905(a)(26) and 1934

X Program of All-Inclusive Care for the Elderly (PACE) services, as
described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to
the categorically needy. (Note: Other programs to be offered to Categorically
Needy beneficiaries would specify all limitations on the amount, duration and
scope of those services. As PACE provides services to the frail elderly population
without such limitation, this is not applicable for this program. In addition, other
programs to be offered to Categorically Needy beneficiaries would also list the
additional coverage—that is in excess of established service limits—for
pregnancy-related services for conditions that may complicate the pregnancy. As
PACE is for the frail elderly population, this also is not applicable for this
program.)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency

NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation(s) Provision(s)

1927(d)(2) and 1935(d)(2) ☑ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

☑ (h) barbiturates (see specific drug categories below)

☑ (i) benzodiazepines (see specific drug categories below)

☑ (j) smoking cessation drugs (Except dual eligibles as Part D will cover) (see specific drug categories below)

(a) Agents when used for anorexia, weight loss, weight gain: Appetite stimulants, anorexic agents, and fat absorption-decreasing agents

(d) Agents when used for symptomatic relief of cough and colds: Antihistamines, antitussives, decongestants, and expectorants

(e) Prescription vitamin and mineral products: Single and multiple vitamins and minerals and combinations

(f) Nonprescription drugs: Coverage for the following categories when an item is a drug of choice for a common medical condition or is an appropriate economical and therapeutic alternative to a prescription drug item: analgesics; anti-emetics; anti-inflammatory agents; anti-parasites; dermatological agents; enzyme replacements; gastrointestinal agents including H-2 antagonists, proton pump inhibitors, laxatives, and antacids; insulin; ophthalmic agents; otic agents; and respiratory agents.

(g) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee: All items

(h) Barbiturates: All items

(i) Benzodiazepines: All items

(j) Smoking cessation drugs: All items

SUPERSEDES: TN- 05-04

No excluded drugs are covered.

TN No. 10-07 Supersedes TN No. 05-04

Approval Date 8-16-10 Effective Date 7-1-10
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency        NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDED

<table>
<thead>
<tr>
<th>Citation</th>
<th>Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935(d)(1)</td>
<td>Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.</td>
</tr>
</tbody>
</table>

STATE New Mexico
DATE REC'D    11-22-05
DATE APPVD   12-16-05
DATE EFF     1-1-06
HCFA 179     05-04

TN No. 05-04
Supersedes Approval Date 12-16-05 Effective Date January 1, 2006
TN No. ________
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Provision(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1927(d)(2) and 1935(d)(2)</td>
<td>1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.</td>
</tr>
</tbody>
</table>

The following excluded drugs are covered:

- [✓] (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)
- [☐] (b) agents when used to promote fertility (see specific drug categories below)
- [☐] (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
- [✓] (d) agents when used for the symptomatic relief cough and colds (see specific drug categories below)
- [✓] (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)
- [✓] (f) nonprescription drugs (see specific drug categories below)

TN No. 05-04
Supersedes
TN No. Approval Date 12-16-05
Effective Date January 1, 2006
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

<table>
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<tbody>
<tr>
<td>1927(d)(2) and 1935(d)(2)</td>
<td>(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)</td>
</tr>
<tr>
<td></td>
<td>(h) barbiturates (see specific drug categories below)</td>
</tr>
<tr>
<td></td>
<td>(i) benzodiazepines (see specific drug categories below)</td>
</tr>
<tr>
<td></td>
<td>(j) smoking cessation drugs (Except dual eligibles as Part D will cover) (see specific drug categories below)</td>
</tr>
</tbody>
</table>

(a) Agents when used for anorexia, weight loss, weight gain: Appetite stimulants, anorectic agents, and fat absorption-decreasing agents

(d) Agents when used for symptomatic relief of cough and colds: Antihistamines, antitussives, decongestants, and expectorants

(e) Prescription vitamin and mineral products: Single and multiple vitamins and minerals and combinations

(f) Nonprescription drugs: Coverage for the following categories when an item is a drug of choice for a common medical condition or is an appropriate economical and therapeutic alternative to a prescription drug item: analgesics; anti-emetics; anti-inflammatory agents; anti-parasitic; dermatological agents; enzyme replacements; gastrointestinal agents including H-2 antagonists, proton pump inhibitors, laxatives, and antacids; insulin; ophthalmic agents; otic agents; respiratory agents; and therapeutic nutrients and electrolytes.

(g) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee: All items

(h) Barbiturates: All items

(i) Benzodiazepines: All items

(j) Smoking cessation drugs: All items

No excluded drugs are covered.

Approval Date: 12-16-05  Effective Date: January 1, 2006
STATE: NEW MEXICO

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

CASE MANAGEMENT SERVICES

I. Case Management For the Chronically Mentally Ill

A. Target Group: Case Management services will be provided to Medicaid eligible chronically mentally ill individuals who are not residents of an institution for mental disease. A chronically mentally ill individual is defined by diagnosis, disability, and duration. The major diagnoses include schizophrenia, affective disorders, bipolar disorders, and serious personality disorders (e.g., borderline personality); duration exceeds one year; and disability reflects serious impairment of functions relative to primary aspects of daily living.

B. Areas of the State in which services will be provided:

- Entire State

- Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

- Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

TN No. 90-19
Approval Date 5/2/91
Effective Date 7/1/90
Supercedes
TN No. _____
STATE: NEW MEXICO

X Services are not comparable in amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a) (10) (B) of the Act.

D. Definition of Services:

The purpose of case management services for the chronically mentally ill is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services. Case management services will provide necessary coordination with providers of medical and non-medical services when services provided by the entities are needed to enable the individual to benefit from programs for which he or she is eligible. No limitation is placed on the number of units of case management service a client may receive each month.

Services - Case Management services include the following activities:

1. Identifying programs appropriate for the individual's needs, and providing assistance to the individual in accessing those programs.

2. Assessing the service needs of the individual in order to coordinate the delivery of services when multiple providers or programs are involved in case provision.

3. Reassessment of the individual to ensure that the services obtained are necessary.
STATE: NEW MEXICO

E. Qualification of Providers: Qualified case management agencies must have responsible personnel management including written policies and procedures that include, but are not limited to, recruitment selection, retention and termination of case managers; job descriptions for case managers; grievance procedures; hours of work, holidays, vacations, leaves of absence; wage scale and benefits; conduct and general rules. In accordance with provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1987, the State will restrict the type of agencies that can provide case management services to the following provider types:

1. Community mental health centers funded by the Single State Mental Health Agency (New Mexico Health and Environment Department).

2. Indian Tribal Governments and Indian Health Service Agencies or clinics.

3. Federally Qualified Health Centers (FQHC).

4. Other agencies which have at least one year direct experience in case management services. Such experience may be through the agency as an entity or through its employees. These agencies must have knowledge of available community services and methods for accessing them.

Case Managers employed by case management agencies must possess the education, skills, abilities, and experience to enable them to perform the activities that comprise a Medicaid case management service. At a minimum, case managers must have at least a bachelor's degree in social work, counseling, psychology, or a related field, from an accredited institution plus one year of experience in the mental health field; OR be a licensed registered nurse with one year of experience in the mental health field.

In the event that there are no suitable candidates with the above qualifications, an individual with, preferably, an Associates Degree and a minimum of three years experience in the mental health field, or with a high school diploma and a minimum of five years experience in
STATE: NEW MEXICO

the mental health field may be employed as a case manager. In some cases, it may be important that individuals have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
STATE: NEW MEXICO

VI. Case Management For Pregnant Women and Infants

A. Target Group: Case Management services will be provided to Medicaid eligible pregnant women and to their infants up to 60 days after the month of their birth.

B. Areas of the State in which services will be provided.

   ______ Entire state

   ___ Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is invoked to provide services less than statewide)

C. Comparability of Services:

   ___ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

   ______ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a)(10)(B) of the Act.
STATE: NEW MEXICO

D. Definition of Services:

The purpose of case management services for pregnant women is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services. Case management services will provide necessary coordination with providers of medical and non-medical services such as nutrition programs like WIC or educational agencies, when services provided by these entities are needed to enable the individual to benefit from programs for which she is eligible.

Case Management will be limited to 5 hours of service per client per pregnancy. Any additional units require prior approval by the State.

Case management services include the following activities:

1. **Identifying** programs appropriate for the individual's needs, including those which teach basic maternal and child health skills and providing assistance to the individual in accessing those programs.

2. **Assessing** the service needs of the individual in order to **coordinate** the delivery of services when multiple providers or programs are involved in care provision.

3. **Reassessment** of the individual to ensure that the services obtained are necessary.

These activities are structured to be in conformance with Section 1902 (a) (23) and not to duplicate any other service reimbursed in the Medicaid program or any other program.
STATE: NEW MEXICO

E. Qualification of Providers:

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act.

1. Agency Qualifications:

Qualified case management agencies must have responsible personnel management including written policies and procedures that include, but are not limited to, recruitment selection, retention and termination of case managers; job descriptions for case managers; grievance procedures; hours of work, holidays, vacations, leaves of absence; wage scale and benefits; conduct and general rules. Agencies which may be certified include:

a. Public Health Division of New Mexico Department of Health;

b. Indian Tribal Governments or Indian health services;

c. Federally qualified health centers (FQHC); and

d. Other agencies which have at least one year direct experience in case management services. Such experience may be through the agency as an entity or through its employees. These agencies must have knowledge of available community services and methods for accessing them.

2. Case Manager Qualifications:

Case managers employed by case management agencies must possess the education, skills, abilities, and experience to enable them to perform the activities that comprise a Medicaid Case Management Service. It is important that individuals have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area.
STATE: NEW MEXICO

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 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 suitable candidates with the above qualifications, an individual with, an associates degree and four years of experience in social work, community health and/or maternal 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 and child health may be considered. Agencies that are considering hiring individuals in option c or d must complete a waiver process.

F. Freedom of Choice

The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services given that the providers meet the qualifications in Section E.

2. Eligible recipients will have free choice in participating in case management.

3. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Reimbursement

Payment for case management services under the plan does not duplicate payments made to public agencies for private entities under other program authorities for this same purpose.
STATE: NEW MEXICO

VI. Case Management for Children up to age Three

A. Target Group: Case Management services will be provided to Medicaid eligible children up to age three (3) who are medically at risk due to family conditions, but are not developmentally delayed. These are children who are not accessing health and social systems adequately or appropriately, which would impair their ability to thrive.

B. Areas of the State in which services will be provided.

X Entire state

______ Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is invoked to provide services less than statewide)

C. Comparability of Services:

______ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a)(10)(B) of the Act.
STATE: NEW MEXICO

D. Definition of Services:

The purpose of case management services for children is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services. Case management services will provide necessary coordination with providers of medical and non-medical services such as nutrition programs like WIC or educational agencies, when services provided by these entities are needed to enable the individual to benefit from programs for which he/she is eligible.

Case Management Services will be limited to four (4) hours per year per child. Any additional units require prior approval by the State.

Case Management services include the following activities:

1. **Identifying** programs appropriate for the individual's needs, including those which teach basic/infant/young child care skills and providing assistance to the individual in accessing those programs.

2. **Assessing** the service needs of the individual in order to **coordinate** the delivery of services when multiple providers or programs are involved in care provision.

3. **Reassessment** of the individual to ensure that the services obtained are necessary.
These activities are structured to be in conformance with Section 1902 (a) (23) and not to duplicate any other service reimbursed in the Medicaid program or any other program.

E. Qualification of Providers:

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act.

1. Agency Qualifications:

Qualified case management agencies must have responsible personnel management including written policies and procedures that include, but are not limited to, recruitment selection, retention and termination of case managers; job descriptions for case managers; grievance procedures; hours of work, holidays, vacations, leaves of absence; wage scale and benefits; conduct and general rules. Agencies which may be certified include:

a. Public Health Division of New Mexico Department of Health;

b. Indian Tribal Governments or Indian health services;

c. Federally qualified health centers (FQHC); and

d. Other agencies which have at least one year direct experience in case management services. Such experience may be through the agency as an entity or through its employees. These agencies must have knowledge of available community services and methods for accessing them.

2. Case Manager Qualifications:

Case managers employed by case management agencies must possess the education, skills, abilities, and experience to enable them to perform the activities that comprise a Medicaid Case Management Service. It is important that individuals have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area.

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 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 suitable candidates with the above qualifications, an individual with, an associates degree and four years of experience in social work, community health and/or maternal 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 and child health may be considered. Agencies that are considering hiring individuals in option c or d must complete a waiver process.

F. Freedom of Choice

The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services given that the providers meet the qualifications in Section E.

2. Eligible recipients will have free choice in participating in case management.

3. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Reimbursement

Payment for case management services under the plan does not duplicate payments made to public agencies for private entities under other program authorities for this same purpose.
STATE: NEW MEXICO

1. Eligible recipients will have free choice of the providers of case management services, provided the providers meet the qualifications as specified in Section E.

2. Eligible recipients will have free choice in participating in case management.

3. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Reimbursement

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
IV. Case Management for Adults with Developmental Disabilities

A. Target Group: Case Management services will be provided for Medicaid eligible individuals who are developmentally disabled and are 21 years of age or older. The Centralized Services Team (CST) of the Department of Health, as the point of entry into services, will determine the urgency of need. Eligible individuals for continuing case management are those who meet the urgency of need based on medical necessity. Eligible individuals will include those needing residential and non-residential services as set forth by the CST, those that do not reside in a Medicaid certified ICF/MR facility; and those that do not participate in the Home and Community Based Waiver program.

B. Areas of the State in which services will be provided:

- [X] Entire State
- _Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide):

  Comparability of Services:

- Services are provided in accordance with Section 1902 (a)(10)(B) of the Act.
- [X] Services are not comparable in amount, duration, and scope. Authority of Section 1915 (g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a)(10)(B) of the Act.

D. Definition of Services:

The purpose of case management services for the adult developmentally disabled is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services. Case management provides a link between the developmentally disabled and the providers
of needed medical, social, educational, and other services. Access to services is enhanced.

Case management services will be provided for up to sixty (60) days after the individual has been moved from the waiting list into the requisite residential or non-residential services as set forth by the CST.

Case management activities include the following activities:

1. Identifying programs appropriate for the individual's needs, and providing assistance to the individual in accessing those programs.

2. Assessing the service needs of the individual in order to coordinate the delivery of services when multiple providers or programs are involved in care provision.

3. Reassessment of the individual to ensure that the services obtained are necessary.

These activities are structured to be in conformance with 1902 (a)(23) and not to duplicate any other service reimbursed in the Medicaid program.

E. Qualification of Providers:

1. Agency Qualifications:

Qualified case management agencies must have responsible personnel management including written policies and procedures that include, but are not limited to recruitment selection, retention and termination of case managers; job descriptions for case managers; grievance procedures; hours of work, holiday, vacations, leaves of absence; wage scale and benefits; conduct and general rules.

They must demonstrate knowledge of the community to be served, its populations and its resources, including methods for accessing those resources.

In accordance with provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1987, the State will restrict the type of agencies that can provide case management services to the following provider types:
a. State agencies in New Mexico providing case management services to persons with developmental disabilities.

b. Indian Tribal Governments and Indian Health Service Clinics.

c. Community-based agencies in New Mexico that do not provide adult day habilitation, work related services and/or adult residential services to persons with developmental disabilities anywhere in New Mexico, and which have demonstrated direct experience in case management services in serving the target population, are eligible providers. Current Medicaid providers of case management for adults with developmental disabilities who also provide any of the above services must phase out case management services and no longer provide that service after October 1, 1994.

Agencies must be certified by the New Mexico Department of Health which serves as the certifying agency for this department.

2. Case Manager Qualifications:

Case Managers employed by case management agencies must possess the education, skills, abilities, and experience to enable them to perform the activities that comprise a Medicaid Case Management Service.

a. At a minimum, case managers must have at least one year of experience working with persons with developmental disabilities and a bachelor's degree from an accredited institution in a human services field or any related academic discipline associated with the study of human behavior or human skill development (e.g., psychology, sociology, speech, gerontology, education, counseling, social work, human development, or any other study of services related to basic human needs or the human condition);
b. OR be a licensed registered nurse or licensed practical nurse with one year experience working with the developmentally disabled;

c. In the event that there are no suitable candidates with the above qualifications, an individual with, preferably, an Associates Degree and a minimum of three years experience working with the developmentally disabled, or with a high school diploma and a minimum of four years experience working with the developmentally disabled may be employed as a case manager. In this case, a training and supervision plan must be submitted and approved by the Department of Health.

F. Freedom of Choice

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Reimbursement

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
V. Case Management for the Traumatically Brain Injured

A. Target Group: Case Management services will be provided to Medicaid eligible adults with traumatic brain injuries who are not residents of an institution. Traumatic brain injury is defined as an insult to the brain, not of a degenerative or congenital nature, but caused by an external physical force that may produce a diminished or altered state of consciousness which results in impairment of cognitive abilities or physical functioning. The impairments may be either temporary or permanent and cause partial or total functional disability or psychological maladjustment.

B. Areas of the State in which services will be provided.

___ Entire state

___ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide):

Santa Fe County, Chaves County, Dona Ana County, McKinley County, San Juan County and San Miguel County.

C. Comparability of Services:

___ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

___ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a)(10)(B) of the Act.

D. Definition of Services:

The purpose of case management services for the traumatically brain injured is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services. Case management services will provide necessary coordination with providers of medical and non-medical services when services provided by these entities are needed to enable the individual to
benefit from programs for which he or she is eligible. No limitation is placed on the number of units of case management services a client may receive each month, however all services provided must be based on medical necessity and be designed to stabilize or improve the client's physical and mental functioning.

Services - Case Management services include the following activities:

1. **Identifying** programs appropriate for the individual's needs, and providing assistance to the individual in accessing those programs.

2. **Assessing** the service needs of the individual in order to coordinate the delivery of services when multiple providers or programs are involved in care provision.

3. **Reassessment** of the individual to ensure that the services obtained are necessary.

E. Case management providers for the traumatically brain injured are restricted to agencies who meet the following qualifications:

1. Community-based agencies which have demonstrated direct experience in providing case management services for the target population. Such agencies must have knowledge of available community services and methods of accessing them. They must be able to provide services on an ongoing basis without interruption.

2. Qualified case management agencies must have responsible personnel management including written policies and procedures that include, but are not limited to; recruitment, selection, retention and termination of case managers; job descriptions for case managers; grievance procedures; hours of work, holidays, vacations, leaves of absence; wage scale and benefits; conduct and general rules.

3. Providers are limited to agencies that can assume twenty four (24) hour responsibility for case management services.
STATE: NEW MEXICO

4. Agencies must be certified by the Department of Health as providers of case management services to adults with traumatic brain injuries.

Case managers employed by case management agencies must possess the education, skills, abilities, and experience to enable them to perform the activities that comprise a Medicaid case management service. At a minimum, case managers must have at least a bachelor's degree in social work, counseling, psychology, or a related field, from an accredited institution, plus one year experience in the traumatic brain injury field or be a licensed registered nurse with one year experience in the traumatic brain injury field.

In the event that there are no suitable candidates with the above qualifications, an individual with, preferably an Associates Degree and a minimum of three years experience in the mental health/traumatic brain injury field, or with a high school diploma and a minimum of five years experience in the mental health/traumatic brain injury field may be employed as a case manager. In some cases, it may be important that individuals have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area.

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies for private entities under other program authorities for this same purpose.
STATE: NEW MEXICO

VI. Case Management of Adult Protective Services

A. Target Group: Case Management services will be provided to Medicaid eligible adults in need of adult protective services who are not residents of an institution. Adult protective services are defined as assistance to any person 18 years or older whom reports received show allegations of abuse, neglect or exploitation and is in need of services furnished by a protective services agency.

B. Areas of the State in which services will be provided:

   __X__ Entire state

   ___ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

C. Comparability of Services:

   ___ Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

   __X__ Services are not comparable in amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (B) of the Act.

D. Definition of Services:

The purposes of case management services for adult protective services is to assist those eligible for Medicaid in gaining access to needed medical, social, educational, and other services. Case management services will provide necessary coordination with providers of medical and non-medical services when services furnished by these entities are needed to enable the individual to benefit from programs for which he or she is eligible. No limitation is placed on the number of units of case management services a client may receive each month.
STATE: NEW MEXICO

Case Management services include the following activities:

1. Identifying programs appropriate for the individual’s needs, and providing assistance to the individual in accessing those programs.

2. Assessing the service needs of the individual in order to coordinate the delivery of services when multiple providers or programs are involved in care provision.

3. Developing, implementing, and reviewing individual plans of care.

4. Monitoring the delivery of services.

3. Reassessment of the individual to ensure that the services obtained are necessary.

E. Qualifications of Providers:

1. Case Management Agencies:

   a. Must be an agency employing staff with case manager qualifications; and

   b. Have established referral systems and demonstrated linkages and referral ability with community resources required by the target population; and

   c. Have a minimum of five years experience in providing all core elements of case management services to the targeted populations; and

   d. Ensure 24-hr. Availability of case management services and continuity of those services; and

   e. Have an administrative capacity to ensure quality of services in accordance with State and Federal requirements; and

   f. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and

   g. Have a capacity to document and maintain individual case records in accordance with State and Federal requirements; and
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h. Have a demonstrated ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program, including the ability to meet Federal and State requirements for documentation, billing and audits.

2. Case Managers employed by the case management agency must meet the following requirements for education and experience as defined below:

   a. At a minimum, must have a bachelor's degree in Social Work and be licensed by the New Mexico Board of Social Work; and

   b. Must possess the knowledge, skills and abilities to perform all of the components of case management services for the target population as determined by the provider agency; and

   c. When necessary, must possess language skills, cultural sensitivity and acquired knowledge unique to a geographic area.

F. Freedom of Choice

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services given that the providers meet the qualifications in Section E.

2. Eligible recipients will have free choice in participating in case management.

3. Eligible recipients will have free choice of the providers of other medical care under the plan.
I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are: Individuals who meet nursing home financial and medical necessity criteria at a special income level to 300% of the SSI federal benefit. 42 CFR 435.217.

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State’s Medicaid plan.)

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State’s approved HCBS waiver(s).

Regular Post Eligibility

1. X SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee’s income.
(a) Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
   1. The following standard included under the State plan (check one):
      (a) SSI
      (b) Medically Needy
      (c) The special income level for the institutionalized
      (d) Percent of the Federal Poverty Level: %
      (e) Other (specify):

2. The following dollar amount: $

   Note: If this amount changes, this item will be revised.

3. The following formula is used to determine the needs allowance:

   ________________________________

   Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1. SSI Standard
2. Optional State Supplement Standard
3. Medically Needy Income Standard
4. The following dollar amount: $

   Note: If this amount changes, this item will be revised.

5. The following percentage of the following standard that is not greater than the standards above: % of standard.

6. The amount is determined using the following formula:

   ________________________________

7. $ Not applicable (N/A)

(C.) Family (check one):

1. AFDC need standard
2. _______ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. _______ The following dollar amount: $ _______
   Note: If this amount changes, this item will be revised.

4. _______ The following percentage of the following standard that is not greater than the standards above: _______%
   of ______ standard.

5. _______ The amount is determined using the following formula:

6. _______ Other

7. NA _______ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. NA _______ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735—States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
   1. _______ The following standard included under the State plan (check one):
      (a) _______ SSI
      (b) _______ Medically Needy
      (c) _______ The special income level for the institutionalized
      (d) _______ Percent of the Federal Poverty Level: _______%
      (e) _______ Other (specify):

2. _______ The following dollar amount: $ _______
   Note: If this amount changes, this item will be revised.

3. _______ The following formula is used to determine the needs allowance:
Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):
1. _____ The following standard under 42 CFR 435.121:

2. _____ The Medically needy income standard

3. _____ The following dollar amount: $ _____
   Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. _____ The amount is determined using the following formula:

6. _____ Not applicable (N/A)

(C.) Family (check one):
1. _____ AFDC need standard
2. _____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. _____ The following dollar amount: $ _____
   Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

5. _____ The amount is determined using the following formula:

6. _____ Other
7. _____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility
3. **X** State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)
   (A) **X** The following standard included under the State plan (check one):
       1. ____ SSI
       2. ____ Medically Needy
       3. **X** The special income level for the institutionalized
       4. ____ Percent of the Federal Poverty Level: ____%
       5. ____ Other (specify):

   (B) ____ The following dollar amount: $____
   Note: If this amount changes, this item will be revised.

   (C) ____ The following formula is used to determine the needs allowance:

   If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State Plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology.

1. X Rates are set at a percent of fee-for-service costs
2. [Blank] Experience-based (contractors/State's cost experience or encounter date) (please describe)
3. [Blank] Adjusted Community Rate (please describe)
4. [Blank] Other (Please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

The PACE UPL was developed in accordance with the Centers for Medicare and Medicaid checklist regarding PACE capitated programs. The PACE program covers individuals ages 55+ who have been identified as needing a nursing home level of care.

In summary, the State utilized multiple years of historical fee-for-service data representative of the population and State Plan services covered under the PACE program. The fee-for-service base data was adjusted according to the CMS PACE checklist for completion factors and pharmacy rebates. Completion factors were developed from the fee-for-service paid claims experience and were grouped by major historical rebates claimed by the State. New rates were developed effective January 1, 2006 to exclude prescription drugs costs for dual eligible PACE participants. Trend factors were developed using linear regression analysis of the historical fee-for-service data. The trend factors were applied to the adjusted base period to the midpoint of the contract period. Programmatic changes were applied to the trended data to develop the upper payment limit (UPL) for the contract period.

The UPL's were developed for the Statewide region. These three following groups were used to research and develop the two rates for Duals and Non-Duals regardless of age. The following Statewide rate category groups were used for the PACE UPL development:

* Non-Dual Eligibles 55 – 64 Years Old,
* Dual Eligibles 55 – 64 Years Old,
* Dual and Non-Dual Eligibles 65+ Years
The state will pay fee-for-service, i.e., co-pay and deductible, for QMB only. Therefore, QMB only is not included in the rate development.

The rates were prepared by:
Mercer Government Human Services Consulting
Phoenix, AZ, US

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment
The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State’s management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.
Item 1  Inpatient Hospital Services

a. Abortion services are limited as described in Item 5. Sterilization Services and hysterectomies are limited as described in Item 4.c.

b. Payment for a private room is limited to those instances in which the Medicaid patient requires isolation either to protect the health of the recipient or to protect the health of others.

c. Grace Day - When it is determined that an individual no longer needs acute level care, the Department will allow one additional day of care upon approval.

d. Awaiting Placement Days - When it is determined that an individual no longer needs acute level care, but a lower level of care placement cannot be located, those days during which a client is awaiting placement in a lower level of care and termed "awaiting placement days". For the "awaiting placement days", no ancillary services will be covered. Medically necessary physician visits are not included in this limitation.

e. Certain hospital service procedures require prior approval. The procedures that require prior approval are primarily those for which the medical necessity may be uncertain, which may possibly be for cosmetic purposes, or which may be of questionable effectiveness or long term benefit.

f. Certain procedures are to be performed in the office, clinic, or as an outpatient institutional service as an alternative to hospitalization. Copies of the list can be obtained from the Medical Assistance Division.

g. Experimental procedures are limited as described in item 5.
Item 2a. Outpatient Hospital Services

a. Abortion services are limited as described in Item 5. below. Sterilization services and hysterectomies are limited as described in Item 4.c below.

b. Physical therapy, occupational therapy, speech therapy, and other rehabilitation medical services are covered on a prior approval basis.

c. Services, supplies, or equipment which require prior approval when performed in an office setting require the same when performed in an outpatient hospital setting.

d. Outpatient hospital psychiatric services are subject to the following limitations and conditions, effective October 1, 1987:

1. Coverage Criteria - The services rendered must comply with current State Mental Health Code and Health and Environment Department standards and regulations, and must meet the following criteria:

   (a) Individualized Treatment Plan - Services must be prescribed by a psychiatrist or certified Ph.D. psychologist and provided under an individualized written plan. A plan is not required if less than 6 services will be furnished in a period of less than six weeks and there is no plan to continue to see the recipient.

   (b) Supervision and Evaluation - Services must be supervised and evaluated by a psychiatrist or certified Ph.D. psychologist.
(c) Reasonable Expectation of Improvement-Services must be for the purpose of diagnostic study or reasonably expected to improve the patient's condition.

2. The following are not covered:

(a) Meals and transportation, (transportation services are covered subject to the transportation program requirements and regulations).

(b) Activity therapies or other services which are primarily recreational or diversional in nature.

(c) Programs which are generally community support groups in non-medical settings for chronically mentally ill persons for the purpose of social interaction.

(d) Vocational training.

(e) Patient education programs.

(f) Services to treat social maladjustments without manifest psychiatric disorders including occupational maladjustment, marital maladjustment, and sexual dysfunction.

(g) Services or programs which the Medicare intermediary determines to be non-covered under their outpatient hospital psychiatric services regulations for reasons of medical necessity.

e. Experimental procedures are limited as described in Item 5.
State Supplement A to Attachment 3.1A

Item 2b. Rural Health Clinic Services

a. Abortion services are limited as described in Item 5. Sterilization services and hysterectomies are limited as described in Item 4.c. Footcare and other physician services are limited as described in Item 5.

b. Some services require prior approval, among them are the following:

1. Services which require prior approval under Physician Services of the Medical Assistance Program also require prior approval for rural health clinics.

2. Prior approval requirements for dental and pharmacy services must be in accordance with the specific requirements for those programs.

Item 2c. Federally Qualified Health Center Services

The following services are limited in coverage when provided by a federally qualified health center as specified in the State Plan for other providers in State Supplement A to Attachment 3.1A.

a. Dental Services

b. Vision Appliances

c. Hearing Appliances

d. Routine Foot Care

e. Prosthetics and Orthotics

f. Medical Supplies Equipment
State Supplement A to Attachment 3.1A

Item 3  Other Laboratory and X-ray Services

a. A professional component associated with laboratory services is covered only when the work is actually performed by a pathologist who is not billing for the complete procedure and is covered only for anatomic and surgical pathology (includes cytopathology and histopathology).

b. Specimen collection fees are covered when drawn by venipuncture or collected by catheterization unless the patient is in a nursing home. Specimen collection fees are not payable for nursing home recipients.

c. Laboratory tests are not covered if the tests are conveyed from an ordering physician's office to a different physician's office, office laboratory, or non-certified laboratory. Physician and other private practitioners may not bill for laboratory tests which are sent to an outside laboratory or other facility.

d. Laboratory specimen handling or mailing charges are not a benefit of the program.

e. Individual lab procedures that are routinely considered to be included in a profile or panel must be billed as a panel.

f. The following services require prior approval (or retrospective approval following an emergency or retrospective eligibility):

1. Cytogenetic Studies.

2. Outpatient Magnetic Resonance Imaging.

Item 4b  EPSDT Services In Excess of Federal Requirements

Nutritional assessment and nutritional counseling.
State Supplement A to Attachment 3.1A

Item 4b  EPSDT Services Not Otherwise In The State Plan

All services provided in Section 1905(a) of the Act which are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions identified during an EPSDT screen, periodic or interperiodic, whether or not such services are covered or exceed the benefit limits in the state plan, are provided.

Specifically, the following services, which are not otherwise covered under the state plan, are provided when medically necessary:

1. Case management for medically at risk children and adolescents.

2. In-Patient services provided by institutions accredited by JCAHO as well as licensed by the New Mexico Department of Health, including free standing psychiatric facilities and residential treatment centers. Services must be provided under the direction of a physician.

   Residential treatment center services are primarily for children or adolescents who have been diagnosed as having a severe emotional disturbance, mental disorder, or chemical dependency (drugs or alcohol), and for whom less restrictive settings are not appropriate. Services must be designed to reduce or control the individual's symptoms or maintain the individual's level of functioning.

3. Outpatient services provided by institutions accredited by JCAHO as well as licensed by the New Mexico Department of Health, including free standing psychiatric facilities. Services must be prescribed by a physician or licensed Ph.D. psychologist.

4. Services provided by licensed masters level practitioners, or by masters level counselors who are graduates of an accredited program. Services must be supervised by a licensed Ph.D. psychologist or a psychiatrist.
Services must be rendered through a community mental health center as designated by the New Mexico Department of Health, a Federally Qualified Health Center, or provider accredited by the Council on Accreditation of Services for Families and Children.

5. Services of licensed masters level independent social work practitioners.

6. Private duty nursing services. Services must be provided through a licensed nursing agency, home health agency, or by a Federally Qualified Health Center. Services must be provided by a registered nurse or a licensed practical nurse.

7. Services of Christian Science Nurses.

8. Personal care services. Services must be provided by an agency licensed by the state.

9. Chiropractic services. Services must be provided by chiropractors licensed by the state.

10. Orthodontic and other dental services not otherwise covered under the state plan. Services must be provided by a dentist licensed by the state.

11. Therapies (physical, speech-language-hearing, occupational, and other rehabilitative therapies) provided by licensed individual therapists and centers. Included are rehabilitative services and therapies which are considered "maintenance" rather than "restorative" in nature.

12. Supplies, prosthetics, orthotics, and durable medical equipment to meet special physical needs.

13. Psychosocial services which are rehabilitative in nature and furnished in accordance with a written treatment plan. Specifically excluded from coverage are room and board, educational programs, and vocational training.
State Supplement A to Attachment 3.1A

Services are as defined in Dallas Regional Medical Services Letter (DRMSL) No. 92-73. They may be provided in either residential or home and community settings. Residential settings include Residential Treatment Centers and Group Homes. Non-residential settings include the home (natural, adoptive, or specialized therapeutic foster care), the school, or any other natural setting within the community. Actual services/settings consist of Non-JCAHO accredited Residential Treatment Centers; Group Homes; Treatment Foster Care; Behavior Management; and Day Treatment.

Each individual has a level of dysfunction determined by an interdisciplinary panel. The level is based upon diagnoses, psychological evaluations, and psychosocial criteria including current situations and past history concerning family and placements.

Activities include individual and group counseling and therapy; activities of daily living which facilitate age-appropriate skills re-development in the areas of household management, nutrition, physical and emotional health, basic skills, time management, money management, independent living, relaxation and self care techniques; crisis intervention.

Providers must be trained and certified in the services being provided, in accordance with the applicable certification standards adopted by the Department. The Department has adopted those certification standards for EPSDT psychosocial rehabilitation services promulgated and administered by the Children, Youth and Families Department. Providers must meet the qualifications as listed for their particular service in these standards.

Services may require prior approval as outlined in the State regulations pertaining to that service to assure medical necessity. Services may require a Plan of Care as outlined in the State regulations pertaining to that service.

SUPERSDES: TN. 90-15
14. Specific school based services provided by school districts or local education agencies certified by the State Department of Education. Services include EPSDT screens (periodic, interperiodic and partial); skilled nursing services; mental health services; case management; occupational therapy; physical therapy; speech pathology; audiology services; and transportation to and from medically necessary services prescribed in an Individual Education Plan (IEP) or an Individualized Family Service Plan (IFSP).

15. Special rehabilitation services which are evaluative, diagnostic and treatment in nature and necessary to correct any defects or conditions or to teach compensatory skills for deficits that directly result from a medical condition. These services include obtaining, interpreting and integrating the above evaluative, diagnostic and treatment information appropriate to an individual’s Individualized Family Service Plan.

Special rehabilitation services include the following:

(a) Speech, Language and Hearing: These are services for individuals with speech, language and hearing disorders. The services are provided by or under the direction of a speech pathologist or audiologist, as the result of a referral by a physician as defined in 42 CFR 440.110(c). These services mean evaluations to determine an individual’s need for these services and recommendations for a course of treatment; and treatments to an individual with a diagnosed speech, language or hearing disorder adversely affecting the functioning of the individual.

(b) Occupational Therapy: These services are prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice and provided by or under the direction of a qualified occupational therapist as defined in 42 CFR 440.110(b). These services mean evaluations of problems interfering with an individual’s functional performance and therapies which are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age appropriate functional performance.

(c) Physical Therapy: These services are prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice and provided by or under the direction of a qualified physical
therapist as defined in 42 CFR 440.110(a). These services mean evaluations to determine an individual's need for physical therapy and therapies which are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem.

(d) Psychological, Counseling and Social Work: These services mean diagnostic or active treatments with the intent to reasonably improve the individual's physical or mental condition as prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice. They are provided to individuals whose condition or functioning can be expected to improve with these interventions. These services are performed by a licensed or equivalent psychological, counseling and social work staff acting within their scope of practice. These services include but are not limited to testing and evaluation that appraise cognitive, emotional and social functioning and self concept; therapy and treatment that is planning, managing, and providing a program of psychological services to individuals with diagnosed psychological problems.

(e) Developmental Evaluation and Rehabilitation: These services mean testing performed to determine if motor, speech, language and psychological problems exist or to detect the presence of any developmental lags. Services include diagnostic, evaluative and consultative services for the purposes of identifying or determining the nature and extent of, and rehabilitating an individual's medical or other health-related condition. These services are performed by or under the supervision of a licensed physician or other provider acting within their scope of practice.

(f) Nursing: These services are performed by a Nurse Practitioner, Registered Nurse, or Licensed Practical Nurse within the scope of his/her practice relevant to the medical and rehabilitative needs of the individual. They are prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice. Services include medication administration/monitoring, catheterization, tube feeding, suctioning, screening and referral for health needs and explanations of treatments, therapies, and physical or mental conditions with family or other professional staff.

Providers of special rehabilitation services must be certified by the Department of
Health and approved for participation and enrolled in the New Mexico Medicaid program. Services are provided directly by the special rehabilitation service provider or through subcontractors; and providers shall:

(a) provide special rehabilitation services under the direction of professionals acting within their scope of practice as defined by State law; and

(b) provide special rehabilitation services in the most appropriate least restrictive environment; and

(c) assure that claiming for special rehabilitation services does not duplicate claiming for EPSDT administrative outreach services.

Item 4b  EPSDT Services Included In the State Plan

Services already included in the state plan are described in Attachment 3.1A. Limitations to those services are described in the other sections of State Supplement A to Attachment 3.1A.
State Supplement A to Attachment 3.1A

Specific program coverage restrictions, limitations in duration or service, and limitations in frequency of service, as described elsewhere in State Supplement A to Attachment 3.1A.

(a) Experimental procedures are limited as described in Item 5, State Supplement A to Attachment 3.1A.

(b) Documentation requirements must be met for abortion services, sterilization services, and hysterectomies.

(c) Limitations in duration and frequency of service otherwise described in the state plan are not applicable when documented as medically necessary for the recipient.
State Supplement A to Attachment 3.1A

Item 6a  Podiatrists' Services

a. Medicaid coverage is limited to the podiatrist's scope of practice as defined by state law.

b. Foot care services ordinarily considered to be routine are covered only if medically necessary due to the medical condition of the recipient.

c. Certain procedures are to be performed in the office, clinic, or as an outpatient institutional services as an alternative to hospitalization.

d. Services directed toward the care or correction of a flat foot condition are not covered.

e. Orthopedic shoes and other supportive devices for the feet are not covered. The exclusion of orthopedic shoes does not apply to such a shoe, however, if it is an integral part of a leg brace.

f. Surgical or non-surgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered unless documented to be medically necessary. Surgical correction of a subluxated foot structure that is an integral part of the treatment for foot pathology is covered if medically necessary based on the medical condition of the recipient.

Item 6b  Optometrists' Services

Orthoptic assessment and treatment are not covered by the New Mexico Medical Assistance Program.

Routine vision exams are allowed only once in a 36-month period except as provided as an EPSDT service or the medical condition of the client requires more frequent examination, treatment or follow up.

Item 6d  Other Practitioners' Services

I. Psychologists

a. The following services are not benefits of the program:

1. Hypnotherapy
2. Biofeedback

SUPERSEDES: TN- 04-08
f. Specimen collection fees are payable when drawn by venipuncture or collected by catheterization unless the patient is in a nursing home. Specimen collection fees are not payable for nursing home recipients.

g. Certain procedures are to be performed in the office, clinic, or as an outpatient institutional service as an alternative to hospitalization. A list is available from the Medical Assistance Division.

h. Prior approval is required for certain procedures. A list is available from the Medical Assistance Division.

i. Certain foot care services considered to be routine (defined under non-covered services) are covered only if they are performed as a necessary and integral part of an otherwise covered service such as diagnosis and treatment of diabetic ulcers, wounds, and infections.

j. Coverage of experimental procedures is restricted to heart, liver, and heart-lung transplants. Experimental procedures and services related to experimental procedures, including but not limited to hospitalization, anesthesiology, laboratory tests and X-ray, are covered on a limited basis with prior approval.

k. Cosmetic surgery performed for aesthetic purposes only are not covered.

l. Services directed toward the care or correction of a flat foot condition are not covered.

m. Well child care, routine vaccinations, physical examinations and examinations for school except as covered under the EPSDT program or SNF regulations are not covered.

n. Dietary counseling, literature, booklets, and other educational services are not covered.
o. Screening type/services unless being used to make a diagnosis are not covered, except as allowed under the EPSDT program.

p. Hair or nail analysis is not covered.

q. Oral topical, otic or ophthalmic preparations dispensed to the recipient by the physician for use at home are not covered.

r. Laboratory specimen handling or mailing charges are not a benefit of the program. Laboratory specimen collection fees for nursing home recipients are not a benefit of the program.

s. Abortions are covered only when performed to save the life of the mother or to terminate a pregnancy resulting from rape or incest. When the abortion is performed to save the life of the mother, the physician must certify the necessity of the abortion as required by federal regulation.
State Supplement A to Attachment 3.1A

Item 6a Podiatrists' Services

a. Medicaid coverage is limited to the podiatrist's scope of practice as defined by state law.

b. Foot care services ordinarily considered to be routine are covered only if medically necessary due to the medical condition of the recipient.

c. Certain procedures are to be performed in the office, clinic, or as an outpatient institutional service as an alternative to hospitalization.

d. Services directed toward the care or correction of a flat foot condition are not covered.

e. Orthopedic shoes and other supportive devices for the feet are not covered. The exclusion of orthopedic shoes does not apply to such a shoe, however, if it is an integral part of a leg brace.

f. Surgical or non-surgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered unless documented to be medically necessary. Surgical correction of a subluxated foot structure that is an integral part of the treatment for foot pathology is covered if medically necessary based on the medical condition of the recipient.

Item 6b Optometrists' Services

Orthoptic assessment and treatment are not covered by the New Mexico Medical Assistance Program.

Item 6d Other Practitioners' Services

I. Psychologists

a. The following services are not benefits of the program:

1. Hypnotherapy

2. Biofeedback
3. Conditions where a reasonable prognosis does not exist

4. Social maladjustments without manifesting psychiatric disorders, including occupational maladjustment, marital maladjustment, sexual dysfunction, and personality disorders.

b. Coverage of psychiatric or psychological services are allowed only for services in which an eligible provider to patient relationship exists. Coverage is not allowed for services performed by paramedicals or other health professionals including M.S.W.'s, counselors, psychiatric social workers, masters level psychologists, etc., even though such service may be under the direction of an eligible provider.

II. Licensed Midwife Services

Services provided by licensed midwives are restricted to prenatal care, home delivery and postpartum care.

III. Certified Nurse Anesthetist's Services

Anesthesia services, physician directed and non-physician directed, provided during a surgical procedure covered under the state plan are a benefit of the Medicaid Program.

IV. Other Certified Nurse Practitioners

Other Certified Nurse Practitioner services (CNP specialties covered as an optional service as opposed to the OBRA '89 mandate) are covered regardless of the practitioner's specialty. Surgical procedures are not a benefit of the program as they are not within the scope of state law.
V. Services of Licensed Independent Social Workers (LISWs) and Clinical Nurse Specialists (CNSs)

Services of Licensed Independent Social Workers (LISWs) are covered consistent with their licensure and includes Licensed professional mental Health Clinical Counselors (LPCCs), Licensed Marriage and Family Therapists (LMFTs), and Clinical Nurse Specialists (CNSs) certified in psychiatric nursing.

VI. Licensed Alcohol and Drug Abuse Counselor

The services of a Licensed Alcohol and Drug Abuse Counselor (LADAC) are covered when provided within a federally qualified health center, an Indian Health Service facility, a PL 93-638 tribally-operated hospital or clinic, or a community mental health center or core service agency licensed by the appropriate state or federal agency or department. All services must be rendered within the scope of practice and licensure for each provider and must be in compliance with the statutes, rules, and regulations of the applicable state practice acts. All requirements for supervision in state law must be met.
Item 7a  Intermittent or part time nursing services provided by a home health agency, etc.

All home health agency services beyond the initial visit for evaluation purposes require prior approval. The medical necessity criteria that a recipient must meet to receive home health services includes the determination that the individual is physically unable or has great difficulty leaving the home to obtain necessary medical care and treatment (i.e., is essentially homebound) or that the medical need for care at home is more appropriate and cost-effective and will prevent or delay institutionalization.

Item 7b  Home health aide services provided by a home health agency

Home health aide services must be provided under the supervision of a registered nurse or other appropriate professional staff member. The registered nurse or other professional staff member must make a supervisory visit to the recipient's residence at least every two weeks to observe and determine whether goals are being met.

Item 7c  Medical supplies, equipment, and appliances suitable for use in the home

Medical supplies must be necessary and reasonable to the treatment plan.

Durable medical equipment (DME) is considered for coverage only if it is reasonable and necessary for treatment of an illness or injury, or to improve the functioning of a body part. A list is available from the Medical Assistance Division identifying items that require prior approval.

Coverage is limited to services and items that are medically necessary for treatment of a medical condition and do not include the following unless specific medical justification can be made:

1. Items that do not primarily and customarily serve a therapeutic purpose and/or are generally used only for comfort or convenience purposes;

2. Environment control equipment not primarily medical in nature;
3. Institutional equipment inappropriate for home use;

4. Items not generally accepted by the medical professional as being therapeutically effective or are determined by Medicare regulations not to be effective or necessary;

5. Items primarily hygienic in nature rather than medical;

6. Hospital or physician diagnostic items not appropriate for home use;

7. Instruments or devices manufactured for use by a physician or other practitioner not appropriate for home use;

8. Items for administration of heat that are primarily for convenience and not essential to administration of heat therapy

9. Exercise equipment not primarily medical in nature;

10. Items which produce no demonstrable or proven therapeutic effect;

11. Support exercise equipment primarily for institutional use where, in the home setting other devices more appropriately satisfy the recipient’s need;

12. Devices for monitoring the pulse of a homebound recipient with or without a cardiac pacemaker not otherwise medically necessary;

13. Items used to improve appearance or are primarily for comfort purposes rather than therapeutic purposes;

14. Items to have available as a precaution not otherwise medically necessary;

15. Emergency communications systems not serving a therapeutic purpose;

16. Oral dietary formula and food products to meet dietary needs in the absence of an inborn metabolic disorder and unless documented as medically necessary and serving a distinct therapeutic need.

17. Pressure support stockings other than those prescribed and custom fitted to meet the needs of the recipient.
Multiple redundant services are not covered. Equipment and supplies are limited in frequency consistent with reasonable use for the medical condition unless justified by a change in the recipient's condition.

Interest and/or carrying charges are not covered.

The delivery of DME is covered only when the equipment is initially purchased or rented; when the supplier customarily makes a separate charge for delivery; and only for delivery charges of over 75 miles (round trip).

**Item 7d**

Physician therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation center.

Therapy must be provided by a qualified physiotherapist, occupational therapist or assistant, speech pathologist, or audiologist as per 42 CFR 440.100, and in conformance with state law and in accordance with an approved plan of treatment.
State Supplement A to Attachment 3.1A

Item 9  Clinical Services

a. Limitations for physicians, item 5, also apply to clinics.

b. Ambulatory surgical center facility services are covered when all the following conditions are met:

1. The surgical procedure and use of the facility is medically necessary and is a benefit of the program.

2. All program requirements for the surgery are met by the physician such as valid consent forms, prior approval requirements, etc.

c. Dialysis Services

1. The New Mexico Medicaid Program will reimburse providers for renal dialysis services for the first three months of dialysis if not covered by Medicare pending the establishment of Medicare eligibility.

2. The New Mexico Medicaid Program will cover fifteen sessions of dialysis training sessions without special medical justification. Additional sessions require medical justification be attached to the claim.
Item 10  Dental Services

New Mexico Medicaid Program does not cover dental services performed for aesthetic or cosmetic purposes only.

Services for which medical necessity may be questionable are covered only with prior approval (or on retrospective approval in emergency situations or following retroactive eligibility). A complete list of those services may be obtained from New Mexico Medical Assistance Division.
State Supplement A to Attachment 3.1A

Item 11(a)(b)(c) Physical Therapy, Occupational Therapy, and Services for Individual with Speech, Hearing and Language Disorders

Therapy and related services provided on an outpatient basis require prior approval.

The following services are not a benefit of the New Mexico Medicaid Program:

1. Services classified as educational.

2. Services provided by home health agencies, independent physical therapists, or out-patient rehabilitation centers to patients in a skilled nursing facility or an inpatient hospital.

3. Speech therapy provided by speech therapists unless certified as a rehabilitation center.

Item 12(a) Prescribed drugs

Limitations are as follows:

a. Drugs rated as ineffective by the FDA are not a benefit of the program.

b. The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3) or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. The State will cover new drugs of participating manufacturers (except excluded/restricted drugs) for six months after Food and Drug Administration approval and upon notification by the manufacturer of a new drug. Any prior authorization program instituted after July 1, 1991 will provide for a 24 hour turnaround from receipt by mail of the request for prior authorization. The prior authorization program also provides for at least a 72 hour supply of drugs in emergency situations.
c. Items must be prescribed by a practitioner licensed to prescribe drugs in accordance with state law.

d. Drug items for which the use or approve indications may be of questionable medical necessity, highly abusable or recreational in nature are subject to a review or prior authorization to assure the use is medically necessary.

e. Review or prior authorization may be required for items for which a lesser expensive or therapeutically preferred alternative should be used first. Establishing these therapeutic “step” requirements will be based on published clinical practice guidelines and professional standards of health care in addition to cost.

f. Drug restrictions include dosage, day supply, and refill frequency limits necessary to ensure appropriate utilization or to prevent fraud and abuse. In establishing such limits, professional standards of health care are considered. Exceptions to these limits are allowed where medically justified.

g. Orphan drugs (drugs used in the treatment of rare diseases), drugs used for unlabeled purposes, and very expensive drugs not routinely stocked in pharmacies may also require review or prior authorization.
h. Drug items are not covered under the program when they are included in another provider's reimbursement (example: floor stock medication in a nursing facility already included in the facilities reimbursement.)

i. Flu and pneumococcal vaccines are covered when prescribed in accordance with the seasonal recommendations of the Public Health Services.
n. Skin and mucous membrane agents

o. Vitamins and Minerals

7. Orphan drugs (drugs used in the treatment of rare diseases), drugs used for unlabeled purposes, and very expensive drugs not routinely stocked in pharmacies may also require prior approval, only if in Section 1927 (k)(6).

8. The following drug items are not covered under the program:

a. Medication supplied by the State Hospital to recipients on convalescent leave from the hospital.

b. Non-drug personal care items.

c. Cosmetic items are also not a benefit of the program (e.g.: Retin-A for aging skin, Rogain for hair loss).
Item 12(d) Eyeglasses

a. Coverage of eyeglasses (frames and lenses) are subject to the following criteria.

1. Dioptric correction must meet or exceed one of the following:
   (a) -1.00 Myopia (nearsightedness)
   (b) +1.00 Hyperopia (farsightedness)
   (c) 0.75 Astigmatism (distorted vision, the combined refractive error of sphere and cylinder to equal 0.75 will be accepted)
   (d) ±1.00 Presbyopia (farsightedness of aging)

2. If updating an existing prescription, there must be a minimum 0.75 dioptric change in the prescription. Exceptions will be made for recipient with cataracts or when an ophthalmologist or optometrist recommends a change due to a medical condition.

3. For bifocal lenses, a correction of 0.25 or more for distance vision and 1 dioptric or more for added power (bifocal lens correction).

4. For Prism, when indicated to prevent diplopia (double vision).

5. For tinted, filtered, or photochromic lenses, the examiner must document the condition which makes the lenses medically necessary and the dioptric criteria listed above must be met.

b. The following services are not covered by the New Mexico Medical Assistance Program:


2. Oversize frames and oversize lenses.

3. Low vision aids.
4. Contact Lenses, except when prior authorized.

5. Glass cases, anti-scratch lenses, anti-reflective coatings, progressive lenses, trifocals and other items not related to medical necessity.

6. Glasses are allowed only once in a 36-month period except as provided as an EPSDT service or the medical condition of the client requires more frequent examination, treatment or follow up.

Item 13 d Rehabilitative Services

Services are limited to mental health rehabilitation services for eligible recipients for whom the medical necessity of such services has been determined and who are not residents of an institution for mental illness.

The services are limited to goal oriented mental health rehabilitative services individually designed to accommodate the level of the recipient’s functioning and which reduce the disability and to restore the recipient to his/her best possible level of functioning.

Services are limited to assessment, treatment planning, and specific services which reduce symptomatology and restore basic skills necessary to function independently in the community including:

1. Therapeutic Interventions: Provides face to face therapeutic services which include assessments, treatment planning, ongoing treatment, and transition planning.

2. Medication Services: Provides for the assessment of the efficacy of medication and evaluation of side effects, and administration of medication by qualified personnel when it cannot be self administered. Also provides educationally structured face to face activities delivered to patients, their families and others who provide care to patients regarding medication management.

3. Community Based Crisis Interventions: Provides coordinated services utilizing a crisis team. The service includes immediate access, evaluation, crisis intervention and respite care to patients.

4. Professional Consultation: Provides consultation services by mental health professionals as part of treatment team, to patients for the purpose of clinical case review, treatment plan development and ongoing treatment.
d. Hearing Aids

1. The following services are covered by the Medical Assistance Programs but require approval from the Medical Assistance Program prior to providing the service:

   (a) Hearing aid dispensing, purchase, rentals, and replacements.

   (b) Hearing aid repairs exceeding $100.
10. Are items which produce no demonstrable therapeutic effect (i.e., Myoflex muscle stimulator);

11. Are items of support exercise equipment primarily for institutional use (i.e., parallel bars) where, in the home setting, other devices satisfy the recipient's need (e.g., a walker);

12. Are not reasonable or necessary for monitoring the pulse of a homebound recipient with or without a cardiac pacemaker (e.g., pulse tachometer);

13. Are used to improve appearance or for comfort purposes (i.e., sauna baths, wigs);

14. Are precautionary in nature (i.e., spare tanks of oxygen in addition to a portable backup system);

15. Are emergency communications systems and do not serve a therapeutic purpose.

Multiple services are not covered. Recipients are limited to one wheelchair, one hospital bed, etc. Supplies are limited in frequency consistent with reasonable use for the medical condition.

Interest and/or carrying charges are not covered.

The delivery of D.M.E. is covered only when the equipment is initially purchased or rented; when the supplier customarily makes a separate charge for delivery; and only for delivery charges of over 75 miles (round trip).

Pressure support stockings are limited to those custom fitted for the recipient.

Nutritional products are limited to enterally and intravenously administered products. Oral nutritional products are not covered for routine dietary needs in the absence of inborn metabolic disorders and documented medical necessity.
State Supplement A to Attachment 3.1A

4. Contact Lenses, except when prior authorized.

5. Glass cases, anti-scratch lenses, anti-reflective coatings, progressive lenses, trifocals and other items not related to medical necessity.

6. Routine vision exams and glasses are allowed only once in a 24-month period except as provided as an EPSDT service or the medical condition of the client requires more frequent examination, treatment or follow up.

Item 13 d. Rehabilitative Services

Services are limited to mental health rehabilitation services for eligible recipients for whom the medical necessity of such services has been determined and who are not residents of an institution for mental illness.

The services are limited to goal oriented mental health rehabilitative services individually designed to accommodate the level of the recipient's functioning and which reduce the disability and to restore the recipient to his/her best possible level of functioning.

Services are limited to assessment, treatment planning, and specific services which reduce symptomatology and restore basic skills necessary to function independently in the community including:

1. Therapeutic Interventions: Provides face to face therapeutic services which include assessments, treatment planning, ongoing treatment, and transition planning.

2. Medication Services: Provides for the assessment of the efficacy of medication and evaluation of side effects, and administration of medication by qualified personnel when it cannot be self administered. Also provides educationally structured face to face activities delivered to patients, their families and others who provide care to patients regarding medication management.

3. Community Based Crisis Interventions: Provides coordinated services utilizing a crisis team. The service includes immediate access, evaluation, crisis intervention and respite care to patients.

4. Professional Consultation: Provides consultation services by mental health professionals as part of treatment team, to patients for the purpose of clinical case review, treatment plan development and ongoing treatment.
Psychosocial Interventions: Provides rehabilitation services directed towards the remediation of functional limitations, deficits, and behavioral excesses exhibited in patients. Services focus on improving daily living skills, impaired social skills, and problem solving.

6. Assertive Community Treatment (ACT): Provides intensive, integrated rehabilitative, crisis, treatment and community support services by an interdisciplinary staff team available 24-hours seven days a week. Services are rendered in a community setting or the home. ACT is an intensive, highly individualized service for individuals discharged from hospitals after multiple or extended stays, or who are difficult to engage in treatment, and have continuous high service needs that are not being met in more traditional service settings. All services must be medically necessary and are limited to Medicaid eligible recipients. Services are rendered through an assembled and fully trained team constituted according to certification requirements of the Behavioral Health Services Division of the New Mexico Department of Health that include standards for education, skills, abilities, and experience necessary to perform the activities that comprise assertive community treatment services. Each assertive community treatment team includes at least one psychiatrist (licensed and board eligible or certified); two registered nurses (licensed); two mental health professionals (licensed psychiatric nurse practitioner or licensed master’s level behavioral health professional); one substance abuse professional (licensed alcohol and drug abuse counselor “LADAC” or licensed master’s level behavioral health professional with experience in substance abuse treatment) and at least one trained peer professional. The qualifications of the peer professional include having been in a similar medical situation as the recipient but successfully having come out of that situation, previous experience in serving as a peer professional, passing a written and/or oral examination, receiving 10 to 12 hours per year in specific program training, and working under the direction and supervision of a licensed behavioral health professional in order to help direct the client toward the appropriate goals of the program, help model the client’s relationship with the therapists, and help monitor the compliance of the client with regards to substance abuse abstinence.

Assertive Community Treatment services include the following activities:

a. Assessing the service needs of the individual to assure the services obtained are medically necessary; and identifying services appropriate for the individual’s needs.

b. Establishing a care plan to assure medically necessary services are provided and reassessing the individual’s needs to ensure that the services obtained continue to be necessary and effective.

c. Crisis intervention for individuals needing emergent psychiatric care, available 24 hours 7 days a week.

d. Medication assessment and management for individuals who need ongoing pharmacological management including prescribing and administering psychiatric medications.

e. Medically necessary psychiatric, psychological, and behavioral health and substance abuse treatment.

Services must be provided by qualified providers of rehabilitative services for the mentally ill, whose staff members are certified by the single state mental health agency or through the Indian Health Services as being trained according to standards for ACT; and who have also signed an ACT agreement with the Human Service Department.

Item 17 Nurse Midwife Services

Nurse midwives participating in the Medicaid Program must be licensed by the Board of Nurses as registered nurses and registered with the Health Services Division of the Department of Health as certified nurse midwives. Services are limited to routine prenatal care, delivery and postnatal care to women with essentially normal pregnancies.
State Supplement A to Attachment 3.1A

Item 18    Hospice Care

The hospice care benefit will follow the amount, duration and scope of services as outlined in the State Medicaid Manual, Hospice Services, Section 4305. Persons eligible for the hospice benefit will be limited to those recipients who are categorically needy, certified as terminally ill and electing to receive hospice services. The recipient may reside in a long term care facility or be admitted into long term care if he or she does not have a family member or friend to assist with home care. Election of the hospice benefit results in a waiver of the recipient's rights to Medicaid payment for only those services which are related to treatment of the terminal illness or related conditions and common to both Title XVIII and Title XIX. The recipient does not waive rights to payment for services related to the terminal illness and unique to Title XIX. The duration of the hospice benefit continues for an unspecified time period as long as the individual remains in hospice care and does not revoke the election.
State Supplement A to Attachment 3.1-A

Item 20a, b, and c  Pregnancy Related Services

The New Mexico Medicaid program will pay for pregnancy related and post-partum services through the two months following the month in which the child is born or the pregnancy terminates. Any services not related to the pregnancy would not be considered covered services for this population through the two months following the month in which the child is born or the pregnancy terminates.

Services or supplies not related to the pregnancy but which are necessary as a result of a condition which may complicate the pregnancy prior to delivery would be covered, as follows.

All services are subject to the same limitations as specified for the service elsewhere in the state plan:

Hospital services
Physician services
Laboratory and Radiology services
Clinic services
Rural Health Clinics services
Federally Qualified Health Clinic services
Drug services
Durable medical equipment and medical supplies
Family planning services
Transportation services
Midwife services
Prenatal case management
Certified Nurse Practitioner services
Vision services
Psychological services
Ambulatory Surgical Center services

Increases in covered services for pregnant women:

Nutritional assessment.
9. Rehabilitative Services – Assertive Community Treatment

Development of Fee Schedule:
To establish a fee schedule amount, the Department uses cost studies to determine the average actual costs to providers to perform Assertive Community Treatment services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. The rates do not include room and board.

Using these factors, an amount is determined that is further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to Assertive Community Treatment services with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examines rates being charged by providers who are already rendering services to other agencies and payers; and, (2) evaluates the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee is also verified by comparing the fees to those paid by other state Medicaid programs for similar services.

Reimbursement for Assertive Community Treatment services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It is also determined the rates are in conformance with OMB Circular A-87.

The fee schedule rate is re-evaluated every two years. The payment rates result in public and private providers receiving the same payment for the same service. The fees are available in a published fee schedule.
State Supplement A to Attachment 3.1-A

Item 23 Certified Nurse Practitioner Services

Surgical procedures are not a benefit of the program as they are not within the scope of state law. Psychiatric services rendered by Certified Nurse Practitioners are not a benefit of the program.

Item 24a Transportation

Out-of-state transportation services (except nearby border cities) are allowable only when the services needed cannot be obtained in New Mexico or the physician provides adequate justification for the out of state travel. Emergency transportation will be reviewed retrospectively to determine if the transport was necessary.

Item 24e Emergency Hospital Services

Emergency hospital services may be provided by facilities not certified by Title XVIII. These services must meet the definition of emergency hospital services as defined in 42 CFR 440.170(e).

See limitations for Items 1 and 2a, inpatient and outpatient hospital services.
1. Inpatient hospital services other than those provided in an institution for mental diseases.
   □ Provided: □ No limitations □ With limitations*

2.a. Outpatient hospital services.
   □ Provided: □ No limitations □ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
   □ Provided: □ No limitations □ With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
   □ Provided: □ No limitations □ With limitations*

3. Other laboratory and X-ray services.
   □ Provided: □ No limitations □ With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
   □ Provided: □ No limitations □ With limitations*

b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.
   □ Provided: □ Limited to Federal requirements □ In excess of Federal requirements

c. Family planning services and supplies for individuals of childbearing age.
   □ Provided: □ No limitations □ With limitations*

*Description provided on attachment.
Methods of providing transportation.

Transportation required by clients to obtain needed medical care under the program is provided when such required transportation cannot be secured without charge through volunteer organizations such as fire departments, public ambulances and other public services, or from relatives.

The methods of providing transportation by the Agency are:

1. By reimbursing providers of transportation by ambulance if other types of transportation are contra-indicated.

2. By reimbursing providers of common carrier and other specialized types of transportation.

3. By providing petty cash to clients in compensation for cost of travel by private automobile.
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NOT APPLICABLE

c. Prosthetic devices.
   [ ] Provided: [ ] No limitations [ ] With limitations*

d. Eyeglasses.
   [ ] Provided: [ ] No limitations [ ] With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

   a. Diagnostic services.
      [ ] Provided: [ ] No limitations [ ] With limitations*

   b. Screening services.
      [ ] Provided: [ ] No limitations [ ] With limitations*

   c. Preventive services.
      [ ] Provided: [ ] No limitations [ ] With limitations*

   d. Rehabilitative services.
      [ ] Provided: [ ] No limitations [ ] With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

   a. Inpatient hospital services.
      [ ] Provided: [ ] No limitations [ ] With limitations*

   b. Nursing facility services.
      [ ] Provided: [ ] No limitations [ ] With limitations*

*Description provided on attachment.
c. Intermediate care facility services.
   □ Provided: □ No limitations □ With limitations*

15. Intermediate care facility services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions, for persons determined, in accordance with Section 1902(a)(31)(A) of the Act, to be in need of such care.
   □ Provided: □ No limitations □ With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.
   □ Provided: □ No limitations □ With limitations*

17. Nurse-midwife services.
   □ Provided: □ No limitations □ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).
   □ Provided: □ No limitations □ With limitations*

*Description provided on attachment.

STATE: NEW MEXICO
DATE REC'D: DEC 31, 1990
DATE APPV'D: APR 25, 1991
DATE EFF: OCT 1, 1990
HCFA 179

TN No. 2423
Supersedes Approval Date: APR 25, 1991
TN No. ____________ Effective Date: OCT 1, 1990
22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).
   □ Provided: □ No limitations  □ With limitations*
   □ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
   a. Transportation.
      □ Provided: □ No limitations  □ With limitations*
   
   b. Services of Christian Science nurses.
      □ Provided: □ No limitations  □ With limitations*

   c. Care and services provided in Christian Science sanitoria.
      □ Provided: □ No limitations  □ With limitations*

   d. Nursing facility services provided for patients under 21 years of age.
      □ Provided: □ No limitations  □ With limitations*

   e. Emergency hospital services.
      □ Provided: □ No limitations  □ With limitations*

   f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
      □ Provided: □ No limitations  □ With limitations*
27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

- [ ] Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

- [x] No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Provision(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935(d)(1)</td>
<td>Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.</td>
</tr>
</tbody>
</table>

NOT APPLICABLE

TN No. 05-04
Supersedes Approval Date 12-16-05 Effective Date January 1, 2006
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency

NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

<table>
<thead>
<tr>
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<th>Provision(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1927(d)(2) and 1935(d)(2)</td>
<td>The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit -Part D.</td>
</tr>
</tbody>
</table>

The following excluded drugs are covered:

- (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)
- (b) agents when used to promote fertility (see specific drug categories below)
- (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
- (d) agents when used for the symptomatic relief of cough and colds (see specific drug categories below)
- (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)
- (f) nonprescription drugs (see specific drug categories below)

NOT APPLICABLE
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency

NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

Citation(s) Provision(s)

1927(d)(2) and 1935(d)(2)    (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

(h) barbiturates (see specific drug categories below)

(i) benzodiazepines (see specific drug categories below)

(j) smoking cessation drugs (Except dual eligibles as Part D will cover) (see specific drug categories below)

(The Medicaid agency lists specific category of drugs below)

NOT APPLICABLE

No excluded drugs are covered.

TN No. 05-04

Supersedes Approval Date 12-16-05 Effective Date January 1, 2006

TN No. 

Attachment 3.1.B.1
Page 3
STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX

Attachment 3.1-C

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

The Medical Assistance Bureau has in operation several separate, but interrelated methods of assuring high quality care. These methods include: review of acute care, long term care and ambulatory care by the New Mexico Professional Standards Review Organization (NMPSRO); drug program monitoring through the Department, operation of the Surveillance and Utilization Review subsystem and the Medical Management Program for recipients; Department monitoring of the NMPSRO review activities; and special provisions relating to quality of care in IHS hospitals.

PSRO operations are discussed in the following Part I; Department operations are discussed under Part II.

PART I - NMPSRO REVIEW FUNCTION

NMPSRO provides utilization review of services to acute care patients and long term care patients through contracts with the Department of Human Services. These activities are described below in Sections A and B. NMPSRO also provides utilization review of services to ambulatory patients through a direct contract with the Department. The specifics of each area of care are described below in Section C.
A. REVIEW OF HOSPITAL ADMISSION

I. INTRODUCTION

The New Mexico Medical Assistance Program (MAP) has directed its review efforts to ensure compliance with the Medicaid program's objectives for cost containment and quality control. The NMMRA, acting under contract to the MAP, will perform medical review under the Medicaid system to ensure that:

1. Admissions to acute care hospitals and medically necessary.

2. All hospital services and surgical procedures provided were appropriate to the patient's condition and were reasonable and necessary to the care of the patient.

3. Patterns of inappropriate admissions and transfers are identified and are corrected. Reimbursement will not be allowed for inappropriate admissions or transfers.

4. The new method of payment and its application by hospitals have not jeopardized quality of patient care.

5. All cases which require a medical peer review decision regarding appropriate utilization of hospital resources, quality of care, or appropriateness of admission, transfer into a different hospital, and readmission, will be reviewed by a NMMRA Physician Consultant or will be reviewed by the NMMRA Medical Director.

II. CRITERIA FOR REVIEW

The NMMRA has developed and the MAP has approved the Acute Level of Care Criteria (ALOCC) and Specialty Criteria for the procedures under medical review in NMMRA's Preadmission Review Program. The criteria are utilization screening tools for use by NMMRA's professional nursing staff.

In the event that these criteria are modified the hospitals will be notified of such modifications including the effective date of implementation.
III. PREADMISSION REVIEW

The NMMRA will perform preadmission review for 100% of those surgical procedures as described in 310.020302 which are proposed as inpatient hospital admissions and all proposed rehabilitation admissions. The preadmission review procedures require that the attending physician's office or the admitting hospital make a request by telephone to the NMMRA for elective surgical procedures prior to the admission. Any such request which is not received for a review determination by the NMMRA prior to the surgery will be subject to retrospective review, denial, and recoupment proceedings, should denial occur.

The NMMRA will utilize Health Service Reviewers and Physician Consultants by appropriate specialty for reviewing elective procedures proposed as inpatient admissions. Any proposed patient admission which fails the criteria will be referred to a Physician Consultant appointed by the NMMRA Medical Director for a determination of medical necessity.

In the event the admission and/or proposed procedures are pending denial, the attending physician and hospital will be contacted by telephone. Should a denial occur, both the physician and the hospital will be notified by NMMRA. It is the responsibility of the attending physician to notify the patient. Should a denial occur, the attending physician and/or patient will have the right to a reconsideration hearing.

IV. CONCURRENT ADMISSION AND CONTINUED STAY REVIEW

The NMMRA will perform concurrent admission and continued stay review for all admissions to specialty hospitals and specialty units within hospitals.

V. RETROSPECTIVE REVIEW

The NMMRA will perform retrospective review on certain types of inpatient cases. Cases will be reviewed on-site at the hospital or in-house for both PDO (reimbursed per discharge) and Non-PDO (reimbursed per TEFRA) hospitals (excluding specialty hospitals and specialty units) based on the volume of cases identified by the Fiscal Agent. On-site review can be expected when the number of cases exceed one hundred (100) per quarter; or, when the NMMRA is in the area for other review reasons. The NMMRA may also perform review at the NMMRA using copies of charts mailed to the NMMRA.

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DATE: JUL 2 1986
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VI. REVIEW OF INTER-HOSPITAL TRANSFERS AND READMISSIONS

A. Review of Inter-Hospital Transfers

The NMMRA will perform prepayment review of all Medicaid discharges resulting in a transfer to another acute care hospital. The NMMRA will review the medical records, either on-site or in-house, and make a determination regarding the medical necessity and appropriateness of the transfer. If the NMMRA determines non-medical necessity, the NMMRA will institute the denial procedure. The hospital inappropriately transferring the patient will be the hospital subjected to the denial of payment. The receiving hospital will be held harmless.

B. Review of Readmissions Within Seven (7) Calendar Days of Discharge From An Acute Care Facility

The NMMRA will perform prepayment review on Fiscal Agent identified admissions which have occurred within seven (7) calendar days of discharge from an acute care facility. Neither the day of discharge, nor the day of admission is counted when determining whether a (re)admission has occurred.

1. When the admissions are for patently different diagnoses (unrelated reasons), the NMMRA follows the standard that no medical record review is required.

2. If the admissions appear to be related, NMMRA will perform medical review.

3. If the admissions are found to be medically necessary and appropriate, no further action will be taken.

4. If either or both admissions are found to be medically unnecessary, denial will follow.

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VII. REVIEW FOR DIAGNOSIS VERIFICATION AND MEDICAL NECESSITY OF THE ADMISSION

A. The MAP and NMMRA will define the sample size for PDO and Non-PDO hospitals and method of selection for those cases to be subjected to diagnosis verification and medical necessity review.

B. If medical necessity criteria for admission are not met, the HSR will refer the case to a Physician Consultant (PC) by appropriate specialty for a determination of approval or denial of the admission.

C. If the admission is approved, the HSR will perform diagnosis verification by review of the discharge summary and complete the appropriate portion of the worksheet.

D. If the admission is denied by the PC, the HSR will complete the appropriate portion of the review worksheet and initiate a medical necessity denial. No further review is required by NMMRA. The reconsideration process is then available.

VIII. EXAMPLES OF MEDICAID NON-COVERED SERVICES THAT CAN RESULT IN TECHNICAL DENIALS

A. Private duty nursing.

B. Custodial care.

C. Surgery for solely cosmetic reasons.

D. Any hospitalization solely for administration of a drug or biological which is not reasonable or necessary (not safe and effective by FDA), including investigational drugs.

E. Hospitalization for procedures excluded from Medicaid coverage.

F. If the patient reaches a Skilled Nursing or Intermediate Level of Care the hospital stay will no longer be covered by the Medicaid inpatient program.

G. Hospitalization for a person who is hospitalized as part of a workman’s compensation claim or a person who is hospitalized as part of a liability claim.

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DATE: JUL 2 1986
TRANSMITTAL NO: 86-5
IX. RECONSIDERATIONS

If a recipient or recipient's next of kin or personal representative or attending physician or hospital is dissatisfied with a NMMRA medical review determination, that party may request a reconsideration. If the patient has been discharged, this request must be made within sixty (60) days of receipt of the contested determination or if more than sixty days have elapsed the requesting party must submit documentation of extenuating circumstances for late filing. The request for reconsideration shall be made in writing to the NMMRA Medical Director and must identify for what part of the determination a reconsideration is being requested.

On receiving such a request, the NMMRA Medical Director shall notify all potential parties of the reconsideration and shall conduct reconsideration hearing(s) with a panel of Physician Consultants by appropriate specialty, at a time convenient for all parties within ten (10) working days of receiving the request. The panel shall consist of NMMRA Physician Consultants who have no previous association with the case and who are at least equal in expertise to that of the attending physician.

If the patient is still an inpatient when the reconsideration is requested, the hospital is required to contact the NMMRA for a review determination by telephone request. The NMMRA will make its reconsideration determination and provide verbal notice with follow-up written notice to the parties within one (1) working day after it receives the verbal request for reconsideration.

If the patient is no longer an inpatient when reconsideration is requested, the NMMRA will make its reconsideration determination and provide written notice to the parties within ten (10) working days after it receives the request for reconsideration and all necessary documents for review. In reconsidering the original determination, the NMMRA shall review the evidence and findings upon which such determination was based and any additional evidence submitted to or otherwise obtained by the Committee. A reconsideration hearing is not an adversary process.

The NMMRA Medical Director and panel of Physician Consultants shall use at least the following information for a reconsideration:

1. The records which were submitted to the panel initially when the attending physician or practitioner proposed to provide services.

2. The findings which led to the adverse initial determination.

3. The complete record of the hospital stay of the patient.

4. Any additional documentary information submitted by the party with its request for reconsideration.

5. Any oral presentation which the appealing party or its authorized representative may choose to present to the Committee.
The NMMRA shall make a reconsideration determination affirming, modifying, or reversing the initial adverse determination.

The reconsideration determination shall be final and binding upon all parties to the determination unless a request is made for a hearing to be conducted by the Human Services Department. In order to preserve a record for possible appeal to the Human Services Department, or possible judicial review, the NMMRA shall document and preserve a record of the reconsideration determination for a period of one year following the date of the reconsideration hearing. This record shall include all documentation of the adverse initial determination, the complete record of the hospital stay of the patient, any additional evidence presented by the appealing party, and a copy of the notice of reconsideration determination.

A party requesting a reconsideration may decide the withdraw the request by submitting a written withdrawal statement to the NMMRA Medical Director.

X. QUALITY ASSURANCE REVIEW

All cases reviewed for any reason by Physician Consultants and the Medical Director of NMMRA, will also be reviewed to assure that the patients received services and treatment appropriate to the condition being treated and were not discharged prematurely. A worksheet will be completed and maintained by the NMMRA for each case reviewed for quality of care.

Any case which fails quality screens or physician standards of care will be referred by NMMRA's Medical Director in writing to the Hospital Chief of Staff or Chairperson of Quality Assurance Review for follow through. In the event that an aberrant pattern is identified, the NMMRA will require that the hospital initiate appropriate action to correct the pattern.

NMMRA's Medical Director will monitor the hospital's progress for assuring quality of patient care in the event that such cases are identified as described above.

XI. DISCHARGE PLANNING

Discharges should be coordinated with utilization review efforts and should never be delayed because post-hospital planning has been neglected. Upon request, the County Income Support Division or Social Services Division caseworker handling the case will assist the hospital's social service department in arranging for the most appropriate post-hospital care for the recipient.
B. REVIEW OF CARE PROVIDED TO RECIPIENTS ADMITTED TO LONG TERM CARE FACILITIES

I. INTRODUCTION

As a result of the loss of Federal funding for binding review of Long Term Care under Title XI on September 30, 1981, the responsibility for assuring that UR/UC review is carried out in Long Term Care facilities was shifted to the Human Services Department.

The Department has elected to contract with the NMPSRO to carry out the Long Term Care review function. The NMPSRO will carry out this function according to the New Mexico Plan for Long Term Care Review which is set forth in this document.

The Department has received a superior performance waiver for this review process because it deviates from the requirements of Section 1861 (k) of the Social Security Act, but has been determined to be a superior review procedure by the Health Care Financing Administration as allowed under Section 1903 (i) (4) of the Act.

II. GENERAL INFORMATION

The N.M. Plan for Long Term Care Review will consist of two basic elements.

1. Level of Care/Length of Stay Determinations
2. On-Site PMR/IPR Review

The level of care/length of stay determinations will be carried out using a combination of in-house abstract review and on-site review. All determinations will be made according to the criteria and guidelines set forth in this plan.

The on-site PMR/IPR review will be carried out using a modified method of the Title XIX regulations.

III. LOC/LOS REVIEW

The LOC/LOS review will be carried out by PSRO staff. This staff consists of Review Coordinators, who are RNs, and physician reviewers.
Medical information supplied by the LTC facility, the attending physician, and/or information gathered on-site by the review coordinator will be utilized in rendering level of care/length of stay determinations.

A. Criteria

An established set of medical criteria will be used in rendering level of care determinations. The Level of Care Criteria has been adopted for screening review and was developed by New Mexico physicians for use in determining need for services which are usually delivered in either skilled or intermediate care facilities. These criteria have been approved and in use since February, 1979. These are screening criteria which are specifically utilized by the Review Coordinators for all LTC admission, re-admission, and continued stay assessment reviews.

If screens are met and the Review Coordinator is satisfied that the recipient's condition justifies the level of care requested, the admission, re-admission, or continued stay review is determined as medically necessary and a level of care and length of stay is assigned.

If the Review Coordinator has some doubt that the screens are met or that the level of care request is appropriate, i.e., the recipient appears to require a higher or lower level of care than that requested, the Review Coordinator will refer the case to a Physician Reviewer for a determination. The Physician Reviewer is not strictly bound by the Level of Care Criteria because his/her own expertise and medical judgment will be utilized and is encouraged as part of the peer review concept.

An exception to this will be made in the case of continued stay recertification review on a recipient who does not clearly meet the screens, but whose condition has remained the same since the last review. Rather than referring this case to a Physician Reviewer, the Review Coordinator may reassign the level of care determined by the Physician Reviewer at the time of the last review. This exception will only be utilized in those cases where the recipient's condition has clearly remained stable and no new medical need has developed.

LEVELS OF CARE

In order to justify stay at a SN level of care, a resident must require skilled nursing services (listed on the following pages)
on a daily basis. The need for a single skilled service on an occasional basis would not justify, by itself, a skilled level of care. In determining the level of care, therefore, consideration must be given to:

1. The level of services required.

2. The frequency with which they are required.

Criteria are predetermined indicators against which aspects of actual care can be compared to judge their necessity for services. The following criteria lists types of care and services that are often appropriate in a skilled or non-skilled LTC facility. The criteria indicate the level of care recommended for residents who require any of the listed services routinely. If a service justifies the skilled level in certain circumstances and the non-skilled services are such that they can only be accomplished in a SNF, through skilled management or observation, assignment of a skilled level of care is appropriate. (See Criterion 9.)

**SKILLED LEVEL OF CARE**

An individual requires a skilled level of services if she/he needs: (1) on a daily basis, (2) skilled nursing care or other skilled rehabilitation services, and (3) such services can be provided only in a skilled nursing facility on an inpatient basis. The patient's medical record must clearly show that all three factors are met and continue to be met.

A. **Daily Skilled Services** — Skilled nursing services or skilled rehabilitation services must be required and provided on a "daily basis" — i.e., on essentially a 7-day-a-week basis. A break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical would not violate the requirement.

B. **Skilled Services Defined** — A skilled service is one which must be furnished by or under the general supervision of skilled personnel to assure the safety of the patient and achieve the medically desired result.

C. **Skilled Nursing Services Defined** — A skilled nursing service is one which must be furnished by or under the general supervision of licensed nursing personnel and under the general direction of a physician to assure the safety of the patient and achieve the medically desired result.

D. **Need Satisfied Only by SNF Inpatient Care** — In determining whether the care needed can only be provided in a skilled nursing facility on an inpatient basis, consideration must be given to the patient's condition and to the availability
and feasibility of using more economical alternative facilities and services.

E. Specific Services which are Skilled Nursing -- Skilled nursing services include but are not limited to the following:

1. Intravenous or intramuscular injections and intravenous feeding. (Injections which can usually be self-administered -- e.g., the well-regulated diabetic who receives a daily insulin injection -- does not require skilled services.)

2. Levine tube and gastrostomy feedings.

3. Naso-Pharyngeal and tracheotomy aspiration.

4. Insertion or replacement of catheters and sterile irrigations of catheters.

INTERMEDIATE LEVEL OF CARE

Services Which Are Not Skilled Nursing (statements contained herein are not intended to negate the Nurse Practice Act but rather are used only in the context of differentiating between Skilled and Intermediate level of care.)

A. Importance of Service to the Patient -- The importance of a particular service to an individual patient does not necessarily make it a skilled service, e.g., a primary need for a nonambulatory patient may be frequent changes of position to avoid development of decubitus ulcers. Since changing of position can ordinarily be accomplished by unlicensed personnel, it would not be a skilled service.

B. Specific Services Which Are Supportive or Unskilled -- Supportive services include but are not limited to the following:

1. Administration of routine oral medications, eye drops, and ointments.

2. General maintenance care of colostomy or ileostomy.

3. Routine services in connection with indwelling bladder catheters. (This would include emptying containers and cleaning them, clamping tubing, and refilling irrigation containers with solution.)

4. Changes of dressings for noninfected postoperative or chronic conditions.

5. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of

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6. General methods of treating incontinence, including use of diapers and rubber sheets.


8. Routine care in connection with braces and similar devices.

9. Use of heat for palliative and comfort purposes.

10. Administration of medical gases after initial phases of teaching the patient to institute therapy.

11. General supervision of exercises which have been taught to the patient.

12. Assistance in dressing, eating, and going to the toilet.

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B. Admission Review

Before authorization for payment, a review of each applicant's or recipient's need for admission must be accomplished. This will be done through submission of a long term care abstract to the NMPSRO for review.

1. SNF Admission

The attending physician must make a medical evaluation of the recipient's need for SNF care, and certify such need on the abstract. This evaluation must include diagnosis, summary of present medical findings, mental and physical functional capacity, and prognosis. After the evaluation is made the attending physician must establish a written plan of care that includes:

- Diagnosis, symptoms and complaints
- Description of functional level
- Objectives
- Any orders for medications, treatments restorative or rehab services, diet, and special procedures
- Plans for continuing care
- Plans for discharge

The above required information will be condensed onto the abstract and forwarded to the NMPSRO for review. The NMPSRO will make a level of care determination and assign an initial continued stay review date will. The initial continued stay review date will in most instances be 30 days. The Review Coordinator may assign a length of stay shorter than 30 days based on the recipients needs and stability of conditions. Under no circumstances, will the initial period exceed 30 days.

2. ICF Admission

The attending physician must make an evaluation of the recipient's need for ICF care and certify such need on the abstract. This evaluation must include diagnosis, summary of present medical and social findings, mental and physical functioning, prognoses, and kind of services needed. After the evaluation is made the attending physician must establish a written plan of care that includes:

- diagnosis, symptoms, complaints
- functional level description
- objectives
- any orders for medications, treatments, restorative and rehab services, activities, therapies, social services, diet, special

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procedures, plans for continuing care, and plans for discharge.

The above required information will be condensed onto the abstract and forwarded to the NMPSRO for review. The NMPSRO will make a level of care determination and assign an initial continued stay review date. The initial continued stay review date will in most instances be 90 days. The Review Coordinator may assign a length of stay shorter than 90 days based on the recipient's needs and stability of condition. Under no circumstances will the initial period exceed 90 days.

3. ICF/MR Admission

The same as set forth above for ICF admissions will apply with the following addition. An interdisciplinary team of health professionals must make a comprehensive medical, social, and psychological evaluation of the recipient's need for admission to the ICF/MR. This evaluation will include diagnoses, summary of present medical, social and developmental findings, medical and social family history, mental and physical functional capacity, prognoses, kinds of services needed, evaluation of resources available in the home, family and community, and a recommendation concerning the need for admission to the ICF/MR.

C. Continued Stay Review

Continued stay review will be accomplished through the submission of an abstract to the NMPSRO for review and/or through on-site review.

Using the level of care criteria described in this plan, the reviewer will review the abstract and make a determination as to the continued need for level of care and assign a recertification date for review.

1. SNF

In most instances the reviewer will assign a continued stay review date of 90 days. The reviewer has the option of assigning a period of less than 90 days, based on the recipient's medical needs and stability of condition. Under no circumstances will the continued stay review date exceed 90 days.

2. ICF

In most instances the reviewer will assign a continued
stay review date of 6 months. The reviewer has the 
opportunity of assigning a period less than 6 months, based 
on the recipient's medical needs and stability of condition. Under no circumstances will the continued stay review date exceed 6 months.

3. ICF/MR

Same as above for ICF.

4. Change in Level of Care

When it has become apparent that a recipient's condition and needs have changed sufficiently to warrant a different level of care, it is the responsibility of the physician and the facility to submit an abstract reflecting these changes so that a new level of care determination can be made.

D. Abstract & Forms

Attached is a copy of the abstract and other forms to be used in carrying out long term care review. Instructions for completion of the abstract can be found in the accompanying manual.

E. Appeals

Should the NMPSRO, through carrying out this plan, render an adverse decision regarding admission, level of care, or length of stay, the following appeal procedure is available.

Any resident, admitting/attending physician or provider of services who is dissatisfied with an adverse review determination of the NMPSRO may request a reconsideration of such determination by the NMPSRO LTC Subcommittee. After the procedures for the reconsideration (contained in the manual) are carried out, should the appealing party still be dissatisfied with the NMPSRO reconsideration determination, the appealing party may then avail themselves of the State Fair Hearing Process.
IV. On-Site PMR/IPR Review

To accomplish the on-site PMR/IPR Review process, the Department contracts with the New Mexico Professional Standards Review Organization. Using Registered Nurses as on-site evaluators with NMPSRO physician participation when appropriate, NMPSRO staff reviews each facility on an annual basis observing 100% of the Title XIX population in the facility as described below. The method employed allows a concentration of effort on those recipients receiving and those facilities delivering what might be presumed to be a quality of care not in accordance with accepted medical standards.

A. Introduction

The on-site review will consist of two stages. Stage I will consist of a rapid review of 100% of the Medicaid population in a facility. This rapid review will be directed towards filtering out those recipient's where a possibility of a lesser degree of quality of care exists.

Stage II will consist of a comprehensive review on the quality of care being rendered to those recipients that have been focused on during Stage I. Theoretically, this will enable the on-site review team to direct their time and efforts towards those facilities where problems or potential problems exist, with the outcome being an improvement in quality of care rendered to all recipients.

B. Stage I

Stage I of the PMR/IPR is a very rapid review of all Medicaid recipients in the facility to determine the absence or presence of a Signal For Review (SFR). This review will be accomplished in two steps.

Before going on-site to a facility, the on-site reviewer will gather information from the abstracts that have been submitted on each resident. This will enable the reviewer to establish the core group sample which will be used for Stage II review. Once in the facility, the reviewer will further screen incident reports and use direct observation of the recipients to further add to or delete from the sample for Stage II review.

Using a combination of the abstracts, on-site review and observation to determine the sample will allow us to assess the accuracy of information being provided on the abstract for level of care and length of stay determinations. Should discrepancies in the accuracy of the abstract exist, corrective action will be taken with the facility.
1. Signal for Review (SFR)

An SFR is simply an event or outcome that leads the reviewer to ask "why did this occur?" The presence of an SFR does not necessarily mean that inadequate care is being rendered by the facility, rather it may be caused by circumstances beyond the facility's control. It is a means by which the reviewer can concentrate on those recipients where potential problems may exist.

a. SNF/ICF SFR Definitions

Accidents/Incidents

In the past 6 months: occurrence of a) two or more accidents or b) one accident/incident which led to serious injury.

Behavioral Problems

In the past three months: occurrence of behaviors which are uncontrolled, disruptive, and/or dangerous to self and others.

Decubitus Ulcer/Lesions

On the day of the review visit: one or more decubitus ulcers as evidenced by an area of soft tissue breakdown resulting from sustained pressure or other causes.

Contracture (To be used for SNF's only)

On the day of the review visit, one or more contractures. EXCEPTION: treatment is contraindicated.

Lack of Ambulation

In the past three months: decrease in the level of ambulation. EXCEPTION: a permanent or temporarily identified physical impediment which makes ambulation impossible.

Indwelling Urethral Catheter

On the day of the review visit. (ICF's only) Insertion of a catheter in the last three months (SNF only).
Poor Grooming

On the day of the review visit: evidence of poor personal care, failure of the facility to promote or assist in personal care, inappropriate or unclean clothing, unclean immediate environment (bed, chair, room)

Discharge/Transfer

In the past three months: discharge to a higher or lower level of care.

Poor Nutrition

In the past three months: occurrence of unplanned or fluctuating weight changes, emaciation, dehydration, edema, constipation and other nutritional problems.

Contagious Infections

In the past three months: presence of a contagious infection.

Incontinence

In the past three months: indication that recipient should be receiving bowel and bladder retraining. EXCEPTION: Physical or mental impairment that prohibits successful retraining.

Therapies

In the past three months: recipient has received physical, occupational or speech therapy.

b. ICF/MR SFR Definitions

Accident/Incidents

In the past three months: occurrence of a) two or more accidents/incidents; or b) one accident/incident which led to serious injury.

Behavioral Problems

In the past three months: occurrence of behaviors which are uncontrolled, disruptive, and/or dangerous to self, others, or the facility environment.
Decubitus Ulcer/Lesions

On the day of the review visit: one or more decubitus ulcers as evidenced by an area of soft tissue breakdown resulting from sustained pressure or other causes.

Poor Eating Habits

On the day of the review visit: failure of the facility to promote or assist in teaching of self feeding, failure to provide adaptive eating equipment.

Poor Grooming

On the day of the review visit: evidence of poor personal care, failure of the facility to promote or assist in personal care; inappropriate, unclean or poorly maintained clothing.

Contagious Infections

In the past three months: presence of a contagious infection.

Annual Physical

Lack of an annual physical examination.

Interdisciplinary Program Plan (IPP)

Lack of an updated IPP.

2. Focusing methodology

All recipients who have an indication of one or more SFR's will go into the focused populace for which comprehensive review of quality of care will be performed.

C. Stage II

Stage II of the process is directed toward assessment of the resident's status, the clinical record of his/her treatment, services, and progress, and the facility's overall ability to deliver quality care. This is carried out during each facility assessment visit to insure that Title XIX LTC residents throughout New Mexico are receiving proper medical, nursing, personal, social and rehabilitative services at a level of care appropriate to their needs which met local standards for care.
These review program objectives will be met by on-site quality of care assessment by professionals with knowledge and expertise in the various fields of nursing but particularly in medical and geriatric areas. The NMPSRO on-site evaluators shall be Registered Nurses with NMPSRO physician participation, when appropriate.

A. Review of Title XIX Residents' Record to evaluate the following standards:

1. Physician Participation - Frequency of visits by attending physician, physical examinations, medical treatment, medical plans of care, medications ordered, response to request for medical attention, etc.

2. Nurses Participation - Nursing observations, notes, documentation of unusual events and illnesses, treatment, plans of care, response to medications, etc.

3. Treatments and Medications - Facility handling, distribution, and ordering of medication, etc.

4. Laboratory Work - Insure that studies ordered by the physician are carried out as ordered and that abnormal values are reported immediately to the attending physician and appropriately noted by the nurses.

5. Diets - Insure that there is a dietetic care plan written by a dietician and that the resident's reactions to therapeutic diets are recorded and that special diets are ordered when necessary and carried out properly by facility dietary personnel.

6. Health Care Plans - Insure that the plans are goal oriented, that the individual resident's problems and solutions to those problems are stated in multidisciplinary terms, and that the plans are revised as needed, including the discharge plan.

B. Conduct a personal interview and clinical nursing examination of the Title XIX resident population sample on each visit to determine the following:

1. That no life threatening/endangering situation exists.

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2. Adequacy of nursing care through observed prevention of skin breakdown; care of decubiti, signs of malnutrition or dehydration, personal hygiene, use and positioning of restraints, etc.

3. The type and quality of restorative care being administered.

4. The mental and psycho-social functioning of each resident.

5. The resident's response to the facility's program.

6. The competency of health care personnel who are carrying out the prescribed plans of care.

7. The abilities and disabilities of the resident.

C. Assess the level of care needed by each resident as indicated by his/her physical and mental condition, as to the following levels:

1. Actue Care Level
2. Skilled Care Level
3. Intermediate Care Level
4. Non-medical Setting (Residential Care/Boarding Home/Home)

D. Review and evaluate the environment of the facility to insure that it does not adversely affect the facility's capability to render quality care. The following areas will be assessed:

1. General cleanliness and sanitation
2. Utilization of dining area during meals
3. Staffing ratio
4. Physical Therapy Department/Services
5. Bathrooms
6. Living area for adequacy of space
7. Activities area
8. Laundry Area
9. Medication and Treatment Rooms

E. Reports

After Stage II of the process is completed all the findings shall be compiled preliminarily and reported verbally to the administration and staff of the facility in an exit interview. This is an ideal time for
both parties to clarify issues and to consider on-site findings, agree upon what areas should be targeted for improvement in services delivery, and how to best implement any needed changes, and a future date set for successfully implementing any changes.

The NMPSRO on-site evaluation process is an assessment "tool" and the evaluator(s) may provide advice and recommendations, including referral of non-XIX matters to appropriate agencies. Problems, actual or potential, and approaches to problem management will be discussed during the exit interview concerning any areas relating to the quality of care and welfare of the residents.

After returning to the NMPSRO office, the on-site evaluator(s) shall compile the information obtained from individual resident assessments during the on-site assessment and complete a facility report. A copy of this report shall be distributed to the State Licensing and Certification Agency, the Title XIX State Agency, and the LTC facility Administrator.

The Title XIX State Agency will review the reports and request a plan of correction with reasonable time frames to implement such correction.

V. Coordination with Licensing and Certification

Copies of all on-site review reports will be forwarded to Licensing and Certification. When possible on-site review will be scheduled to fall approximately 4 to 6 weeks prior to the annual Certification Survey. This will enable the Certification Survey team to focus in on those areas where known problems and possible non-compliance to Standards of Participation exist.

Should the on-site review indicate that substantial non-compliance to Federal Standards exists, an Exception Report will be prepared. The State Agency will act upon the exception report by requesting that Licensing and Certification perform an immediate re-survey of the facility.

VI. Monitoring of PSRO Performance

The State Agency will carry out formal monitoring of the PSRO performance under the contractual arrangement. A copy of the monitoring plan is attached.

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C. REVIEW OF CARE PROVIDED TO RECIPIENTS ON AN AMBULATORY BASIS

1. Retrospective Review

Operate a retrospective professional review system based on focused review of Medicaid ambulatory services. This ambulatory care review system will involve retrospective analysis of providers' practice patterns. Claims as determined necessary by MAB will be subjected to prepayment screening and review. Claims subjected to this method of review will represent a fraction of claims submitted thus allowing the majority of claims to flow rapidly through the claims processing system. In implementing the overall review approach, NMPSRO will have access to the Medicaid data base in order to obtain reports which contain information concerning medical procedures, providers and patients.

2. Prepayment Review

Place upon prepayment review the claims of any provider whose practice pattern, in the opinion of the MAB, shows an identified overutilization of Medicaid ambulatory services. Such review will be conducted by review physicians and will result, to the extent appropriate, in the denial or adjustment of claims payment. In the event that serious and/or chronic practice problems are identified (such as overutilization or underutilization of services, inappropriate medications, etc.), the Ambulatory Review Committee may contact the provider and undertake the proper educational activities. Any provider placed on prepayment review will be monitored by the MAB. Such action will cease when it is determined that his/her practice pattern falls within established quality and utilization parameters or for a specific time frame designated by the MAB. PSRO also performs prepayment review on claims failing medicaid payment edits, such as those for emergency room services.

3. Prior Approvals

Administer system of prior approval by means of ongoing review for certain ambulatory services and supplies in the following areas:

a. Vision  
  b. Psychiatric and Psychological  
  c. Home Health Agency  
  d. Elective Outpatient  
  e. Rehabilitative  
  f. Prosthetic  
  g. Orthotic  
  h. Medical Equipment and Supplies  
  i. Dental  
  j. Selected Inpatient surgeries which can be provided on an outpatient basis in most circumstances  
  k. Podiatric

Determine the medical necessity for, and the appropriateness of, certain ambulatory services and supplies in the areas specified in a through k above, in accordance with the Department's medical assistance regulations.

APPROVED BY DHHS/HCFA/DPO
DATE: 8/24/82
TRANSMITTAL NO: 82-7
Utilizing a professional standards review system, review retrospectively all claims for certain ambulatory services and supplies in the areas specified in a through i above; such review to be limited to those claims for which prior approval ordinarily is required but, due to circumstances beyond the control of the provider, was not obtained and the requirement for prior approval has been waived by MAB.

In addition to these services, the NMPSRO provides the Department with professional assistance in evaluating medical necessity of new and/or established therapeutic procedures, within the constraints of the regulations in the State’s medical assistance manual.

PART II - UTILIZATION REVIEW ACTIVITIES OF THE STATE AGENCY

A. S/UR SUBSYSTEM

1. Objectives

Primary objectives in implementing the S/UR Subsystem are as follows:

a. Develop a comprehensive statistical profile of health care delivery and utilization patterns of provider and recipient participants in the services covered by New Mexico’s medicaid program.

Identify and investigate potential misutilization, and promote correction of actual misutilization of the Medicaid Program on the part of either provider or recipient.

Provide information to assist in detection and investigation of potential problems in the quality and quantity of medical services provided under the medicaid program.

2. Methods for developing essential information

a. The State uses the S/UR subsystem of the federal MMIS.

b. The State also uses certain MARS ranking reports to select providers for review. As of October 1978 the State has available and is using all elements of the SURS subsystem.

3. Procedures for using S/UR information

Qualified staff of the Medical Assistance Bureau.

a. Select appropriate S/UR reports as specified in 2, above.

b. Develop statistical profiles of health care delivery and utilization patterns, identify potential misutilization, identify defects in quality and quantity of services provided under the New Mexico Title XIX Program.
c. Carry out recommendations based on findings from S/UR reports and related factors; such recommendations to be consonant with New Mexico statutes, New Mexico Medicaid policies and procedures, federal statutes, federal Medicaid rules, regulations, and guidelines, and sound medical practice.

d. Coordinate with Legal Services Bureau of DHS on all matters involving legal aspects, including rights of recipients. Coordinate fully with A.G.'s office on all matters involving legal aspects including rights of providers.

e. Coordinate with local Income Support and Social Service staff as indicated in work with recipients and providers.

f. Coordinate with appropriate professional organizations as indicated in work with providers.

g. Support the MNPSC and the fiscal agent in their efforts to use educational and counseling approaches as the method of choice in dealing with most problems.

h. Arrange for further corrective action if necessary, such as but not limited to:

(1) Recipient may be brought under the Medical Management Program. (See Section C, below for discussion of the Medical Management Program),

(2) Provider may be asked to refund payment received for inappropriate services,

(3) Provider may be suspended from Medicaid participation,

(4) Provider may be referred to his professional association,

(5) Provider may be referred to his state licensing board,

(6) Provider may be referred to law enforcement authorities for prosecution for fraud.

B. Drug Utilization Review

Medical Assistance Bureau professional staff from the Operations and S/URS Sections perform utilization review of the Title XIX Drug Program. They review drug program policies and make recommendations to the Bureau on methods to ensure a quality drug
program. They act as consultants on issues presented by the drug program administrator which may affect future priorities in the program. They also review candidates for the medical management program, based on the recipients drug use history.

C. MEDICAL MANAGEMENT PROGRAM

1. Objectives

The Medical Management program is designed to monitor recipients with a history of over-utilization of services provided by the Medicaid program. Objectives of the Medical Management program are:

a. To identify over-utilization of services by recipients of medical benefits.

b. To assure quality and appropriate care for recipients of medical benefits.

c. To assist in identifying provider problems related to recipient over-utilization.

2. Organization and Procedures for Medical Management

The Surveillance and Utilization Review (SUR) Unit of the Medical Assistance Division has primary responsibility for placing recipients on the medical management program. Prospective candidates for medical management are identified through several sources:

a. Recipients identified by the claims processing agent through appropriate audits and edits in their claims processing system.

b. Recipients identified through sources outside the Medical Assistance Division, i.e., Income Support Division Specialists, private citizen, providers, etc.

c. Recipients identified in the SUR reports, particularly those who have received numerous services, those who have been to several different providers and those for whom Medicaid has paid a large dollar amount.

3. Selection for Medical Management

The SUR staff analyze statistical reports and the claim histories of each candidate for Medical Management. If additional information is needed, other sources, including medical records or information maintained by the claims processing contractor, are analyzed.
a. If the analysis indicates that the individual's aggregate use of service was not medically necessary, the SUR staff develop a recommendation that the individual be assigned to Medical Management.

b. The recommendation includes a description of the utilization problem, information analyzed in making the recommendation, type of restriction(s), designed provider(s), utilization objectives, effective date of the assignment, and date for reevaluation.

c. After reviewing the SUR staff recommendation and supporting documentation, the Medical Director of the Medical Assistance Division determines whether the individual should be assigned to Medical Management.

d. If the individual is to be assigned to Medical Management, the SUR staff notifies the recipient and the claims processing contractor of the assignment. The individual placed on Medical Management receives an identification card which indicates "Medical Management" and the name of the designated provider(s).

Part III - State Agency Monitoring of NMPSRO

It is the responsibility of Professional Standards Review Organizations to determine that services rendered are medically necessary and that the quality of the services meets acceptable professional standards of care. It is desirable, therefore, for states to be able to monitor the performance of PSROs so that they can determine that PSRO review is effective in utilization of services and that State dollars are being appropriately spent for necessary and quality care.

In response to the above the Medical Assistance Bureau has established a plan to monitor the performance of NMPSRO. The monitoring plan focuses on results of the NMPSRO review and avoids overseeing procedures used by the NMPSRO to do its review. In this way the monitoring process is entirely objective.

A. Objectives

1. To determine that the NMPSRO review is being carried out in a timely and accurate manner.

2. To determine that the NMPSRO review follows program policies and guidelines established by the Medical Assistance Bureau.

3. To determine the impact of the NMPSRO review on utilization of services and expenditures.
4. To identify areas of concern which should be addressed by the NMPSRO, the State Agency and the DHHS.

5. To ensure that State and Federal funds for institutional health care and ambulatory health care are being spent appropriately for medically necessary services and quality care.

These objectives are accomplished through several approaches which are discussed below.

B. AMBULATORY CARE MONITORING PLAN

I. Introduction

The Human Services Department contracts with the New Mexico Professional Standards Review Organization for specified services. The Ambulatory Care Monitoring Plan defines the monitoring procedures for the responsibilities identified in the scope of work contained in the contract. The Medical Assistance Bureau of the Human Services Department is responsible for monitoring:

1. Prior Approval Review – the performing of prior approval review for the medical necessity of ambulatory services as specified in the contract.

2. Pre-payment Claims Review – the review of claims of providers on review, emergency room claims and universal claims review for selected procedures.

II. Objectives of PSRO Monitoring

The objectives of the PSRO Ambulatory Monitoring Plan are to insure that the performance standards as specified in the contract are met. Specifically, the objectives are as follows:

1. Monitor the timeliness of pre-payment claims review.

2. Monitor the timeliness and accuracy of quarterly statistical reports.

3. Monitor the timeliness of processing prior approval requests.

4. Monitor the review process for adherence to Medical Assistance Bureau program policies, guidelines, and criteria and the PSRO Ambulatory Care Review Manual, for the appropriate level of review, consistency of review and for appropriateness of review determinations.
III. Monitoring Methodology

The methodology to be employed in this plan consists of both on-site observation and the review of documents related to the monitoring objectives. In order to accomplish the monitoring, NMPSRO will provide the Medical Assistance Bureau with the following:

1. Advance notice of all scheduled review sessions with notice of all changes in such a schedule.

2. Advance notice of all meetings scheduled for provider groups, peer reviewers, ad hoc committee meetings and Ambulatory Review Committee meetings.

3. Access to files on Medicaid recipients, provider correspondence, professional peer review sessions, claims and prior approval requests scheduled for review, and claims and prior approval requests as handled by the review coordinator or review assistants.

4. Access to internal activity reports.

5. Access to the review sessions.

The following is the specific methodology to be used for each defined monitoring objective:

Objective 1 – Monitor the timeliness of prepayment claims review.

The timeliness of prepayment claims review will be monitored using the weekly aged claim lists produced by the fiscal agent, the process date of claims and worksheets being reviewed at review sessions, the process date of claims and worksheets being returned to the fiscal agent. The attendance at selected review sessions and other on-site visits will be used to collect this data.

Objective 2 – Monitor the timeliness and accuracy of quarterly statistical reports.

Reports will be reviewed for accuracy and appropriateness of methodology. Internal reports resulting in the preparation of quarterly reports as well as a
sampling of documents will be used. NMPSR0 may be required to furnish documentation regarding the content of any report or statistics produced. The timeliness will be considered using the date received by the Medical Assistance Bureau. The monitoring of this data shall be at the discretion of the Medical Assistance Bureau.

Objective 3 – Monitor the timeliness of the processing of prior approval requests.

The timeliness of processing prior approval requests will be monitored at the review sessions and other on-site visits. The date of receipt of the requests shall be considered with the date that the authorization is mailed to the provider. Attendance at selected review session and other on-site visits will be used to collect this data.

Objective 4 – Monitor the review process as described in the monitoring objectives.

Adherence to Medical Assistance Bureau Program policies, guidelines and criteria will be monitored by the attendance at selected review sessions, other on-site visits, and from a random selection of claims post payment supplied by the fiscal agent. The following shall be considered in monitoring the review process:

1. Claims and prior approval requests are given the level of review appropriate. Approvals, denials, and provider communications within the scope of responsibilities of the review assistants or review coordinator are to be handled at that level. Referrals to professional peer review, the Medical Assistance Bureau, and other review sources are to be appropriate.

2. Claims and prior approval requests are to be reviewed and processed according to the program benefits and limitations.

3. The consistency of review is recognized as being a product of consistent interpretation of program policy, Ambulatory Review criteria, proper instruction to the professional reviewers by PSR0,
and proper functioning of the review assistant and review coordinator. These elements shall all be considered in monitoring for consistancy of review.

4. The appropriateness of review determinations shall be monitored by considering the specific review decision in terms of common professional practice.

IV. On-site Reviews

The Medical Assistance Bureau will conduct on-site reviews, and attend review sessions and other necessary meetings with the recognition that the normal work flow of NMPSRO cannot be interrupted beyond what is necessary for the Medical Assistance Bureau to properly monitor performance. Recognizing also that the Medical Assistance Bureau is able to offer information regarding program policy and requirements, the following procedures will be followed at on-site visits:

1. Medical Assistance Bureau personnel may examine the material scheduled for review, attend the review session, or examine the material after the reviews are completed all at the discretion of the Medical Assistance Bureau.

2. Medical Assistance Bureau personnel in general will not discuss the review or program with the physician reviewers unless the reviewer specifically directs questions regarding program policy relevant to the review session to him or her. Medical Assistance Bureau personnel may clarify a service as not a program benefit if the review assistance fails to do so and the physician reviewer is approving a service which is not within the scope of the program.

3. Written notes will be taken at the review session regarding the review session regarding the appropriateness of the approvals, the level of review required, the adherence to Medical Assistance Bureau program policy and criteria, and the aged status of the material being reviewed.
V. Reports to NMPSRO

The Medical Assistance Bureau will furnish to NMPSRO draft reports on their performance. NMPSRO will have 10 working days during which comments may be made to the Medical Assistance Bureau prior to finalizing the report. NMPSRO will receive a copy of the final report.

The State Agency will maintain regular periodic, informal contact with the PSRO and provide informal feedback on potential or existing problems. It is hopeful that many areas of concern or problems will be resolved at this level. However, at the discretion of the Medical Assistance Bureau NMPSRO may be required to produce a corrective action plan and/or document that specific problems are being resolved.

1. The Medical Assistance Bureau will inform the PSRO in writing of its concerns and will request a written explanation and/or the PSRO position on matters in question.

2. Upon receipt of the PSRO response, the Medical Assistance Bureau will review it and make a determination as to its satisfaction. If the State determines that the issues have been adequately explained and addressed by the PSRO, no further action will be necessary.

3. If the PSRO response is deemed not satisfactory, the Medical Assistance Bureau will request a meeting with the PSRO. If the issues can adequately be resolved at this meeting, the PSRO will confirm in writing any agreements and/or resolutions which result from the meeting and no further action will be required.

4. If the issues cannot be adequately resolved at this meeting the Medical Assistance Bureau will notify the PSRO in writing and request corrective action and response to the notification within 30 days.

5. If there has not been resolution of the problems within 30 days, the Medical Assistance Bureau will transmit all pertinent information to the Director of the Income Support Division for administrative action.
Part IV - Special Provisions relating to IHS Hospitals

Indian Health Service Hospitals will be certified as Medicaid providers in the New Mexico Title XIX Program on the same basis as any other qualified provider. Medicare has implemented certain departures from reimbursement policies and procedures normally applied to Medicare hospitals in order to temporarily accommodate certain problems, primarily in the area of inadequate and untrained personnel in those institutions. Until these problems can be alleviated, Medicare and Medicaid will utilize per-diem rates established by the Office of Management and Budget for interim reimbursement and final settlement.

Directly related to the above procedure, the State of New Mexico has temporarily implemented the following procedures in order to allow IHS facilities to participate in the Title XIX Program.

A. IHS Facilities will use a newly developed procedural code for all outpatient visits and will not be required to enter all services provided on an outpatient basis.

In order to accomplish utilization review on these claims it will be required that diagnosis be entered. This will enable the State to monitor overutilization by recipients and whether outpatient treatment is appropriate to the diagnosis. As staff can be augmented and trained normal claims submission will be required.
Attachment 3.1-D
Methods of providing transportation.

Transportation required by clients to obtain needed medical care under the program is provided when such required transportation cannot be secured without charge through volunteer organizations such as fire departments, public ambulances and other public services, or from relatives.

The methods of providing transportation by the Agency are:

1. By reimbursing providers of transportation by ambulance if other types of transportation are contra-indicated.

2. By reimbursing providers of common carrier and other specialized types of transportation.

3. By providing petty cash to clients in compensation for cost of travel by private automobile.
Attachment 3.1-E
STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The New Mexico Medicaid program covers those medically necessary major organ transplant services which are not considered unproven or experimental by the Medicaid program or its Utilization Review Contractor for the condition for which they are intended or used.

Kidney and cornea transplants are covered by the Medicaid program without prior approval. Written prior approval must be obtained for reimbursement for the following covered transplants services:

1) Heart;
2) Liver;
3) Heart-lung;
4) Lung; and
5) Bone Marrow.

A transplant is considered unproven or experimental if it meets any of the following conditions:

1) The procedure does not have final approval from the appropriate government regulatory agencies, if such exist.

2) The procedure is not currently recommended by the appropriate recognized national professional peer organization if such exists and if chartered to review the particular type of procedure.

STATE: New Mexico
DATE REC'D: 4/1/94
DATE APP'ED: 4/26/94
DATE EFF: 5/1/94

TN No. 94-04
Supersedes 87-14
Approval Date 4/30/94
Effective Date 5/1/94

HCFA ID: 1047P/0016P
STANDARDS OF THE COVERAGE OF ORGAN TRANSPLANT SERVICES

3) As determined by the Medical Assistance Division, the current scientific evidence, published in appropriate professional peer reviewed journals, does not substantiate the following conclusions concerning the effect of the procedure on health outcomes:

a) The procedure must improve the new health outcome.

b) The procedure must be at least as beneficial as any established alternatives.

c) The procedure must be associated with no more risk to the patient than any established alternatives or the risk to benefit ratio must be at least as favorable as established alternatives.

d) The improvement must be attainable outside the investigational setting.

4) A written informed consent required by the treating facility or a research protocol being executed by the treating facility makes reference to the procedure as being experimental, investigation educational, for a research study, or posing an uncertain outcome or having an unusual risk.

5) The procedure is the subject of an on-going phase, I, II or III clinical trial or an on-going review by an Institutional Review Board.

STATE: New Mexico
DATE REC'D: 2/26/94
DATE APPVD: 4/19/94
DATE EFF: 4/19/94
HCFA 179

TN No. 8214
Superseded
Approval Date 4/19/94 Effective Date 4/19/94
HCFA ID: 1047P/0016P
State/Territory: New Mexico

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

6) Local peer review of the procedure by the appropriate professional determined that the procedure falls outside accepted professional standards of health care.

To be reimbursed for services, facilities performing the procedures must be certified by the State's Licensing and Certification Bureau and/or by the Health Care financing Administration as state transplantation center.
Attachment 3.2-A
The following method is used to provide benefits under Part A and Part B of Title XVII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:
   1. [ ] Individuals receiving SSI under Title XVI or State supplementation, who are categorically needy under the State's approved Title XIX plan.

   Persons receiving benefits under Title II of the Act or under the Railroad Retirement System are included:
   Yes [ ]  No [ ]

   [ ] Individuals receiving SSI under Title XVI, State supplementation, or a money payment under the State's approved Title IV-a plan, who are categorically needy under the State's approved Title XIX plan.

   Persons receiving benefits under Title II of the Act or under the Railroad Retirement System are included:
   Yes [ ]  No [ ]

   [ X ] All individuals eligible under the State's approved Title XIX plan.

   [ X ] Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium billing arrangement with HCFA. This arrangement covers the following groups:

   Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and B deductible and co-insurance costs. Such payments are made in behalf of the following groups:
   1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.
   2. All categorically - eligible Medicaid recipients.
   3.
Attachment 4.11-A
State Plan Under Title XIX of the Social Security Act
State of New Mexico
Standards for Institutions

A. The standards for institutions are in accordance with 42 CFR 401.610, formerly designated as 42 CFR 450.100; Public Law 92-223 for Intermediate Care Facilities; and Public Law 92-603 as it relates to care in Skilled Nursing Facilities and Intermediate Care Facilities. Standards for hospitals applicable under Part A of Title XVIII also apply to participating hospitals in the New Mexico Title XIX Program.

B. Recipients Personal Funds Accounts - As a condition for participation in the New Mexico Medical Assistance Program, each SNF or ICF will establish and maintain an acceptable system of accounting for a recipient's personal funds when a Title XIX-Medicaid recipient requests that his personal funds be cared for by the facility. Requests for the facility to care or not care for Title XIX-Medicaid recipients' personal funds will be in writing and secured by ISD Form 386. This form must be retained in the recipient's file.

The Title XIX-Medicaid recipient's personal fund consists of a monthly maintenance allowance established by Department policy. Any income in excess of this allowance is computed according to policy applied, when applicable, towards the cost of the recipient's medical care at the facility. This amount is reported as a Medical Care Credit to the facility on ISD 383 by the County ISD Office whenever applicable.

It is very important that all facilities have definite and clear-cut procedures on the handling of Title XIX-Medicaid recipients' funds. These procedures must not allow the facility to commingle Title XIX-Medicaid recipients' funds with facility funds and may be developed along the following guidelines.

1) Fund Custodians:
   a. Designate a full-time employee and an alternate as fund custodians for handling all Title XIX-Medicaid recipients' monies on a day-to-day basis.
   b. Designate an individual other than the persons having day-to-day responsibility to reconcile balances of the individual Title XIX Medicaid recipients' accounts with the collective bank account, to periodically audit and reconcile the petty cash fund, and to authorize checks for the withdrawal of funds from the bank account.

2) Bank Accounts:
   a. Establish a collective bank account for the deposit of all Title XIX-Medicaid recipients' private monies.
b. Recipients personal funds will be held separately and not be commingled with facility funds.

c. The account may be a regular checking account or an interest-bearing savings account. Unless the bank account accumulates to a substantial amount, a non-interest bearing account would be more advantageous.

3) **Pro Rata Distribution of Interest:**

   a. If an interest-bearing bank account is established, all interest earned must be pro-rated to each Title XIX-Medicaid recipient with funds in the account, and the amount entered in his individual account record.

   b. For this pro rata distribution, use the balance recorded on the individual ledger account sheet on the last day of the month that interest was earned.

4) **Individual Recipient's Account:**

   a. Establish an account for each Title XIX-Medicaid recipient to record all transactions. It is suggested that this be maintained in a type of general ledger book commonly used for bookkeeping purposes although a card file or a looseleaf binder may be used.

   b. For money received: Record the source, amount, and date of all monies received. Issue a receipt to the Title XIX-Medicaid recipient or his authorized representative for funds deposited, and retain a copy for the record. The copy could be maintained in a card file.

   c. For money expended: Record the purpose, amount, and date of all disbursements to or on behalf of the Title XIX-Medicaid recipient. All monies spent either on behalf of the recipient or withdrawn by the recipient or his representatives should be supported by a receipt or signature on the individual ledger sheet.

   d. If the individual recipient account reaches $1,400.00 contact the local County ISD Office for instructions.

5) **Reconciliation:**

   a. Balances of the individual accounts, the collective bank account, and the petty cash fund should be reconciled on at least a monthly basis.

   b. Provide the Title XIX-Medicaid recipient or his authorized representative with an accounting of his funds on at least a quarterly basis. (A copy of the individual account record would be the most expeditious method of providing statements.)
6) Petty Cash Fund:

a. A cash fund specifically for this use should be maintained in the facility to accommodate the small cash requirements of the recipients. Generally five dollars or less per individual recipient should be sufficient. However, the amount of money should be determined by the number of recipients using the service and the frequency and availability of bank service.

b. Establish a Petty Cash Fund ledger to record all actions regarding these monies.

c. To establish the fund: (a) Write a check against the collective bank account to the custodian. (b) Cash the check and deposit in locked cash box.

d. To use: (a) Give the recipient or his authorized representative cash when small amounts of spending money are requested. (b) Enter on the individual ledger record amount disbursed. (c) Have recipient or representative sign on account record when receiving money or issue a receipt with a duplicate.

e. To replenish: (a) Count the money left in the cash box. (b) Total all disbursements since the last replenishment. (The total of the disbursements plus cash on hand should equal the beginning amount). (c) Write a check against the collective bank account for the amount of the disbursement.

f. To reconcile: At least monthly (a) Count money on hand; (b) total cash disbursed either from receipts or individual account records; (c) cash on hand plus total disbursements equals petty cash total.

7) Termination of the Recipient Account:

a. Enter date of termination of account, and state reason for termination.

b. Write a check against the collective bank account for the balance shown on the individual account record.

c. Have recipient or his authorized representative sign the individual recipient account record as receipt of payment.

d. If termination of the account is caused by death of a recipient, notify the local County ISD Office, so that timely action may be taken to terminate assistance.

e. If the deceased recipient had no relatives, applicable state laws will prevail. The nursing home should consult with its attorney for proper handling of the account.
8) **Retention of Records:**

All account records should be retained for at least 3 years or in case of an audit, until audit is completed.

9) **Non-Acceptable Uses of Recipients' Personal Funds:**

a. Payment for services or supplies covered under the Title XIX Medicaid program.

b. Differences in what providers bill and what Title XIX-Medicaid pays.

c. Payment for services or supplies routinely provided by the facility such as linens and nightgowns.

10) **State Monitoring of Recipients' Personal Funds:**

a. All files and records involving recipients' personal funds will be made available for inspection of authorized state personnel or federal auditors.

b. HED Licensing and Certification Bureau will verify that a facility has a system of accounting for recipients' personal funds that includes the components described above. Failure to provide an acceptable accounting system will constitute a deficiency that must be corrected.

c. DHS Audit and Audit Agent will accomplish a complete and thorough audit of recipients personal funds accounts on an over-a-year basis.
PREAMBLE: This agreement is entered into between the Department of Human Services, hereinafter DHS and the Health and Environment Department, hereinafter HED, both parties being Departments in the Executive Branch of the government of the State of New Mexico, for the purpose of defining the coordination of certain functions in connection with provision of the services established under Title XIX (the Medicaid Program) of the Social Security Act.

WHEREAS DHS is the Single State Agency with authority to administer or supervise the administration of the State Plan under Title XIX of the Social Security Act, and

WHEREAS HED is the State authority responsible for establishing and maintaining standards for the operation of certain private or public health care facilities and agencies not including Christian Science sanitoria operated or listed and certified by the First Church of Christ Scientist, Boston, Massachusetts, hereinafter health care facilities, at which persons eligible for medical assistance under the Title XIX State Plan may receive care and services, and

WHEREAS State federal regulation, 42 C.F.R. 450.100(c) (formerly designated prior to September 1, 1977 as 45 C.F.R. 250.100 (c)), requires written agreement between DHS and HED.

NOW, THEREFORE, DHS and HED enter into the following agreement:

A. CERTIFICATION OF FACILITIES.

1. HED shall determine whether health care facilities meet the certification requirements for participation as providers of health care services in the Title XIX Program as set forth in federal regulations.

2. The HED staff making such determinations shall be in the Health Services Division and shall be the same staff responsible for such determinations for institutions or agencies participating under Title XVIII of the Social Security Act.

3. The federal certification standards, and such forms, methods and procedures as may be designated by the Administrator of the Health Care Financing Administration, shall be used in determining health care provider eligibility and certification as Title XIX health care providers.

4. Certification survey documents made by HED staff must:

(a) Identify the health care provider surveyed,

(b) Indicate whether each requirement for which survey is made is, or is not, satisfied; and

(c) Include documentation of all deficiencies.

5. HED shall provide to the Medical Assistance Bureau of DHS, following each certification survey, resurvey or special on-site inspection of a health care facility applying for participation or participating in the Title XIX program:

(a) Written notice as to the certification or recertification status of each such facility, including a report of all deficiencies found;
(d) Recommendation concerning the appropriate length of any proposed
time limited agreement; and

(e) Prompt and complete information when applications are received
for participation, licensure or changes which would affect current
accuracy of such information as to ownership, capacity, and category
or which affect any provision of an agreement on the term of provider
participation.

6. HED shall maintain on file all information and reports used in deter-
mining whether federal certification requirements for health care
facilities participating in Title XIX as providers of health care
services are being met. HED shall provide access to such files by
the Department of Health, Education and Welfare and to DHS as may be
necessary to meet other requirements under the Title XIX State Plan
and for purposes consistent with DHS's effective administration of the
Title XIX Program.

B. DETERMINATION OF COMPLIANCE WITH CIVIL RIGHTS ACT OF 1964. HED shall:

1. Perform federally required on-site certification surveys of partici-
   pating health care facilities and shall document provider compliance
   with civil rights requirements by completion of a civil rights
   compliance report and shall advise DHS at the time of each certi-
   fication or recertification of such compliance; and

2. Provide DHS a special report on any facility determined not to be in
   compliance with civil rights requirements, setting forth the basis
   for such determination.

C. PERSONNEL QUALIFICATIONS. HED shall:

1. Provide assurance that personnel performing on-site certification
   survey or inspection functions hereunder are appropriately classified
   under the New Mexico State Personnel system; and

2. Provide for consultation with architects or the New Mexico State Fire
   Marshall, as required, for technical interpretation of facility com-
   In addition to providing professional consultation services to DHS
   upon request,

3. To the extent feasible within HED and DHS staffing capability and
   agency workload HED shall endeavor to work with the DHS medical review
   team to resolve particular provider problems mutually recognized as
   hazards to the health and safety of recipients served.

D. PROFESSIONAL CONSULTATION SERVICES. HED shall:

Provide consultation to facilities unable to qualify for participation under
the Title XIX regulations in those instances in which deficiencies:

1. Are not susceptible to corrective action as may be determined as an
   integral part of the certification survey process; and

2. Are of a nature within the expertise of the disciplines represented by
   HED personnel and consultants available to HED.

E. FISCAL ADMINISTRATION. HED shall:
3. Identify by appropriate accounting code or other designation, vouchers submitted or other documents representing charges for transportation, meals, lodging and consultant fees attributable to the functions performed hereunder.

4. Provide for allocation of costs attributable to Title XIX in accordance with federal and state regulations for items 2 and 3 above in the event of required attendance at any certification surveyor training course by HED personnel.

5. Provide sufficient state matching funds necessary to secure full federal financial participation in the Title XIX portion of the survey and certification activities covered by this agreement.

F. DELEGATION OF AUTHORITY

DHS specifically delegates to HED its authority for certification surveys and compliance in accordance with federal and state regulations as follows:

1. The performance of certification surveys, re-surveys, revisits and maintenance of appropriate documentation files;

2. The determination of whether and the issuance of permissible waivers;

3. The determination that the health care facilities are in conformance with utilization review procedures in those instances where utilization review has been assumed by P.S.R.O.

4. The determination whether participating health care facilities staffing are or are not in compliance with requirements.

5. The determination of whether any deficiencies or waiverable conditions represent a hazard to the health and safety of the patients served by the facility.

G. REGULATIONS AND INTERPRETATIONS. DHS shall:

1. Provide HED with information concerning proposed and final changes in Title XIX regulations, policies and interpretations, as such information is pertinent to the performance of services rendered by HED hereunder.

2. Furnish HED with copies of the on-site review reports developed by the DHS Medical Review - Independent Professional Review teams.

3. Negotiate required written agreements with recommended certified facilities.

H. ADMINISTRATIVE DISCRETION.

1. DHS retains its sole responsibility for exercising administrative discretion in the administration and supervision of the Title XIX State Plan. Nothing in this agreement shall be construed as delegating to HED any of DHS's responsibility for exercising administrative discretion in the administration or supervision of the Title XIX State Plan, including the issuance of policies, rules and regulations or program matters.

2. In the performance of its functions under this agreement, HED shall not have any responsibility to review, change or disapprove any administrative decision of DHS, or otherwise substitute its judgment
I.  INDEMNIFICATION AND HOLD HARMLESS

Each party shall be solely responsible for fiscal or other sanctions occasioned by its own violation or alleged violation of federal requirements in the performance of this agreement and shall indemnify and hold harmless the other party therefrom.

APPROVED by DHHEW/HGTA/MS
DATE: MAR 30, 1979
TRANSMITTAL NO: 79-5

GEORGE S. GOLDSTEIN, PH.D.
Secretary
Department of Health & Environment

Date 7/10/78

Fernando E. C. De Baca
Secretary
Department of Human Services

Date 7/10/78

Approved for Legal Content
Department of Health and Environment

Date

Juliet C. S. Henderson
Approved for Legal Content
Department of Human Services

Date 7/13/78
Attachment 4.14-A
From 1974 until January 31, 1979, The New Mexico Professional Standards Review Organization (NMPSRO) performed long term care admission and concurrent review for the NM Medicaid Program under a memorandum of understanding with the Department. The State Agency retained the responsibility for the Medical Review Team and Independent Professional Review on-site activities.

On February 1, 1979, the NMPSRO was nominated by HHS as a conditional PSRO with binding review authority in the area of long term care under Title XI of the Social Security Act. Under this authority the NMPSRO performed all admission review, concurrent review, and on-site quality of care for SNFs, ICFs, and ICF/MRs.

As a result of the loss of Federal funding for binding review of Long Term Care under Title XI on September 30, 1981, the responsibility for assuring that UR/UC review is carried out in Long Term Care facilities was shifted to the Human Services Department.

The Department has elected to contract with the NMPSRO to carry out the Long Term Care Utilization review function. The NMPSRO will carry out this function according to the New Mexico Plan for Long Term Care Review which is set forth in Part I.B. of Attachment 3.1-C of this State Plan. Please see that attachment for specific details relating to the Utilization Review Plan for Intermediate Care Facilities. Section A.2 of Article II of the current Human Services Department - Professional Standards Review Organization contract under which this responsibility is delegated to the PSRO is here attached as Supplement 1 to Attachment 4.14-A.
The NMPSRO will perform pre-admission, admission, continued stay and on-site quality of care review for all licensed long term care facilities in the State during the contract year. The NMPSRO will perform pre-admission, admission and continued stay review and on-site quality of care review for all acute care hospitals with swing beds. In carrying out LTC Review the NMPSRO shall utilize NMPSRO Physician Advisors, a Nurse Review Coordinator, Nurse On-Site Evaluators and when indicated seek the advice and counsel of the Director of Professional Affairs and appropriate authorities in the Medical Assistance Bureau. The LTC Review shall be carried out in accordance with the Human Services Department Long Term Care Review Plan.
Attachment 4.16-A
State Plan for Medical Assistance
under Title XIX, SSA
New Mexico

Attachment 4.16-A

Cooperative Arrangements with State Health
and State Vocational Rehabilitation Agencies
and with Title V Grantees

The New Mexico Medical Assistance Bureau has current agreements with the
Crippled Children's Services Program, a section of the New Mexico Department
of Health and Environment; with the Division of Vocational Rehabilitation,
a section of the New Mexico Department of Education; and with the SSI Disabled
Children's Program.

The agreements currently in force are included with this attachment as Sup-
plements 1, 2 and 3.
MEMORANDUM OF AGREEMENT

Between

STATE HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

And

STATE DEPARTMENT OF EDUCATION
VOCATIONAL REHABILITATION DIVISION

The Rehabilitation Act of 1973, as amended, and implementing regulations require State vocational rehabilitation agencies to assist eligible handicapped individuals to enter, return to, or remain in gainful employment, through the provision of various services. Many of these handicapped individuals are also eligible for Medicaid. Therefore, it is appropriate and necessary to define the cooperative roles of the Division of Vocational Rehabilitation and the State agency responsible for administration of the Medicaid Program in assuring the provision of services for these individuals.

This agreement is entered into between the Income Support Division of Human Services Department, hereinafter ISD, and the Division of Vocational Rehabilitation of the Department of Education, hereinafter DVR, for the purpose of defining the coordination of functions in connection with provision of the services available under both programs.

NOW, THEREFORE, ISD AND DVR enter into the following agreement:

A. PAYMENT FOR MEDICAL SERVICES

1. For any medical services covered under the Title XIX (Medicaid Program), and delivered in accordance with regulations of the Medicaid Program, ISD will assume first and primary responsibility for payment. However, benefit payments from other sources such as hospitals or health insurance, or other third parties which are under obligation to provide such benefits for Medicaid eligibles, must be used before drawing on Medicaid funds.

2. DVR operates the New Mexico Rehabilitation Center at Roswell, its northern New Mexico Rehabilitation Center at Las Vegas, and the Psychological Services Unit in Albuquerque, all of which receive payment for medical services under separate provider agreements. Those payments are accepted as full payment for services rendered and the proceeds used to meet operating expenses.

3. ISD agrees to consider extending provider status to DVR for other services as it is demonstrated that DVR meets program requirements for participation in additional areas, and as it is demonstrated that DVR can assist in maximizing the delivery of comprehensive health care services to Medicaid eligibles.

B. EQUAL SERVICES

The DVR agrees to consider any Medicaid recipient for all possible services available to any handicapped individual under any other program which might meet in whole or in part the cost of certain services. The fact that an individual is eligible for Medicaid should not restrict that individual's eligibility to receive other services available.

ISD will reciprocate by considering any DVR recipient for all possible services available under the programs administered by ISD field offices. An individual's receipt of DVR services should not restrict that individual's eligibility to receive other available services.

C. COMMUNICATIONS BETWEEN ISD AND DVR

1. County ISD offices will refer all potential rehabilitation cases to the local DVR office if it appears that the individual may benefit from such services. All AFDC recipients determined to be incapacitated for purposes of participation in the WIN Program will be referred to DVR. In return, the local DVR offices will refer all individuals determined to be in need of financial, food, or medical assistance to the county ISD office if it appears that the individual may be eligible under the programs administered by ISD.
Arrangements for transmittal of referrals on a regular and frequent basis will be worked out between the county offices, with consideration given to expediency and maximum efficiency. Referrals made by ISD and DVR staff will contain:

a) adequate identifying information to allow the receiving office to contact the individual referred; and,

b) medical information as available and deemed appropriate. When such information is shared, the recipient's permission must be obtained for its release.

The receiving office will acknowledge all referrals and, when appropriate, outline services provided.

2. County offices for ISD and DVR will establish a liaison person for communications between the two agencies. Whenever possible, a backup person will be designated to serve this function in the liaison person's absence. The designation of a liaison person will not restrict communications between individual DVR and ISD workers who are mutually involved in providing services to a particular Medicaid recipient. Rather, the liaison person will function so as to maximize communications between the two agencies on both the individual case level as well as the office level. The ISD liaison person on the state level will be the supervisor of Program Development Unit of the Medical Assistance Bureau. The DVR liaison person on the state level will be the Assistant Chief of DVR Field Services.

D. TRAINING FOR DVR AND ISD STAFF

ISD agrees to develop training materials and provide training to appropriate DVR staff to assure they are knowledgeable about current Medical Assistance Program coverage and procedures. DVR agrees to develop training material and provide training to appropriate ISD staff to assure they are knowledgeable about services available through DVR and which ISD recipients are appropriate referrals for DVR services. Both DVR and ISD agree to complete the above training within 12 months of the effective date of this agreement.

E. EXEMPT DVR PAYMENTS

The DVR makes payments to individuals in training to help them meet the additional costs of training. These payments are made to meet needs not met by the financial assistance grant and are disregarded in their entirety in computation of financial assistance grants from ISD. In determination of eligibility for the Food Stamp Program, ISD shall consider any training allowance specifically intended for payment of tuition and mandatory fees to educational institutions in accordance with applicable food stamp guidelines.

F. EXPEDITING PRIOR APPROVALS FOR MEDICAID SERVICES

The Medical Assistance Bureau of ISD will assist DVR staff in expediting the prior approval process for medical services in instances in which it is demonstrated that an unnecessary delay has occurred in normal prior approval procedures. ISD will provide training to DVR staff on how to assist providers in obtaining prior approvals for medical services.

G. CONFIDENTIALITY

Pursuant to 42 CFR 431.300 et seq. and 42 CFR 51a.112, all information as to personal facts and circumstances obtained, and all records kept by either of the parties hereto shall constitute privileged communication, shall be held confidential, and shall not be divulged without the client's consent except as may be necessary to provide needed services to that client.
H. PERIOD OF AGREEMENT, RENEWAL, REVIEW AND AMENDMENT

This Agreement shall become effective on May 1, 1981, and shall terminate June 30, 1982. This agreement will be reviewed and renegotiated on an annual basis. Periodic reviews and revisions in response to changes in State and/or Federal statutes may be initiated by either party to this agreement, with written notification of proposed amendments being made to the other party. Discussion of the proposed amendments will be undertaken as appropriate to ensure that the function and goals of both parties are duly considered. All amendments must be agreed upon mutually by written consent prior to finalization and implementation.

This memorandum of agreement is the basis for relations and cooperation between ISO and DVR.

In Witness Whereof, the parties hereto have set their hands.

[Signatures]

DATE

[Signatures]

DATE

[Signatures]

DATE

[Signatures]

DATE

[Signatures]
Supplement 2 to
Attachment 4.16-A
This Agreement is entered into by and between the Department of Human Services, hereinafter referred to as "DHS", and the Health and Environment Department, hereinafter referred to as "HED".

ARTICLE 1: PERIOD OF AGREEMENT

This Agreement shall become effective on July 1, 1979 or upon approval of the Department of Finance and Administration whichever is later, and shall terminate one (1) year after the last required signature has been obtained so long as notice of intent to terminate is received by the other agreeing party within sixty (60) days of said termination date; otherwise this Agreement shall be automatically renewed for successive State Fiscal Years.

ARTICLE 2: DEFINITIONS

The words quoted below will have the following meanings unless the context clearly requires otherwise:

A. Medicaid means the program of medical assistance under Title XIX of the Social Security Act administered by DHS through its Income Support Division (ISD).

B. Crippled Children's Service (CCS) means the program of medical assistance and Social Services under Title V of the Social Security Act administered by HED through its Health Services Division (HSD).

C. Aid to Families with Dependent Children (AFDC) means the program of financial assistance under Title IV-A of the Social Security Act administered by DHS through its ISD.

D. Supplemental Security Income (SSI) means the program of financial assistance under Title XVI of the Social Security Act administered by the Social Security Administration.

E. Supplemental Security Income-Disabled Children's Program (SSI-DCP) means the program of counseling, developing individual service plans and referring of disabled children under age 16 and providing medical, social, developmental, and rehabilitative services for disabled children under age 7 and those who have never attended public school authorized by Public Law 95-566, Section 1615 (b) administered by HED through its HSD.

F. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) means a program of medical assistance in the form of early and periodic screening, diagnosis, and treatment under Title XIX of the Social Security Act administered by DHS through its ISD.

ARTICLE 3: STATUS OF CHILDREN

The programs set out above affect the following groups of children:

A. All children who are under the age of 21 and who receive AFDC or SSI and who reside in New Mexico are eligible for Medicaid and EPSDT.

B. Some children who are under the age of 21 and who reside in New Mexico are eligible for CCS.

C. A small number of children who are under the age of 21 and who reside in New Mexico are eligible for both Medicaid and CCS.

D. A small number of children who are under the age of 16 and who reside in New Mexico are eligible for SSI-DCP.

ARTICLE 4: PURPOSE

One purpose of this Agreement is to improve coordination in the providing of health care services to children eligible both for Medicaid and CCS with efforts specifically directed to improving program management and evaluation in the EPSDT program.
A second purpose of Project C is to provide diagnostic and treatment services in clinics conducted by the CCS program in three medical specialty areas of orthopedics, cardiology, cleft-palate, plastic surgery and neurology to children under the age of 12 who are eligible for AFDC or SSI and who reside in New Mexico.

ARTICLE 5: SCOPE OF SERVICES AND STAFFING PLAN

HED will provide the professional services as set for in Scope of Services and Contractual Services and Staffing Plan. EXHIBIT A, which is hereby incorporated and made a part of this Agreement.

ARTICLE 6: REIMBURSEMENT

HED will submit claims, as rates agreed upon in Exhibit A for services provided to the Fiscal Agent of the Medicaid (Title XIX) program. DHS will assure that the Fiscal Agent will process the claims in a timely manner and submit payments to HED to be credited to the account of CCS.

ARTICLE 7: MEDICAID (TITLE XIX) RESOURCES.

DHS will be the primary state resource for payment for care of Medicaid eligible children seen and/or referred by CSS specialty clinics for all services designated as covered services under Medicaid (Title XIX). However, payment benefits from other sources of hospital or health insurance, or third parties, which are under obligation to provide such benefits for Medicaid eligible children, must be used before drawing on Medicaid funds.

ARTICLE 8: COORDINATION OF EPSDT SERVICES

Within HED an SSI-DCP Unit has been set up to provide for counseling, development of individual service plans and referral of disabled children under age 15 and to provide medical, social, developmental, and rehabilitative services for disabled children under age 7 and those who never attended public school. This unit will assume responsibility for case management to assure that necessary EPSDT services are provided on a continuing basis to children eligible for this program which is operative in selected project areas in New Mexico.

DHS, through its EPSDT program, will retain responsibility for case management of Medical eligible children receiving specialty clinic services.

ARTICLE 9: REFERRALS

HED will refer handicapped children receiving assistance or services under Title V to the DHS field offices when it appears that the child and his family may be eligible for assistance under Medicaid and would benefit from the receipt of such assistance.

DHS will refer any Medicaid (Title XIX) eligible child to the HED field offices when it appears that the child requires or may benefit from specialty clinic services and in those instances where the child requires or may benefit from Title V covered services not covered under Title XIX. Referrals may be made by DHS field office staff or EPSDT staff as appropriate.

HED will refer Medicaid eligible children to the local DHS offices to obtain transportation money to receive Title XIX covered services when no other source of transportation is available.

In those instances where a Medicaid eligible child is not in possession of a current Medicaid Identification Card, HED will not assume continuation of eligibility under Medicaid and will refer the child's parent to the DHS field office.

In those instances where HED does not know the Medicaid eligibility status of a child, DHS field office staff will ascertain the status and advise HED.

ARTICLE 10: JOINT EVALUATION

Program representatives from DHS and HED shall periodically jointly evaluate the program and discuss any problems that might arise between the CCS program, SSI-DCP, and the New Mexico Medicaid Assistance Program.
Appropriate representatives from DHS and HED will be the supervisors of Program Development of ISD's Medical Assistance Bureau and the managers of HED's CCD program and the manager of HSD's IIS-DCP.

Meetings will be scheduled at least every six (6) months.

ARTICLE CONFIDENTIALLY:

Pursuant to 42 CFR 431.300 et seq. and 42 CFR 51a.111, all information as to personal facts and circumstances obtained, and all records kept by either of the parties hereto shall constitute privileged communication, shall be held confidential, and shall not be divulged without the client's consent except as may be necessary to provide needed services to the client. HSD's Regulation Governing Public Access to Information shall also apply.

ARTICLE 12: Amendments

This Agreement cannot be altered, changed, or amended by instrument in writing executed by the parties hereto.

ARTICLE 13: Scope of Agreement

This Agreement incorporates all the Agreements, covenants, and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, Agreements and understandings have been merged into this written agreement. No prior Agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

DEPARTMENT OF HUMAN SERVICES

[Signature] [Date]

Lawrence S. Ingram, Secretary

[Signature] [Date]

George S. Goldstein, Ph.D, Secretary

[Signature] [Date]

Julie Southerland,
Assistant Attorney General

Chief Attorney, DHS

[Signature] [Date]

State Contracts Officer
Department of Finance and Administration

HEALTH AND ENVIRONMENT DEPARTMENT

[Signature] [Date]

Geoffrey Sloan
Assistant Attorney General

[Signature] [Date]

STATE
DATE REC'D 9/12/79
DATE APPV'D 9/14/80
PCO-11
EXHIBIT A

SCOPE OF SERVICES AND CONTRACTUAL SERVICES AND STAFFING PLAN

HSD will provide the following services under the Authority of this Agreement:

1) Provide services at CCG Specialty Clinics to children under the age of 11, who reside in New Mexico, and who are eligible for AFDC or SSI.

Services provided at CCG Specialty Clinics are:

A) Orthopedics:
   Medical services for diagnosis and treatment of orthopedic conditions.

B) Cardiology:
   Medical services for diagnosis and treatment of cardiac conditions.

C) Cleft Palate:
   Medical and dental services for diagnosis and treatment of Cleft Palate and Cleft Lip conditions.

D) Plastic Surgery:
   Medical services for diagnosis and treatment of conditions requiring plastic surgery.

E) Neurology:
   Medical Services for diagnosis and treatment of neurologic conditions.

2) Submit all claims for diagnosis and treatment promptly as each clinic is completed to the Title XXIX Fiscal Agent for reimbursement, at the following rates:

   Medical Services, Orthopedic: $25.00
   Medical Services, Cardiac: $37.00
   Medical Services, Cleft Palate: $18.00
   Medical Services, Plastic Surgery: $25.00
   Medical Services, Neurologic: $70.00

The name of the child and the identification number issued by DHS will be entered on the claim form.

Co-payment fee(s) will be deducted from the above quoted rates except in EPSDT related services.

The reimbursement rate for each specialty area is a capitation fee and is to be the local reimbursement for all medical services provided per visit to each specialty clinic per child eligible for AFDC or SSI. HSD will use the following provider numbers and procedure codes in submitting claims:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic</td>
<td>46789</td>
</tr>
<tr>
<td>Cardiac</td>
<td>46988</td>
</tr>
<tr>
<td>Cleft Palate</td>
<td>48157</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>48405</td>
</tr>
<tr>
<td>Neurologic</td>
<td>46441</td>
</tr>
</tbody>
</table>

3) Submit to DHS the name and identification number of each child diagnosed and treated and program reports as requested and available.

4) Coordinate with DHS the effort to meet requirements, deadlines, and reporting data required by involved Federal Agencies; and cooperate in the development of methods of exchange of information between DHS and HSD.
Contractual Services and Staffing Plan

HED's Staffing Plan for services under the authority of this Agreement is as follows:

Orthopedic:
- 5 Orthopedic Physicians
- 1 Brace Shop Manager
- 1 Social Worker 1

Cardiac:
- 1 Pediatric Cardiologist (Physician)
- 1 Administrative Assistant (Clinic Coordinator)
- 1 Social Worker 2

Cleft Palate:
- 1 Pedodontist
- 1 Orthodontist
- 1 Plastic Surgeon
- 1 Ear, Nose, Throat Specialist (Physician)
- 1 Speech and Hearing Therapist

Plastic Surgery:
- 1 Plastic Surgeon
- 1 Speech and Hearing Therapist

Neurology:
- 1 Neurologist
- 1 Social Worker 2

(5)
Supplement 3 to
Attachment 4.16-A
AGREEMENT

This Agreement is entered into by and between the Department of Human Services hereinafter referred to as "DHS" and the Health and Environment Department, hereinafter referred to as "HED".

RECITALS:

THAT, 1615b of the Social Security Act provides for the referral by the Social Security Administration (SSA) of blind or disabled Supplemental Security Income (SSI) recipients who are under age 16 to a designated State agency, under a State plan, and

THAT, pursuant to the applicable federal regulations 42 CFR 513 and the approved State plan, the Health Services Division of HED is the designated State agency, and

THAT, a unit of the Health Services Division the Supplemental Security Income-Disabled Children's Program (SSI-DCP) is to provide for counseling, development of individual service plans and referral of disabled children under age 16, and to provide medical, social, developmental, and rehabilitative services for disabled children under seven years and those who have never attended public school; and

THAT, the Income Support Division (ISD) of the Department of Human Services (DHS) administers Title XIX Medicaid Services and Medicaid is the primary source of medical care for SSI-DCP children, except in those instances when another party is determined liable for payment of care;

NOW, THEREFORE, DHS and HED in consideration of their mutual undertaking as hereinafter set forth, do now agree as follows:

ARTICLE 1 PERIOD OF AGREEMENT

This Agreement shall become effective October 1, 1979, and shall terminate one (1) year after the last required signature has been obtained so long as notice of intent to terminate is received by the other agreeing party within sixty (60) days of said termination date; otherwise this agreement shall be automatically renewed for successive Federal Fiscal Years.

ARTICLE 2 PURPOSE

One purpose of this agreement is to assure that the Title XIX program remain the primary resource for purchase of medical care for SSI-DCP and all services designated in Section 300-319 of the Income Support Division Medical Assistance Manual be made available.

SSI-DCP agrees to adhere to all administrative procedures designated in Volume I of the ISD Manual and to use the designated appeals mechanism, Section 272 and 306, to appeal eligibility and patient coverage decisions whenever appropriate.

SSI-DCP agrees to refer SSI-DCP clients whose specific service needs cannot be covered by ISD to the Crippled Children's Services Program.

ARTICLE 3 REFERRALS

The SSI-DCP clients will be referred to the local ISD field office to obtain transportation money to enable provision of necessary services. In the case that the SSI-DCP client does not receive a monthly Medicaid identification card, parents of the client should inquire at the ISD field office.

ARTICLE 4 EXCHANGE OF REPORTS

The ISD will provide the SSI-DCP Administrator with the following reports:

1. The SDX Medical Eligible Registers printout monthly.
2. Utilization on a six month basis.
The SSI-DPC, upon request from the ISD will provide a list of SSI-DPC clients on a quarterly basis. The list will include the following information:

Name of child
Birthdate of child
Social Security number of child
Date of initiation of services by the DCP

ARTICLE 5 FINANCING SERVICES

No budget or fund transfers are required under this agreement. There will be no charges for transfer of materials or information between ISD and SSI-DCP, and each party shall bear its own costs.

ARTICLE 6 MECHANISM FOR ENSURING CONTINUING AND CLOSE COOPERATION

The ISD and SSI-DPC will each designate one staff member who will hold primary responsibility for all liaison activities between the two parties.

ARTICLE 7 LEVELS OF SERVICE

The SSI will assure that current levels of service to eligible SSI-DPC clients will not decrease. If the scope of services or other coverage is reduced in the overall New Mexico Title XIX program, these program changes would also apply to SSI-DCP clients.

ARTICLE 8 PERIODIC REVIEW OF AGREEMENT

This agreement will be reviewed on an annual basis.

ARTICLE 9 CONFIDENTIALITY

Pursuant to 42 CFR 431.200 et seq. and 42 CFR 51a.112, all information as to personal facts and circumstances obtained, and all records kept by either of the parties hereto shall constitute privileged communication, shall be held confidential, and shall not be divulged without the client's consent except as may be necessary to provide needed services to that client.

ARTICLE 10 SCOPE OF AGREEMENT

This Agreement incorporates all the Agreements, convenants, and understandings between the parties hereto concerning the subject matter hereof, and all such convenants, Agreements and understandings have been merged into this written agreement. No prior Agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

DEPARTMENT OF HUMAN SERVICES

Laurence S. Ingram
Secretary

DATE: 12/7/81

HEALTH AND ENVIRONMENT DEPARTMENT

George S. Goldstein, M.D.

DATE: 12/7/81

Florence Ruth Joy Brown
Chief Attorney, HSD
Citation(s)
42 CFR 433.36 (c)
1902(a) (18) and
1917(a) and (b) of
The Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917 (a) of the Act and regulations at 42 CFR 433.36 (c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

The State imposes liens on real property on account of benefits incorrectly paid.

The State imposes TEFRA liens 1917 (a) (l) (B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State Plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

The State imposes liens on both real and personal property of an individual after the individual's death.

STATE New Mexico
DATE REC'D 5-17-10
DATE APPVD 8-11-10
DATE EFF 4-1-10
HCFA 179 10-06

TN No.: 10-06
Supersedes
TN No.: 83-04

Approval Date: 8-11-10
Effective Date: 4-1-10

SUPERSEDES: TN- 83-04
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (b)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual’s estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) The State determines “permanent institutional status” of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917 (a) (1) (B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual’s estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:

No other recovery

STATE New Mexico
DATE REC'D 5-17-10
DATE APPV'D 8-11-10
DATE EFF 4-1-10
HCFA 179 10-06

TN No.: 10-06
Supersedes TN No.: 63-04
Approval Date: 8-11-10
Effective Date: 4-1-10

SUPERSEDES: TN- 83-04
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.
The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

The State adjusts or recovers from the individual’s estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset and resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

The State does not adjust or recover from the individual’s estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

If an individual covered under a long-care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual’s estate for the amount of assets or resources disregarded.

<table>
<thead>
<tr>
<th>STATE</th>
<th>New Mexico</th>
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<tbody>
<tr>
<td>DATE REC'D</td>
<td>5-17-10</td>
</tr>
<tr>
<td>DATE APP'VD</td>
<td>8-11-10</td>
</tr>
<tr>
<td>DATE EFF</td>
<td>4-1-10</td>
</tr>
<tr>
<td>HCFA 179</td>
<td>10-06</td>
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</table>

TN No.: 10-06

SUPERSEDES: NONE - NEW PAGE

Effective Date: 4-1-10
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

(1) Adjustments or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustments or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

STATE: New Mexico
DATE REC'D: 5-17-10
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HCFA 179

TN No.: 10-06
Supersedes Approval Date: 8-11-10 Effective Date: 4-1-10

SUPERSEDES: NONE - NEW PAGE
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36 (d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangements).

- individual's home,

- equity interest in the home.

- Residing in the home for at least 1 or 2 years,

- on a continuous basis,

- discharge from the medical institution and return home, and

- lawfully residing.

STATE New Mexico
DATE REC'D. 5-1-10
DATE APPVD. 8-1-10
DATE EFF. 4-1-10
HCFA 179 10-06

TN No.: 10-06
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(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective.
   Defines cost-effective and includes methodology or thresholds used to determine cost effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

STATE New Mexico
DATE REC'D 5-17-10
DATE APP'ED 8-11-10
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TN No.: 10-06
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Approval Date: 8-11-10 Effective Date: 4-1-10
The following enrollment fee, premium or similar charge is imposed on the medically needy:

<table>
<thead>
<tr>
<th>Gross Family Income (per mo.)</th>
<th>Charge Family Size</th>
<th>Liability Period</th>
<th>Frequency of Charge</th>
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<tr>
<td></td>
<td>1 or 2</td>
<td>3 or 4</td>
<td>5 or more</td>
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<tr>
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<td>(2)</td>
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<td>(4)</td>
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<td>$150 or less</td>
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<td>151 - 200</td>
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<tr>
<td>More than $1000</td>
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Attachment 4.18-C
TRANSMITTAL NO: 85-10
DATE 1-30-86
APPROVED BY DH/SH/HCFA/DPC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

V. The following charges are imposed on the medically needy for services:

EXCESSIVE CHARGES
APPROVED DATE 3-6-86
RECEIVED DATE 10-1-85
HCFA ID: 003930-0051B
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

B. The method used to collect cost sharing charges for medically needy individuals:

☐ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Not Applicable

E. Cumulative maximums on charges:

☑ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

Not Applicable

APPROVED BY DHHS/HCFA/DPO
DATE: 1-30-86
TRANSMITTAL NO: 85-10

TN No. 85-10
Supersedes
TN No. New

Approval Date: 1-30-86
Effective Date: 10-1-85

HCFA ID: 0053C/0061E
Attachment 4.18-D
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

TN No. 91-17
Supersedes Approval Date JAN 15 1992 Effective Date OCT 1 1991
HCFA ID: 7986E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

C. State or local funds under other programs are used to pay for premiums:
   Yes [ ] No [ ]

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

TN No. 91-19
Supersedes Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. [Blank]

HCFA ID: 7986E
Attachment 4.18-E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:           NEW MEXICO

Optional Sliding Scale Premiums Imposed on Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

TN No. 91-19
Supersedes Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. New Page

HCFA ID: 7986E
C. State or local funds under other programs are used to pay for premiums:

☐ Yes  ☐ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.*

<table>
<thead>
<tr>
<th>TN No.</th>
<th>91-19</th>
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</thead>
<tbody>
<tr>
<td>Supersedes Approval Date</td>
<td>JAN 15 1992</td>
</tr>
<tr>
<td>TN No.</td>
<td>New Page</td>
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</tbody>
</table>

Effective Date OCT 1 1991

HCFA ID: 7986E
Attachment 4.19-A
The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.
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 plan. 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 plan.

I. GENERAL REIMBURSEMENT POLICY

The State of New Mexico Human Services Department (hereafter called the Department) will reimburse inpatient hospital services in the following manner:

A. Covered inpatient services provided to eligible recipients admitted to acute care hospitals and acute care inpatient units will be reimbursed at a prospectively set rate, determined by the methodology set forth in Section III of this plan, unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in subsections C through D below.

B. Covered inpatient services provided to eligible recipients admitted to acute care hospitals and acute care units within hospitals located in border areas (within 100 miles of the New Mexico border, Mexico excluded) will be reimbursed at a prospectively set rate as described in Section III.C.16 of this plan unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsection C through D below. Out of state hospitals (more than 100 miles from the New Mexico border, Mexico excluded) will be paid at the same rate as border hospitals 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 department 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 principle 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 Section II of this plan.
Pediatric, psychiatric, substance abuse, and rehabilitation cases treated in non-exempt general acute care hospitals or non-PPS-exempt units will be included in the PPS.

D. Indian Health Services hospitals will be reimbursed using a per diem rate established by the Federal Government.

E. New providers entering the Medicaid program will be reimbursed at the peer group median rate for the applicable peer group, until such time as rebasing occurs, unless the hospital meets the criteria for prospective payment exemption as described in subsection C and D above.

F. All hospitals which meet the criteria in Section IV.A of this plan 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 Department 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 age one in all hospitals. The outlier adjustment for these cases is described in Section III. F. of this plan.
II. 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:
   - The amount payable by the Department through its fiscal agent for services covered under the Medical Assistance Program and provided to Title XIX recipients; and
   - The manner of payment and the manner of settlement of overpayments and underpayments for inpatient services provided by hospitals for Title XIX 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 services rendered during the period October 9, 1991, through September 30, 1992, for which the inflation factor will be .5% for urban hospitals and 1.5% 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 individual who is an inpatient on his 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 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 Department shall review the supporting documentation and, if appropriate, grant an exemption from or modification of the target rate. The Department's determination on the merits of the appeal will be made within 180 days of receipt of the appeal request, although the State may make a determination to extend such period to a specified date as necessary.

III. PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS

Payment for all covered inpatient services rendered to Title XIX recipients admitted to acute care hospitals (other than those identified in Section I, subsections C through E) 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 Medicaid discharges will be determined by the Department 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 Medicaid discharge. Hospitals may not separately bill the patient or the Medicaid 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 a patient or upon completion of the transfer of the patient to another acute care hospital.

2. The prospective payment rate shall include all services provided to hospital inpatients, including:

   a. All items and non-physician services furnished directly or indirectly to hospital inpatients, including but not limited to 1) laboratory services; 2) pacemakers and other prosthetic devices including lenses and artificial limbs, knees and hips; 3) radiology services including computed tomography (CT) or magnetic resonance imaging (MRI) scans furnished to patients by a physician's office, other hospital or radiology
4) 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 patient is transferred from one hospital to another and is admitted as an inpatient to the second hospital.

b. Physician services furnished to individual patients.

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 Medicaid 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 Medicaid inpatient discharges will be classified using the Diagnostic Related Group (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 Version 6.0 of the Health Systems International 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 Section III.C.8 of this plan.
4. Initial relative weights are computed by calculation of the average Medicaid charge for each DRG category divided by the average charge for all DRGs.

5. Where the New Mexico Medicaid-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 whatever DRG Grouper version is currently in use by Medicare.

C. Computation of Hospital Prospective Payment Rates

1. Rebasing of Rates

Beginning October 1, 1997, the Department will discontinue the rebasing of rates every three years. Hospital rates in effect October 1, 1996 will be updated by the most current Market Basket Index (MBI) as determined by the Health Care Financing Administration (HCFA) for rates effective October 1, 1997. Thereafter, rates will be updated every October 1 using the MBI adjusted for any past forecast corrections.

2. Base Year Discharge and Cost Data

a. The State's fiscal agent will provide the Department with Title XIX discharges for the provider's last fiscal year which falls in the calendar year prior to Year 1.
Effective for services on or after October 1, 1997, the rates that were in effect as of October 1, 1996 will be updated.

The rates will be updated annually for inflation, effective October 1 each year, using the methodology in paragraph C.1.

Cost reporting periods ending in 1993 are used as the base year for the rates in effect as of October 1, 1996.

The October 1, 1996 base year cost per discharge was determined from Title XIX discharges from audited or desk reviewed cost reports for reporting periods ending in calendar year 1993 and inflated forward to the midpoint of the federal fiscal year 1997 using the update factors specified in III.C.8 — as described in paragraphs C.2.b. through C.13. Below.

The operating cost per discharge and the excludable cost per discharge as of October 1, 1996 will be combined into one base year cost per discharge. The combined base year cost per discharge will be updated for inflation using the update factor in paragraph C.1.

The excludable cost per discharge will be handled in the same manner as described in III.E.

The methodology described in paragraphs C.2.b. through C.13. below represent the methodology in effect prior to October 1, 1997, and is retained intact in the state plan solely to document how the rates in effect as of October 1, 1996 were determined.
b. The State's audit agent will provide Title XIX costs incurred, reported, audited, and/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 Department will:

   • Exclude estimated outlier discharges and costs as described in Section III.C.4 of this plan.

   • Exclude pass-through costs, as identified in Public Law 97-248 (TEFRA) provisions and further defined in subsection C.3 below.

3. Definition of Excludable Costs Per Discharge: Reduction of Excludable Capital Costs

   a. The approach used by the Department 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 15 percent as required by Section 4006 of Public Law 100-203 (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 Medicaid 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 Section III.F.1. of this plan.
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 Medicaid discharges to produce the base year operating cost per discharge. The base rate methodology is described below.

\[
BYOR = \frac{OC}{D}
\]

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 = Medicaid discharges for the hospital's base year as provided by the Department'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 Department with a hospital's base year discharges and costs as of June 1 prior to Year 1, the Department 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 Section III.C.8 of this plan) to bring the costs to the midpoint of the base year. When the provider's actual base year costs and discharges become available, the Department 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 1, 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 Department has determined that the actual cost submission is suitable. A submission shall be deemed suitable 180 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 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 1 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 the Health Care Financing Administration (HCFA) to update Medicare inpatient prospective payment rates. The Medicare prospective payment update factor (MPPUF) is determined by HCFA, usually on an annual basis, and may differ depending upon the hospital type (urban, large urban, or rural) as defined by HCFA.

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 1, 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 HCFA 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 1) and ending with the midpoint of operating Year 1. For Years 2 and 3, the inflation factors will be the applicable MPPUF as specified by HCFA.

c. For the period October 9, 1991, through September 30, 1992, an exception to a. and b. above will be
made. The inflation factor used to update rates for that period will be .5% for urban hospitals and 1.5% for rural hospitals.

9. Case Mix Adjustments for Base Year Operating Cost Per Discharge Rate

a. The Department 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 Diagnostic Related Group (DRG) methodology established and used by the Medicare program.

b. For each DRG, the Department 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 Department's methodology for computing DRG relative weights was discussed earlier in Section III, subsection B. Case-mix adjustments will be computed using the methodology described below:

Case-Mix Computation

Each base year, a hospital's case-mix index will be computed by the Department and its fiscal agent as follows:

- All Title XIX discharges are assigned to appropriate DRGs.
- 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.

The case-mix adjustment is applied to the base year operating cost per discharge as described in Section III.C.10.d 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 Medicaid discharges per year.)

At the time of the next rebasing year following October 1, 1989, the criteria regarding low-volume will be dropped along with the low-volume peer groups, thus leaving four possible peer groups for assignment: (Teaching, Referral, Regional and Community).

b. The Department will determine the peer group assignment of each hospital, and appeal of such assignment will be allowed only as described in Section III.D.1 of this plan.

c. A ceiling on allowable operating costs will be set at 110 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).

d. The case-mix equalization for each hospital in a peer group will be calculated as follows:

\[
PGR = \frac{BYOR}{CMI}
\]

PGR = Hospital rate equalized for peer group comparison
BYOR = Base year operating cost per discharge
CMI = Case-mix index in the base year

e. The allowable operating cost per discharge rate (hospital-specific rate) will be the lower of:

- The ceiling for the hospital's peer group; or
The hospital rate resulting from the computation found in Section III.C.10.d. 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 1, 2, and 3:

**Year 1**

\[ PD01 = HSR \times (1 + MPPUF) \]

**PD01** = Per discharge operating cost rate for Year 1

**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 Section III.C.8

**Year 2**

\[ PD02 = PD01 \times (1 + MPPUF) \]

**PD02** = Per discharge operating cost rate for Year 2

**PD01** = Per discharge operating cost rate for Year 1

**MPPUF** = The applicable Medicare prospective payment update factor as described in Section III.C.8

**Year 3**

\[ PD03 = PD02 \times (1 + MPPUF) \]

**PD03** = Per discharge operating cost rate for Year 3

**PD02** = Per discharge operating cost rate for Year 2

**MPPUF** = The applicable Medicare prospective payment update factor as described in Section III.C.8

12. Computation of Excludable Cost Per Discharge Rate

Total Medicaid excludable cost, as identified in Public Law 97-248 (TEFRA), with excludable capital costs reduced as indicated in Section III.C.3, will be paid in the following manner:

a. An excludable cost per discharge rate is computed
using the following methodology:

$$ER = ECP/DCY$$

$$ER = \text{Excludable Cost Per Discharge Rate}$$

$$ECP = \text{Excludable costs on the hospital's most recently settled cost report prior to the rate year, as determined by the audit agent}$$

$$DCY = \text{Medicaid discharges for the calendar year prior to the rate year, as determined by the Department's fiscal agent}$$

b. The retrospective settlement will be determined based on the actual allowable amount of Medicaid excludable costs incurred by a hospital during the hospital's fiscal year.

13. Computation of Prospective Per Discharge Rate

The excludable cost per discharge, as described in Section III.C.12 above, will be added to the appropriate operating per discharge rates to determine the prospective rates.

14. Effective Dates of Prospective Rates

Rates will be effective for implementation October 1, 1989 and effective thereafter 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:

1) The hospital inpatient service mix for Medicaid admissions has changed due to a major change in scope of facilities and services provided by the hospital.

2) 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.

3) The expanded services were a) not available to Medicaid patients in the area or b) are now provided to Medicaid patients by the hospital at a lower reimbursement rate than would be obtained in other hospitals providing the service.

4) The magnitude of the proposed (as appealed) prospective per discharge rate for the subsequent year will exceed 105 percent of the rate that would have otherwise been paid to the hospital.

5) In addition to requirements 1-4 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 Department shall be limited to the following options:

1) Reject the appeal on the basis of a failure of the appellant to demonstrate necessary
conditions and documentation for an appeal as specified in 1.a. above; or

2) accept all of the specific recommendations, as stated in the appeal, in their entirety; or

3) adopt modified versions of the recommendations as stated in the appeal; or

4) reject all of the recommendations in the appeal.

c. Hospitals are limited to one appeal per year, which must be filed in writing 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 Department shall offer the appellant the opportunity for hearing of the appeal. If such a hearing is requested, it shall occur within 30 days of the filing date. The Department 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.

The Department'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 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 is less than the final rate, the Department will include the amount of underpayment in a subsequent payment to the facility within 30 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 days from the date of notification of overpayment to submit the amount owed to the Department in full. If the amount is not submitted on a timely basis, the Department 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
   Effective for discharges occurring on or after April 1, 1992, 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 days or more, when such services are provided to children who have not attained the age of six years in disproportionate share hospitals, and to infants under age one in all hospitals. These cases will be removed from the DRG payment system and paid at an amount equal to 90% 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.

   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 Department 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:

1) A hospital inpatient shall be considered "transferred" when he or she has been moved from one acute inpatient facility to another acute inpatient facility. Movement of a patient from one unit to another unit within the same hospital shall not constitute a transfer, unless the patient is being moved to a PPS exempt unit within the hospital.

2) 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 III.F. of this plan. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio.

3) The receiving hospital which ultimately discharges the patient 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 patient 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

Readmissions occurring within 15 days of prior acute care admission for a related condition will 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 Department.
4. **Payment for Inappropriate Brief Admissions**

Hospital stays of up to two days in length will be reviewed for medical necessity and appropriateness of care. (Discharges involving healthy mothers and healthy newborns are excluded from this review requirement). 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 Department.

5. **Payment for Non-Medically Warranted Days**

   a. Reimbursement for hospital patients 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 Medicaid program is determined based only upon medical necessity for an acute level of hospital care.

   b. When it is determined that an individual no longer requires acute-level care but does require a lower level of institutional care, and when placement in such care cannot be located, the hospital will be reimbursed for "awaiting placement" days. Reimbursement will be made at the weighted average rate paid by the Department 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 individual as soon as possible. During "awaiting placement" days, no ancillary services will be paid, but medically necessary physician visits will be reimbursed.

6. **Sole Community Hospital Payment Adjustment**

Effective for the quarter beginning July 1, 1993, in-state acute care hospitals that qualify as Sole Community Hospitals are entitled to receive a sole community hospital payment adjustment in accordance with the provisions specified below:
a. To qualify for a sole community hospital payment adjustment, an acute care hospital must meet the Medicare classification criteria for a sole community hospital as set forth at 42 CFR 412.92 as of July 1, 1993 and retain such qualification regardless of a subsequent change in their Medicare classification. The hospital must qualify for a sole community hospital designation in the month prior to the effective date for the sole community adjustment. If a hospital already has a sole community designation from Medicare, this designation will be accepted by the Medicaid program. If for some reason, the hospital elected not to apply for sole community hospital designation under Medicare but wishes to apply for Medicaid purposes only, such application must be made directly to the Medicaid program. The Medicaid program will review the application in accordance with the criteria contained at 42 CFR 412.92. Any acute care general hospital entering the program who wish to qualify for a sole community hospital designation must meet all of the criteria contained at 42 CFR 412.92 (a) with the exception of being located more than 35 miles from other like hospitals. The new hospital must also be enrolled as a Medicaid provider for a minimum of one year in order to received the sole community hospital designation.

b. For an in-state acute care hospital that qualifies as a sole community hospital in accordance with paragraph (a) above, the Department will made a quarterly sole community hospital payment at the end of each quarter. For the initial payment year (July 1, 1993, through June 30, 1994), the payment is the amount specified under paragraph (c) below. For subsequent years, the amount will be the amount calculated under paragraph (d) through (f) below.

c. For the initial payment year, the sole community hospital payment amount will be equal to the amount the hospital received from county government, either through the County Indigent Claims Act or by mill levy revenues dedicated to supporting the hospital's operating expenses, for calendar year 1992 (the base year) plus the inflation factor described in §III.C.8. of this plan. Verification of the base year amount will be made from the official report of expenditures by each county. Hospitals will have the opportunity to challenge the amount by filing an appeal with the Department within 30 days from the date they receive notice from the state of their sole community payment amount. If the hospital qualifies for the sole community designation later than the effective date of this plan amendment, the Medicaid program will prorate the sole community payment adjustment for the first quarter from the date of qualification to the end of that

* Pen & ink change made per State's request.

SUPERSEDES: TN. NM-92-14
quarter.

d. For each subsequent plan year, the sole community hospital is required to submit to the Department, no later than January 15 for the subsequent state fiscal year, a sole community hospital payment request. If the hospital cannot meet the January 15 deadline, the hospital may submit a written request for up to 30 day extension. Such requests must be received prior to the January 15 deadline.

e. The sole community provider payment request must be reviewed and approved by the county government in which the hospital is located. In order for the request to be valid, the county government's approval must be submitted with the hospital's request. If the hospital does not submit a valid request within the time frame identified above, it will not be eligible for a sole community provider adjustment for that year regardless of the hospital's status as a sole community hospital.

f. For years subsequent to the initial payment year, the sole community hospital payment adjustment will be the lessor of the amount paid by the Department for the previous year trended forward. The Department will use the market basket forecast published periodically in the HCFA Regional Medical Services letter, or an amount mutually agreed upon by the hospital and the county government.

g. The Department will calculate the Medicare payment limit (specified at 42 CFR 447) annually. If the upper limit has not been exceeded, additional payments will be distributed by the Department. Should the amounts requested from the hospitals exceed the amount available under the upper limit, the amounts will be prorated and distributed based on the amount of the request received by the Department.

7. State Operated Teaching Hospital Adjustment

Teaching hospitals (as defined in section 4.19-A.III.F.8.a operated by
the State of New Mexico or an agency thereof, shall qualify for an inpatient State Operated Teaching Hospital rate adjustment. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility’s Medicare-related upper payment limit (specified at 42 CFR 447.272). The Department will calculate the Medicare upper payment limit for State Operated Teaching Hospitals annually. If the upper payment limit has not been exceeded, additional payments will be distributed by the Department to the State Operated Teaching Hospital. The adjustment shall be calculated as follows:

a. Each federal fiscal year, the Department shall determine each State Operated Teaching Hospital’s Medicare per discharge rate and Medicaid per discharge rate. The Medicare and/or Medicaid discharge rate will be adjusted to reflect any acuity differences that exist between the Medicare and Medicaid patients served. Acuity differences will be determined from the Medicare and Medicaid case-mix indices (CMI) for Medicaid discharges at the hospital using Medicare and Medicaid DRG weights in effect at the time (using data from the most recent state fiscal year for which complete data is available).

b. The Medicaid per discharge rate shall be subtracted from the Medicare per discharge rate.

c. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent state fiscal year. The result shall be the amount of the State Operated Teaching Hospital Adjustment for the current federal fiscal year.

d. For federal fiscal year 2000, and subsequent federal fiscal years, payment shall be made on an annual basis before the end of the federal fiscal year.

e. In the event that the State Operated Teaching Adjustment amount exceeds the Medicare-related upper payment limit for that year, the State Operated Teaching Hospital adjustment will be revised by the difference.
8. **Indirect Medical Education (IME) Adjustment**

Effective August 1, 1992, acute care hospital that qualify as teaching hospitals will receive an indirect medical education (IME) payment adjustment, which covers the increase operating or patient care costs that are associated with approved intern and resident programs.

a. In order to qualify as a teaching hospital and be deemed eligible for an IME adjustment, the hospital must:

1) Be licensed by the State of New Mexico; and

2) Be reimbursed on a DRG basis under the plan; and

3) Have 125 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

b. Determination of a hospital's eligibility for an IME adjustment will be done annually by the state, 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 qualifications were met.

c. The IME payment amount is determined by multiplying DRG operating payments, which are DRG payments and outlier payments, by the IME adjustment factor computed by the following formula:

\[ 1.89 \times (1 + R)^{405} - 1 \]

Where \( R \) equals the number of approved full-time equivalent residents divided by the number of available beds (excluding nursery and neonatal bassinets). Full-time equivalent residents are counted in accordance with 42 CFR 412.105(f). For purposes of this paragraph, DRG operating payments include the estimated average per discharge amount that would otherwise have been paid for Medicaid managed care enrollees.
if those persons had not been enrolled in managed care.

d. Quarterly IME payments will be made to qualifying hospital at the end of each quarter. Prior to the end of each quarter, the provider will submit to the Department's audit agent the information necessary to make the calculation, i.e. number of beds, number of estimated residents for the quarter, and the Medicaid DRG amount. After review and adjustment, if necessary, the audit agent will notify the Department of the amount due to/from the provider for the applicable 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.

9. Payment for Direct Graduate Medical Education (GME)

Effective 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.

a. To be counted for Medicaid reimbursement, a resident must be participating in an approved residency program, as defined by Medicare in 42 CFR 413.86. With regards to categorizing residents, as described in paragraph b of this section, the manner of counting and weighting resident FTEs will be the same as is used by Medicare in 42 CFR 413.86.

Resident FTEs whose costs will be reimbursed by the Department as a medical expense to a Federally Qualified Health Center are not eligible for reimbursement under this section.

To qualify for Medicaid GME payments, a hospital must be licensed by the State of New Mexico, be currently enrolled as a
Medicaid provider, and must have achieved a Medicaid inpatient utilization rate of 5% or greater during its most recently concluded hospital fiscal year. For the purposes of this section, the Medicaid inpatient utilization rate will be calculated as the ratio of New Mexico Medicaid eligible days, including inpatient days paid under Medicaid managed care arrangements, to total inpatient hospital days.

b. Approved resident FTEs are categorized as follows for Medicaid GME payment:

1) Primary Care/Obstetrics Resident. Primary care is defined per 42 CFR 413.86(b).

2) Rural Health Resident. A resident 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.

3) Other approved resident. Any resident not meeting the criteria for categories 1 or 2, above.

c. Medicaid GME Payment Amount per Resident FTE

1) The annual Medicaid payment amount per Resident FTE for state fiscal year 1999 is as follows:

   Primary Care/Obstetrics Resident: $22,000
   Rural Health Resident: $25,000
   Other Resident: $21,000

2) The per resident amounts specified in paragraph 9.c.1 will be inflated for state fiscal years beginning on or after July 1, 1999 using the annual inflation update factor described in paragraph 9.d.
d. Annual Inflation Update Factor

Effective for state fiscal years 2000 and beyond, the Department will update the per resident GME amounts and the upper limit on GME payments for inflation, using the market basket forecast published in the HCFA 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).

The Department will use the market basket forecast shown for PPS hospitals that is applicable to the period during which the rates will be in effect. For example, the Department will use the forecast shown for July 1, 1999 - June 30, 2000 to update the rates for state fiscal year 2000.

e. Annual Upper Limits on GME Payments

1) Total annual Medicaid GME payments will be limited to $5,800,000 for state fiscal year 1999. This amount will be updated for inflation, beginning with state fiscal year 2000, in accordance with paragraph 9.d.

2) Total annual GME payments for residents in Category b.3, “Other,” will be limited to the following percentages of the $5,800,000 total annual limit (as updated for inflation in accordance with paragraph 9.d).

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SUPERSEDES: TN • 98-28
f. Reporting and Payment Schedule

1) Hospitals will count the number of residents working according to the specification in this section during each fiscal year (July 1 through June 30) and will report this information to the Department 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 Department may require hospitals to provide documentation necessary to support the summary counts provided.

2) The Department 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 paragraph d, the amount payable to each will be proportionately reduced.

3) The annual amount payable to each hospital is divided into four equal payments. These payments will be made by the Department on or about the start of each prospective payment quarter.

4) Should a facility not report timely with the accurate resident information as required in paragraph 1, 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 paragraph e, after prospective payment amounts to timely filing facilities have been established.
IV. 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.

B. Criteria for Deeming Hospitals Eligible for a Disproportionate Share Payment

Determination of each hospital's eligibility for a disproportionate share payment for the Medicaid inpatient utilization rate as listed below, will be done annually by the department'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 Department by March 31 of each year.
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.

The following criteria must be met before a hospital is deemed to be eligible:

1. **Minimum Criteria**
   
a. The hospital must have:
   
i. A Medicaid inpatient utilization rate greater than the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state; or
   
   ii. A low-income utilization rate exceeding 25 percent. (Refer to subsection 2 for definitions of these criteria.)

b. The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under Medicaid. 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 U.S. Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

c. Subsection 1b does not apply to a hospital which meets the following criteria:
   
i. The inpatients are predominantly individuals under 18 years of age; or
   
   ii. The hospital did not offer non-emergency obstetric services as of December 22, 1987.

d. The hospital must have, at a minimum, a Medicaid inpatient utilization rate (MUR) of one percent.

**SUPERSEDES: TN - 94-13**

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DISPROPORTIONATE SHARE HOSPITALS

A. Criteria for Deeming Hospitals Eligible for a Disproportionate Share Payment:
   (3) The following criteria must be met before a hospital is deemed eligible:
      (b) Definitions of Criteria:
         (i) Medicaid inpatient utilization: For a hospital, the total of its Medicaid inpatient days in a cost reporting period, divided by the total number of the hospital's inpatient days for the same period. These include both Medicaid managed care and Medicaid non-managed care inpatient days.
         (ii) Low-income utilization rate: For a hospital, the sum (expressed as a percentage) of the following fractions: The sum of total Medicaid inpatient and outpatient net revenues (this includes Medicaid 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 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 Medicaid state plan), that is, reductions in charges given to other third-party payers, such as HMOs, Medicare, or Blue Cross.

| STATE     | New Mexico         |
| DATE REC'D | 08-30-01           |
| DATE APPVD | 05-07-01           |
| DATE EFF   | 01-01-01           |
| HCFA 179   | NM-01-03            |

SUPERSEDES: TN - NM - 97-04
(iii) The Medicaid utilization rate (MUR) is computed as follows:

\[ \text{MUR}\% = 100 \times \frac{M}{T} \]

\( M = \) Hospital’s number of inpatient days attributable to patients who for these days were eligible for Medical Assistance under the State Plan. These include Medicaid managed care and non-managed care days.

\( T = \) Hospitals’ total inpatient days.

(iv) Newborn days, days in specialized wards, and administratively necessary days are included in this calculation. Additionally, days attributed to individuals eligible for Medicaid in another state are included. Medicaid inpatient days includes both Medicaid managed care and non-managed care patient days.

The numerator (M) does not include days attributable to Medicaid patients 21 or older in Institutions for Mental Disease (IMD) as these patients are not eligible for Medicaid coverage in IMDs under the New Mexico State Plan and can not be considered a Medicaid 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 section IV.A. Qualifying hospitals will be classified in one of 3 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 4th pool: reserve pool as explained in this section IV.C. 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 approval teaching programs.

2. A non-teaching PPS (DRG) hospital qualifies if it is an instate 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 (Tax Equity and Finance Reduction Act) methodology as described in Section II of this policy.

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 Medicaid-covered inpatient days in any given quarter. A hospital will qualify for payment from the reserve pool if its charity ratio, as described in paragraph A.2.b.ii, exceeds 20 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

The DSH funds allocated to each pool are paid to qualifying hospitals based on the number of Medicaid discharges. These include both Medicaid 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.

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 Medicaid discharges during that quarter. The quarterly payment to each hospital qualifying for DSH pools 1, 2, or 3 will be computed by dividing the number of Medicaid discharges for that hospital by the total number of Medicaid 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 sections IV.E. and IV.F.

The Medical Assistance Division 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 Medicaid and low-income/indigent care patients.

SUPERSEDES: TN-94-13

<table>
<thead>
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<th>STATE</th>
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<td>7-31-97</td>
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The amounts allocated to each pool for state fiscal year 98 are as listed below. The total allocations shall be adjusted in subsequent state fiscal years based on the Medicare Prospective Payment Update Factor (MPPUF) and/or the DSH budget as defined by HSD. The base year DSH budget for state fiscal year 98 is $22,000,000.00.

1) The Teaching PPS hospital DSH pool is 56% of the overall DSH budget, as defined by HSD.

2) The Non-teaching PPS (DRG) hospital DSH pool is 22.5% of the overall DSH budget, as defined by HSD.

3) The PPS-exempt hospital (TEFRA) DSH pool is 1.5% of the overall DSH budget, as defined by HSD.

4) The reserve DSH pool is 20% of the overall DSH budget, as defined by HSD. 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 Medicaid discharge, where \( N \) is equal to the fraction described in paragraph A.2.b.ii of this section minus 20% multiplied by $1750.

D. Request for DSH Payment Procedures

Hospitals must submit to the Department the number of Medicaid discharges (both managed care and fee for service discharges), which they have incurred 30 days after the end of each quarter. The Department will review the hospital’s documentation supporting their discharge information. Any requests received later than 60 days from the end of the quarter will be denied as untimely.

E. DSH Limits

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 under sections IV.B. through IV.D. shall not exceed that hospital’s hospital-specific DSH limit, as determined under section IV.E. This limit is calculated as follows:

| STATE | NM |
| DATE REC'D | 9-24-97 |
| DATE APPV'D | 12-2-97 |
| DATE EFF | 1-31-97 |
| HCIA 117 | A |

SUPERSEDES: TN. 94-13
DSH Limit = M + U

M = Cost of services to Medicaid patients, less the amount paid by the Medicaid program under the non-DSH payment provisions of this plan.

U = Cost of services to uninsured patients, less any cash payments made by them.

The cost of services will include both inpatient and outpatient costs for purposes of calculating the limit. The “costs of services” is 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.

F. Limitations In New Mexico DSH Allotment

If the DSH payment amounts as described in section IV.C. through IV.E. 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.

V. 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 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 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 department or its audit agent an itemized list of allowable costs (financial and statistical report) on the New Mexico Title XIX cost reporting form. The cost report must be submitted within 90 days after the close of the hospital’s fiscal year. Failure to file a report within the 90 day limit, unless an extension is granted, will result in suspension of Title XIX payments, until such time as the report is received.

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 not less than four years following the date of submittal of the New Mexico Title XIX cost report to the Department. 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 Department, the State of New Mexico Audit Agent, or the United States Department of Health and Human Services.

SUPERSEDES: TN - 94-13
2. The Department or its audit agent will retain all cost reports submitted by providers for a period of not less than three 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 Department.

2. **Field Audit:** Field audits will be performed on all facilities as 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 are 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 Department. 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 Department 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 HCFA-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 HIM-15.
VI. 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 Medical Assistance Program audit agent that its cost report has been requested, by whom the request was made, and that the provider shall have 10 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.

VII. SEVERABILITY

If any provision of this regulations is held to be invalid, the remainder of the regulations shall not be affected thereby.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

I. Except as otherwise provided in this state plan, payment to providers on a fee for service basis is limited to the lesser of the actual charge or the fee schedule established by the Department.

Providers reimbursed on a fee for service basis include physicians, dentists, radiologists and radiological laboratories, pathologists and clinical pathology laboratories, free-standing clinics (other than rural health clinics or federally qualified health centers), podiatrists, psychologists, optometrists, audiologists, and therapy providers (including occupational therapy, physical therapy, speech-language-hearing therapy, and other rehabilitative therapies).

a. The fee schedule was established using the following:

1. Relative Value Scales

Relative Values for Physicians, 2nd Edition, 1986 was used to assign unit values to physician procedures. The unit values established an appropriate relativity between the procedures and was used as initial base upon which to begin constructing the fee schedule. For dental services, association reports on dental fees JADA. Vol. 113, November, 1986, was used to assign a relative value scale. For other services, billed charge history of the Medical Assistance Program for the calendar year 1986 was used to develop relative value units.

2. Groups for Calculation of Reimbursement

Frequently billed procedures were identified and divided into groups according to CPT body system, type of physician visit, type of provider, or type of service. The groupings were used to establish appropriate reimbursement for a procedure relative to other procedures in the same group.
3. Billed Charges

Average billed charges to the New Mexico Medical Assistance Program were calculated for each procedure for the calendar year 1986. For frequently performed procedures, significant deviation between the average billed amount for a procedure and the assigned unit value resulted in a re-examination of the unit value. When appropriate, the unit value was changed to accurately reflect billed charge history. A conversion factor was calculated for each of the frequently billed procedures by dividing the unit value into the average billed amount. An average conversion factor was then calculated for each group.

4. History of Paid Claims

The average amount of payment for each procedure was calculated for the calendar year 1986. As the fee schedule was not intended as fee increase, the average conversion factor was reduced by the percentage paid of billed charges for 1986 for the procedures in each group.

5. Weighted Conversion Factors

A final conversion factor weighted by frequency was calculated for each group of procedures. The weighted conversion factor for each group of procedures was reduced by the necessary percentage to assure expenditures would be within budgeted amounts. The final weighted conversion factor for each group was multiplied by the unit value of each procedure to calculate the maximum reimbursement for each procedure.

6. Establishing a Fee Schedule

A final review establishing the fee schedule was conducted by the Medical Assistance Division. Services are added to the fee schedule as needed (such as for new or infrequently billed procedures) using the same methodology. For services without a billing history, the Department establishes the maximum allowed reimbursement at rates comparable to procedures on the fee schedule having similar complexity, having similar risk factors, and requiring a similar amount of time, and with consideration of the payment levels established by other third party payers.
7. Adjustments To Fee Schedule

When appropriations are made to adjust payment for physician services by the legislature, the appropriation will be applied to low paid procedures and to services for which access problems exist, or as otherwise directed by the appropriation following a public hearing on such adjustments.

a. Pursuant to State legislative appropriations, physician fees are increased effective March 1, 1996, for office-based Evaluation and Management Services, prenatal and obstetrical delivery services, and the medical screen of the Tot to Teen HealthCheck. Increased fees are based on the 1994 Medicare Participating Provider Fee Schedule. Routine global prenatal care and Cesarean delivery currently exceed the Medicare 1994 fee schedule, therefore the fees for these two services are increased 10 percent. The Tot to Teen HealthCheck is increased to $45.00.

b. Pursuant to State legislative appropriations, Level 1 Common Procedural Terminology (CPT) Evaluation and Management Services, Surgery Services, Radiology Services and Medicine Services codes are increased effective 10/01/2000 to 95% of the 2000 Medicare Fee Schedule.

b. A group practice is reimbursed at the rate payable to the individual performing physician or provider. For service for which a performing physician or provider is not identified, reimbursement will be made at the rate payable to the group.

c. Reimbursement for physician services furnished in hospital outpatient settings that are also ordinarily furnished in a physician’s office is determined by using the Department’s fee schedule for each professional service and multiplying the allowed amount by .60.

This reimbursement methodology is applicable only to physician’s professional services in hospital outpatient settings (i.e., a hospital clinic, hospital office, the outpatient department). Excluded from this reimbursement methodology are services provided in rural health clinics, surgical services in an ambulatory setting, emergency services, anesthesiology services, diagnostic and therapeutic radiology services, and services provided by physicians who are compensated by or through the hospital and whose services are reimbursed on a compensation related charge basis. Services billed by physicians in teaching hospital whose Medicare Part B reimbursement is not based on a compensation related basis are subject to this methodology.

d. Payment for the professional component of a radiology service performed in an inpatient, outpatient, or office setting will not exceed 40 percent of the allowed amount.

SUPERSEDES: TN 96-19
payable for the complete procedure in an office setting. Nuclear medicine, radiation oncology, CT scans, and arteriogram are excluded from this limitation.

e. Payment to free standing ambulatory surgical centers does not exceed the maximum allowed by the Medicare Carrier. For procedures not covered by Medicare, the Department establishes a payment level which does not exceed the amount allowed for procedures of similar complexity.
f. Payments for care or service are not in excess of the upper limits allowed by federal regulations.

g. This single State Agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or service, or fee plus costs of materials.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

h. The state agency has access to data identifying maximum charges allowed and such data will be made available to Secretary of HHS upon request.

i. A separate fee schedule for obstetric and pediatric services is maintained in order to demonstrate that the fee-for-service rates will insure these services are available to Medicaid recipients at least to the extent that such services are available to the general population in a geographic area.

j. Payments to licensed midwives are made at the lesser of the actual billed charge or 77% of the amount allowed by the fee schedule for the same service when provided by a physician.

k. Certified nurse anesthetist and anesthesiologist assistants are reimbursed a rate per anesthesia unit for the procedure and for units of time at rates for medically directed and non-medically directed services.

l. Certified nurse practitioners and clinical nurse specialists will be reimbursed at 90% of the payment rate made to physicians.

m. Licensed Independent Social Workers (LISW’s) will be reimbursed according to the fee schedule as described in item i of Attachment 4.19-B.

n. A separate fee schedule for Personal Care is maintained in order to demonstrate that the fee-for-service rates will insure these services are available to Medicaid recipients.

8. The fee schedule is examined periodically and adjusted. The fees are available in a published fee schedule. The payment rates result in public and private providers receiving the same payment for the same service, except as described in number 9. Supplemental Payments, below.

9. Supplemental Payments will be made in addition to payments otherwise provided under the state plan to physicians, dentists and mental health professionals who qualify for such payments under the criteria outlined below in part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in parts (b) and (c) of this section.

a. To qualify for a supplemental payment under this section, the provider must meet the following criteria.

i. Be a licensed physician, dentist or mental health professional enrolled in the New Mexico Medicaid program; and

ii. Be a member of a practice plan under contract to provide professional services at a State-owned academic medical center as determined by the Department.

b. For providers qualifying under part (a) of this section, a quarterly supplemental payment will be made equal to the difference between Medicaid payments otherwise made to these providers and the average rate paid for the services by commercial insurers. The average commercial rates are determined by:

i. Calculating a commercial payment to charge ratio for all services paid to the eligible providers by commercial insurers using the providers’ claims-specific data from the most currently available fiscal year period.

ii. Multiplying the Medicaid charges by the commercial payment to charge ratio

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

to establish the estimated commercial payments to be made for these services; and

iii. Subtracting the interim Medicaid payments already made for these services to establish the supplemental payment amount.

c. Providers eligible under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made on a quarterly basis subject to available claims data.

II. Payment for prescribed drugs in the New Mexico Title XIX Program shall be based upon the following provisions. The Department will reimburse the lesser of the computed price or the usual and customary charge.

a. Computed Price

- The computed price is defined as the allowed cost plus a dispensing fee established by the Department.

The allowed cost will be the lower of the following.
II. Payment for prescribed drugs.

The Department will reimburse the lesser of the computed price or the usual and customary charge for drug items reimbursed by the Medicaid Fee-for-Service Program. This pricing methodology does not apply to drug items reimbursed under the Section 1915(b) Waiver for Managed Care.

a. Computed Price

The computed price is defined as the allowed cost plus a dispensing fee established by the department. The allowed cost is the lower of the following:

1. State Allowed Costs (SAC) - Reimbursement is limited to a lesser-expensive therapeutically equivalent drug. The “FDA Approved Therapeutically Equivalent Drugs” rating must be used to determine which products are therapeutically equivalent. A physician may prohibit drug selection by writing in his own handwriting “brand medically necessary” on the prescription. This constitutes physician certification that substitution is not permitted. With this certification, the SAC limit shall not apply.

State allowed costs are established considering Medicare reimbursement when available, pharmaceutical wholesaler information, and actual invoice information when available from providers.

State allowed costs are determined after (1) assuring availability of FDA approved therapeutically equivalent drugs using information available from the FDA and from the American Society of Hospital Pharmacists on drug shortages; (2) determining the typical package size used; (3) calculating an amount at 150% of the lowest cost product and 20% above the second lowest cost product.

In establishing the State Allowed Costs, the New Mexico Medicaid Program will not exceed, in the aggregate, payment levels established by CMS for multiple source and other drugs as required by 42 CFR 447.331 and 42 CFR 447.332.

2. Estimated Acquisition Cost (EAC) - EAC is limited to the published average wholesale price (AWP) minus 14%, or other available pricing sources which approximate EAC (manufacturers’ price lists, wholesaler average cost information as available under state law, audited actual pharmacy invoices, and Widely Available Market Prices ‘WAMP’ as published by the General Accounting Office.)

3. Federal Upper Limit (FUL) - FUL is a federal maximum amount established by CMS.

b. Usual and Customary Charge

The usual and customary charge is defined as the charge made to a non-Medicaid patient for the same drug item. Usual and customary charges specifically must consider the following:
IV. Reimbursement Methodology for Family Planning Services

(a) Payment for family planning services is made in accordance with the provisions contained in Section 4.19-B item I (payment to providers on a fee for service basis), item II (prescribed drugs), item III (outpatient hospital services), item VI (laboratory services), item VIII (federally qualified health centers and rural health clinics), and 4.19-D (inpatient hospital reimbursement); depending on the service and the provider type. For all providers which are physician-directed and are approved to provide family planning services under this state plan, the upper payment limits will not be in excess of a fee schedule approved by the single state agency, for each of the professional services authorized as benefits.
b. Usual and Customary Charge - The usual and customary charge is defined as the charge made to a non-Medicaid patient for the same drug item. Usual and customary charges specifically must consider the following:

1. Discounts given to non-Medicaid patients for criteria such as age or being in a nursing home when the Medicaid patient meets the criteria for the discount.
2. Discounts for paying cash. If any patient group gets discounts for paying cash, those discounts must be reflected in the usual and customary charge.
3. Medicaid is to be given the advantage of discounts that the general public receives.

c. Prescription Refills - There are limitations on the frequency for which it will reimburse the same pharmacy for dispensing the same drug to the same recipient. The limitation is established individually for each drug. Most drugs are subject to a maximum of three (3) times in ninety (90) days, with grace days as needed to account for necessary early refills, lost medications, dosage changes, etc. Controlled drugs and certain other drugs may require special consideration, as necessary, due to their specific indication, dosage form, or packaging, and are subject to limitations as may be appropriate. Refills must be consistent with the dosage schedule prescribed and all existing federal and state laws.

The maximum quantity that may be dispensed at one time is a thirty-four (34) day supply, except for oral contraceptives that may be dispensed in greater quantities if the proper agent for the patient is established, and for maintenance medications which may be dispensed up to a ninety (90) day supply.

d. Dispensing Fee - The dispensing fee for pharmacies is $2.50 unless product selection by the pharmacist has taken place, in which case the dispensing fee will be $3.65. Product selection occurs when the pharmacist selects a lower priced equivalent generic drug item to dispense in place of a higher priced brand name drug item when consistent with state and federal laws. The Department establishes the dispensing fee by taking into account such factors as the cost studies on pharmacy operations; the amount pharmacies have agreed to accept for providing similar services for Medicare part D and other contracts; dispensing fees paid by other common insurers, health maintenance organizations, and managed care organizations; and payments made by other state Medicaid programs that are similar to that of New Mexico.

e. Reimbursement Limitations

1. Payment will not be made for drug items for which the manufacturer has not entered into a rebate agreement with the federal government except as specified in the provisions of sections 1902(a)(54) and 1927 of the Social Security Act.

2. Payment will not be made to physicians for oral medication or medications that can be appropriately self-administered by the recipient. Payment to physicians for drugs will be limited to injectable and other medications administered by the physician or under his direction.
III. For outpatient hospital services provided by approved Title XIX hospitals for Title XIX reimbursement purposes, effective for all accounting periods which begin on or after October 1, 1983, the amount payable by the Medicaid program through its fiscal agent for services provided to Title XIX recipients and covered under the Medicaid program, the manner of payment and the manner of settlement of overpayments and underpayments shall be determined under the methods and procedures provided for determining allowable payment for outpatient hospital services under Title XVIII of the Social Security Act. Effective April 1, 1992, for those services reimbursed under Title XVIII allowable cost methodology, the Medicaid program will reduce the Title XVIII allowable costs by 3 percent. The interim rate of payment shall be 77% of billed charges. These provisions shall be applicable to all hospitals approved for participation as Title XIX hospitals in the Medical Assistance Program.

a. In no case can reimbursement for outpatient hospital services exceed reasonable cost as defined under Medicare Title XVIII. Laboratory services will not exceed maximum levels established by Medicare.

b. Effective for reimbursement for outpatient dates of service beginning March 15, 1978, reimbursement for oral medications dispensed in a hospital outpatient setting or emergency room will be limited to usual charge up to a maximum of $2.00 per visit per Medicaid recipient.

c. Effective April 1, 1992, emergency room services are reimbursed at an interim rate of 77% of billed charges, subject to retroactive adjustment to allowable and reasonable cost minus 3 percent.

d. Emergency room services are subject to review prior to payment to establish if circumstances warranted emergency room service. If it is determined that emergency services were provided in a non-emergency situation, the emergency room charge is denied. The recipient is responsible for payment of the emergency room charge in these cases, and may be billed by the provider directly. The ancillary
services are reviewed and paid if they are medically appropriate for the condition treated, even though the condition was not an emergency. Ancillary services which are denied as not medically appropriate for treatment of the condition may not be billed to the recipient.

e. Emergency room services rendered in conjunction with an inpatient admission should be included on the claim form with charges for inpatient care. In such cases, emergency room services will be reimbursed in accordance with the inpatient reimbursement methodology.
VI. For laboratory services, payment does not exceed maximum levels allowed by the Title XVIII carrier.

VII. Payment for dental prostheses is made using the same methodology for professional services as outlined in Section I of this attachment.

Payment for durable medical equipment and prosthetic and orthotic appliances is made at the lesser of the provider’s billed charge or the current Medicaid fee schedule.

When a Medicaid fee schedule amount is not available durable medical equipment is reimbursed at the actual acquisition cost plus a percentage. When the actual acquisition cost is $1,000 or more, reimbursement will not exceed actual acquisition cost plus 15 percent. When the actual acquisition cost is less than $1,000, reimbursement will not exceed actual acquisition cost plus 25 percent.

Payment for parenteral and enteral nutrition products is made at amounts that do not exceed those paid by Medicare.

Payment for frames and lenses are made at the lesser of Medicaid fee schedule amount or the invoice cost. This limit, as well as payment for dispensing eyeglasses, is made at a level established by the Department with consideration given to payment practices of other third party organizations, negotiations with appropriate professional societies, and the usual charges of the providers for services to non-Medicaid patients.
VIII. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

a. Reimbursement- FQHCs and RHCs must submit claims for reimbursement on the UB-92 claim form or its successor. Once enrolled, providers receive instructions on documentation, tilling, and claims processing. Interim and final reimbursement for FQHC and RHC services are made by the Medical Assistance Division (MAD) based on submitted claims. Effective January 1, 2001, FQHCs and RHCs will be reimbursed under a prospective payment system (PPS) that conforms to the provisions of the Benefits Improvement and Protection Act (BIPA) 2000.

b. Interim PPS rate for FQHCs and RHCs: FQHCs and RHCs will receive an interim payment rate during the transition to the PPS. The interim rate will be the rate in effect December 31, 2000, updated in accordance with the FQHC and RHC payment regulations in effect on December 31, 2000. These rates are facility specific and will remain in force until such time as the PPS base period rate for each FQHC and RHC has been established. This interim rate will be inflated by the Medicare Economic Index (MEI) each October 1st, starting with Federal Fiscal Year 2002.

c. Base Rates for the Prospective Payment System (PPS): Once FQHC and RHC cost reports filed for periods ending in calendar years 1999 and 2000 are finalized, the PPS base rates will be established for each FQHC and RHC. The PPS base rate per encounter for each FQHC and RHC will be calculated as follows:

The allowable cost per encounter from cost reports filed for periods ending in calendar years 1999 and 2000 will be indexed (inflated) from the mid-point of the cost reporting period to the mid-point of the base rate period. The base rate period will be from January 1, 2001, through September 30, 2001. The simple average rate from these two cost reports will be the PPS base rate.

An Example of the Base Period Rate Calculation:

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Encounter Simple Average (Base Period Rate) $128.60

SUPERSEDES: TN-90-09
Once the base period rate for each FQHC and RHC has been calculated, any claims paid for dates of service on or after January 1, 2001, that were paid an interim rate, will be reprocessed. This reprocessing will adjust the payment on each claim to the PPS base rate amount.

d. Updates to PPS base rates:
Beginning in Federal Fiscal Year (FFY) 2002, and each year thereafter, each FQHC and RHC payment amount (on a per visit basis) will be increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services. This adjustment to the PPS rate will be effective each October 1.

e. Alternative Reimbursement Methodology
An alternative reimbursement methodology will be implemented effective April 1, 2003. This alternative methodology will re-index the PPS rates in effective March 31, 2003 by the cumulative percentage difference between the increase in the Medical Care Component of the Consumer Price Index-Urban (CPI-U) for the 12 months in the calendar year 2001 and the increase in the Medicare Economic Index (MEI) effective for calendar year beginning January 1, 2002, and the increase in the Medical Care Component of the CPI-U for the 12 months in calendar year 2002 and the increase in the MEI effective for the calendar year beginning January 1, 2003. The new rates will be effective April 1, 2003. Thereafter, beginning in Federal Fiscal Year 2004, an evaluation of whether the MEI or the CPI-U will be used as the inflation index to adjust the PPS rates will take place but in no event will the increase be less than the increase in the MEI.

The initial rate for a new provider entering the program will be established either by reference to payment rates to other clinics in the same or adjacent areas with similar caseloads. Or in the absence of such other clinics, through cost reporting methods. Once the initial rate for the new provider is determined, it shall be updated in accordance with other provisions of this rule. A new (additional) location, established by an existing provider participating in the Medicaid program, will receive the same rate as the parent company or organization establishing the additional clinic, unless it can demonstrate a significant change in scope or intensity of services.

f. Change in Scope of Services
Once the PPS Rates are determined as outlined in this section, adjustments to those rates will reflect changes in the scope of services will be made upon the written request of the provider and approval by MAD. A provider’s request for a PPS rate adjustment due to a change in scope of service must be received no later than 90 days after the provider’s fiscal year end during which the change in scope of service occurred. The provider should notify MAD in advance of any impending changes. The provider will be required to submit data supporting that a change in the scope of service transpired. This documentation will include FQHC and RHC information report and any other supporting documentation considered necessary by MAD or its designee.

A minimum of six months should have elapsed since the change in the scope occurred to ensure the change was not temporary and that there is sufficient information upon which to base a rate adjustment. If the change in scope of service occurred in the last six months of a FQHC’s and RHC’s fiscal period, MAD may require the FQHC and RHC to submit and additional information report, covering at least six months since the change in scope of service transpired, to obtain the information necessary to evaluate the request.

MAD and/or its designee will review the request and determine if an adjustment to the established PPS rate is merited. The following criteria will be used to evaluate each FQHC request for a rate adjustment due to a change in scope of service. MAD’s final determination will be communicated to the FQHC and RHC in writing.
1. MAD or its designee will evaluate each request for a rate revision due to a change in scope of service. If it is determined that a significant change in the scope of service has occurred, the reasonable incremental cost per encounter from this change will be added to the PPS rate and a new rate established. This new rate will be effective on the date the change in scope of service has not transpired, no adjustment will be made to the encounter rate.

2. The events that could create a change in the scope of services are defined to include, but are not limited to, such things as significant expansion or remodeling of an existing clinic, the opening of an additional satellite clinic (new site), addition of new services, deletion of existing services, or other changes in the scope/intensity of services offered by a clinic that significantly increase or decrease the clinic’s costs, relative to its PPS rates. A change in scope of services will not be considered to have transpired unless it increases or decreases an FQHC’s and RHC’s cost per encounter by more than 2.5%.

g. Managed Care Wrap-Around Payments:
MAD will pay a supplemental ‘wrap-around’ payment for managed care organization (MCO) encounters. FQHCs and RHCs must submit invoices, on a regular basis (at least quarterly), but no more frequently than monthly, which identify the number of encounters per each MCO. Supporting documentation must be provided upon request.

1. Interim Wrap-Around Payment Percentages:
MAD will pay a percentage of the FQHCs and RHCs PPS rate as the wrap-around payment. MAD will determine this payment percentage, with input from its designee and from each FQHC and RHC. MAD’s determination will be communicated to each FQHC in writing. Wrap-around payments will be made directly by MAD, not as a pass through from the managed care entity.

2. Final Settlement of MCO Encounters:
On an annual basis MCO encounters will be settled. This process will be done to reconcile MCO encounter payments to the PPS rate(s). To perform this reconciliation total payments due will be calculated by multiplying MCO encounters by the PPS rate(s). MCO payments and Interim Wrap-Around payments received during the period will then be subtracted from the total amount due. Any over or under payment

<table>
<thead>
<tr>
<th>STATE</th>
<th>New Mexico</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE REC'D</td>
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</tr>
<tr>
<td>DATE APPV'D</td>
<td>2-2-04</td>
</tr>
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<td>DATE EFF</td>
<td>1-1-03</td>
</tr>
<tr>
<td>HCFA 179</td>
<td>03-02</td>
</tr>
</tbody>
</table>
determine from this reconciliation will be made as a lump sum settlement.

The provider must submit the documentation required to perform the final settlement within 150 days of their fiscal year end. The reconciliation will then be performed by MAD or its designee within 150 days of receipt of all required information

3. Change in MCO Payments:

If a clinic renegotiates its payment rates with an MCO, the clinic is required to notify MAD that this occurred within 30 days of the effective date of this change. Upon receipt of this information, MAD may re-determine the FQHCs and RHCs interim wrap-around percentage. MAD may also periodically request MCO payment/rate information from the MCOs to determine if the interim wrap-around payment percentage should be reestablished.

h. Initial Rate for New FQHCs and RHCs:
The initial PPS rate for new FQHC and RHC providers will be established either by reference to payment rates to other clinics in the same or adjacent areas with similar caseloads, or in the absence of such other clinics, through cost reporting methods. Once the initial PPS rate for the new FQHC and RHC is determined, it shall be updated in accordance with other provisions of this rule.

A new (additional location, established by an existing FQHC and RHC participating in the Medicaid program, will receive the same PSP rate as the parent company or organization establishing the additional clinic, unless it can demonstrate a significant change in scope or intensity of services, as defined in section VIII.f has occurred. This provision does not, however alleviate the clinic’s responsibility to be licensed and to otherwise comply with Medicaid certification and other requirements for participating in the Medicaid program.

i. Information Reporting Requirements:

1. Annual Filing Requirements for FQHCs and RHCs:

All FQHCs and RHCs will be required to file annual information report with MAD. This report is for general information purposes of MAD. The

SUPERSEDES: TN-01-02
The reports could be used to assist in the evaluation of a change in scope of service, to assist in setting the initial PPS rate for a new FQHC and RHC, and for other purposes.
IX. Payment for hospice service is made according to the reimbursement rate schedule and local adjustment methodology as outlined in the State Medicaid Manual, Hospice services, Section 4306 – 4308, less 1.5 percent.

Payment to a hospice for inpatient care has the following limitation: The aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during the same period.

The benefit does not exercise an option to cap overall reimbursement made to a hospice during the cap period. When hospice care is furnished to an individual residing in a nursing facility, the hospice is paid an additional amount on routine home care and continuous home care days furnished by the facility. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility equals at least 95 percent of the per diem rate that would have been paid to the nursing facility for that individual in that facility under this State Plan. For dually eligible recipients residing in a Medicaid-reimbursed long term care facility and electing Medicare hospice, Medicaid will reimburse the hospice for drug and respite care co-payments as well as room and board services.

Payment to a hospice for physician services is made in accordance with the usual Medicaid reimbursement policy for physician services as the usual Medicaid reimbursement policy for physician services as outlined in Section I of this attachment. Physician services include direct care services furnished to individual hospice patients by hospice employees and physician services furnished under arrangements made by the hospice unless the patient care services were furnished on a volunteer basis.

Payment for services related to the terminal illness or related conditions and unique to Title XIX will be made according to the reimbursement policies set forth in the New Mexico Medicaid Program manual.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Item X. a. Payment of Targeted Case Management Services for individuals who are chronically mentally ill.

Development of Fee Schedule:
To establish a fee schedule amount, the Department initially used cost studies developed by a consulting firm to determine the average actual costs to providers to perform case management services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. To assure salaries were reasonable, allowed costs for salaries for case managers were based on that of a state social worker adjusted for two years tenure at 4% per year and caseloads were based on a 1:30 staff/consumer ratio.

Using these factors, an amount was determined that was further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to case management responsibilities with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examined rates being charged by providers who were already rendering services to other agencies and payers; and, (2) evaluated the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee was also verified by comparing the fee to the case management fees paid by several other states’ Medicaid programs for similar services.

Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined the rates are in conformance with OMB Circular A-87.

Case Management is reimbursed according to a fee schedule. The level of the fee is evaluated annually. In all cases, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.

SUPERSEDES TIN 92-22
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Item X. c. Payment of Targeted Case Management Services for pregnant women and their infants for up to 60 days after their birth.

Development of Fee Schedule:
To establish a fee schedule amount, the Department initially used cost studies developed by a consulting firm to determine the average actual costs to providers to perform case management services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. To assure salaries were reasonable, allowed costs for salaries for case managers were based on that of a state social worker adjusted for two years tenure at 4% per year and caseloads were based on a 1:30 staff/consumer ratio.

Using these factors, an amount was determined that was further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to case management responsibilities with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examined rates being charged by providers who were already rendering services to other agencies and payers; and, (2) evaluated the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee was also verified by comparing the fee to the case management fees paid by several other states’ Medicaid programs for similar services.

Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined the rates are in conformance with OMB Circular A-87.

Case Management is reimbursed according to a fee schedule. The level of the fee is evaluated annually. In all cases, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER
TYPES OF CARE

Item X. b. Payment of Targeted Case Management Services for adults who are developmentally disabled.

Development of Fee Schedule:
To establish a fee schedule amount, the Department initially used cost studies developed by a consulting firm to determine the average actual costs to providers to perform case management services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. To assure salaries were reasonable, allowed costs for salaries for case managers were based on that of a state social worker adjusted for two years tenure at 4% per year and caseloads were based on a 1:30 staff/consumer ratio.

Using these factors, an amount was determined that was further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to case management responsibilities with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examined rates being charged by providers who were already rendering services to other agencies and payers; and, (2) evaluated the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee was also verified by comparing the fee to the case management fees paid by several other states’ Medicaid programs for similar services.

Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined that the rates are in conformance with OMB Circular A-87.

Case Management is reimbursed according to a fee schedule. The level of the fee is evaluated annually. In all cases, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.
Item X.  d. Payment of Targeted Case Management Services for children up to age three.

Development of Fee Schedule:
To establish a fee schedule amount, the Department initially used cost studies developed by a consulting firm to determine the average actual costs to providers to perform case management services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. To assure salaries were reasonable, allowed costs for salaries for case managers were based on that of a state social worker adjusted for two years tenure at 4% per year and caseloads were based on a 1:30 staff/consumer ratio.

Using these factors, an amount was determined that was further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to case management responsibilities with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examined rates being charged by providers who were already rendering services to other agencies and payers; and, (2) evaluated the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee was also verified by comparing the fee to the case management fees paid by several other states’ Medicaid programs for similar services.

Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined the rates are in conformance with OMB Circular A-87.

Case Management is reimbursed according to a fee schedule. The level of the fee is evaluated annually. In all cases, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.
Item X.  e. Payment of Targeted Case Management Services for individuals who are traumatically brain injured.

Development of Fee Schedule:
To establish a fee schedule amount, the Department considered prevailing charges and the existing fee schedule for services similar to case management responsibilities with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examined rates being charged by providers who were already rendering services to other agencies and payers; (2) evaluated the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks; and (3) examined cost data from providers to substantiate their cost to provide the service. Cost considerations included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration.

Cost data was used to assure the reasonableness of the fee schedule rate only; a provider is not reimbursed on the basis of cost. The reasonableness of the fee was also verified by comparing the fee to the case management fees paid by several other states’ Medicaid programs for similar services.

Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined the rates are in conformance with OMB Circular A-87.

Case Management is reimbursed according to a fee schedule. The level of the fee is evaluated annually. In all cases, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.
PAYMENT RATES - OTHER TYPES OF CARE

Item X. e. Payment of Targeted Case Management Services for adult individuals who have been abused, neglected or exploited.

The Medicaid client case management unit rate is determined by dividing the adjusted field services budget by the total Medicaid client case management eligibles. Because field service personnel perform non case management services and they service non Medicaid clients, the total field service budget is adjusted to exclude all field service related costs not related to case management activities. It is further adjusted to exclude non Medicaid eligible case management clients. A random sampling of the field workers time is performed to assist in computing the amount to adjust. This unit rate is reviewed every year and adjustments made as necessary to reflect any over or under payments from the prior year, and is performed within three months after the closing of the subject year.

The Department used a case management rate methodology developed and applied by the Children, Youth and Families Department (CYFD) to determine the actual costs to providers. Allowable are salaries plus fringe benefits, costs for supervision, costs for indirect administration. A fee for service cost was determined which will be billed using a monthly unit rate. Claims are prepared by CYFD and transmitted to the Human Services Department on a monthly basis.

Reimbursement for case management services is consistent with the requirements of Section 1902 (a) (30) of the Act and 42 CFR 447.200 which stipulates that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined that the rates are in conformance with OMB Circular A-87.
# XI.

**OBRA '89 OB/PEDS COMPLIANCE REPORTS**

**NEW MEXICO MEDICAID PROGRAM**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>59000</td>
<td>Amniocentesis, any method</td>
<td>81.91</td>
</tr>
<tr>
<td>59012</td>
<td>Cordocentesis (intrauterine), any method</td>
<td>214.91</td>
</tr>
<tr>
<td>59015</td>
<td>Chorionic villus sampling, any method</td>
<td>118.62</td>
</tr>
<tr>
<td>59020</td>
<td>Fetal contraction stress test</td>
<td>75.81</td>
</tr>
<tr>
<td>59025</td>
<td>Fetal non-stress test</td>
<td>49.54</td>
</tr>
<tr>
<td>59030</td>
<td>Fetal scalp blood sampling</td>
<td>127.02</td>
</tr>
<tr>
<td>59050</td>
<td>Fetal monitoring during labor by consulting physician with written report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(separate procedure); supervision and interpretation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>interpretation only</td>
<td>84.52</td>
</tr>
<tr>
<td></td>
<td></td>
<td>35.38</td>
</tr>
<tr>
<td>59051</td>
<td></td>
<td>68.06</td>
</tr>
<tr>
<td>59100</td>
<td>Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion)</td>
<td>370.40</td>
</tr>
<tr>
<td>59120</td>
<td>Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring</td>
<td></td>
</tr>
<tr>
<td></td>
<td>salpingectomy and/or oophorectomy, abdominal or vaginal approach</td>
<td></td>
</tr>
<tr>
<td>59121</td>
<td>tubal or ovarian, without salpingectomy and/or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>oophorectomy</td>
<td>449.88</td>
</tr>
<tr>
<td>59130</td>
<td>abdominal pregnancy</td>
<td>490.13</td>
</tr>
<tr>
<td>59135</td>
<td>interstitial, uterine pregnancy requiring total hysterectomy</td>
<td>808.39</td>
</tr>
<tr>
<td>59136</td>
<td>interstitial, uterine pregnancy with partial resection of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>uterus</td>
<td>547.10</td>
</tr>
<tr>
<td>59140</td>
<td>cervical, with evacuation</td>
<td>338.62</td>
</tr>
<tr>
<td>59150</td>
<td>Laparoscopic treatment of ectopic pregnancy; without salpingectomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and/or oophorectomy</td>
<td>398.61</td>
</tr>
<tr>
<td>59151</td>
<td>with salpingectomy and/or oophorectomy</td>
<td>553.31</td>
</tr>
<tr>
<td>59160</td>
<td>Curettage, postpartum (separate procedure)</td>
<td>203.33</td>
</tr>
<tr>
<td>59200</td>
<td>Insertion of cervical dilator</td>
<td>48.44</td>
</tr>
</tbody>
</table>

**Introduction**

- Episiotomy or vaginal repair, by other than attending physician: 119.37
- Cerclage or cervix, during pregnancy; vaginal: 156.16
- Abdominal: 244.88
- Hysterorrhaphy of ruptured uterus: 311.26
### Vaginal Delivery, Antepartum and Postpartum Care

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<thead>
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<th>PRICE</th>
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</thead>
<tbody>
<tr>
<td>59400</td>
<td>Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care</td>
<td>1,030.85</td>
</tr>
<tr>
<td>59409</td>
<td>Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care</td>
<td>629.22</td>
</tr>
<tr>
<td>59410</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59412</td>
<td>External cephalic version, with or without tocolysis</td>
<td>107.49</td>
</tr>
<tr>
<td>59414</td>
<td>Delivery of placenta (separate procedure)</td>
<td>101.22</td>
</tr>
<tr>
<td>59425</td>
<td>Antepartum care only; 4 - 6 visits</td>
<td>253.42</td>
</tr>
<tr>
<td>59426</td>
<td>7 or more visits</td>
<td>434.38</td>
</tr>
<tr>
<td>59430</td>
<td>Postpartum care only (separate procedure)</td>
<td>84.26</td>
</tr>
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### Cesarean Delivery

<table>
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</thead>
<tbody>
<tr>
<td>59510</td>
<td>Routine obstetric care including antepartum care, cesarean delivery, and postpartum care</td>
<td>1,478.17</td>
</tr>
<tr>
<td>59514</td>
<td>Cesarean delivery only;</td>
<td>967.55</td>
</tr>
<tr>
<td>59515</td>
<td>including postpartum care</td>
<td>1,040.07</td>
</tr>
<tr>
<td>59525</td>
<td>Subtotal or total hysterectomy after cesarean delivery</td>
<td>447.20</td>
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### Abortion

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>59812</td>
<td>Treatment of incomplete abortion, any trimester, completed surgically</td>
<td>247.69</td>
</tr>
<tr>
<td>59820</td>
<td>Treatment of missed abortion, completed surgically; first trimester</td>
<td>274.32</td>
</tr>
<tr>
<td>59821</td>
<td>second trimester</td>
<td>255.07</td>
</tr>
<tr>
<td>59830</td>
<td>Treatment of septic abortion, completed surgically</td>
<td>371.21</td>
</tr>
<tr>
<td>59840</td>
<td>Induced abortion, by dilation and curettage</td>
<td>226.30</td>
</tr>
<tr>
<td>59841</td>
<td>Induced abortion, by dilation and evacuation</td>
<td>257.15</td>
</tr>
<tr>
<td>59850</td>
<td>Induced abortion, by one or more intra-amniotic injections</td>
<td>344.96</td>
</tr>
<tr>
<td>59851</td>
<td>with dilation and curettage and/or evacuation</td>
<td>360.72</td>
</tr>
<tr>
<td>59852</td>
<td>with hysterotomy (failed intra-amniotic injection)</td>
<td>484.34</td>
</tr>
<tr>
<td>59855</td>
<td>Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria);</td>
<td>217.62</td>
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<tr>
<td>59856</td>
<td>with dilation and curettage and/or evacuation</td>
<td>197.84</td>
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<tr>
<td>59857</td>
<td>with hysterotomy (failed medical evacuation)</td>
<td>329.73</td>
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### Other Procedures

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<th>CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>59870</td>
<td>Uterine evacuation and curettage for hydatidiform mole</td>
<td>256.39</td>
</tr>
<tr>
<td>59899</td>
<td>Unlisted procedure, maternity care and delivery (% of billed after review)</td>
<td></td>
</tr>
</tbody>
</table>
XII. OBRA '89 OB/PEDS COMPLIANCE REPORTS
NEW MEXICO MEDICAID PROGRAM

<table>
<thead>
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<th>CODE</th>
<th>DESCRIPTION</th>
<th>PRICE</th>
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<tbody>
<tr>
<td></td>
<td>Evaluation and Management</td>
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<tr>
<td></td>
<td><strong>Office Or Other Outpatient Services</strong></td>
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</tr>
<tr>
<td></td>
<td><strong>New Patient</strong></td>
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</tr>
<tr>
<td>*99201</td>
<td>Physicians typically spend 10 minutes</td>
<td>25.14</td>
</tr>
<tr>
<td>*99202</td>
<td>Physicians typically spend 20 minutes</td>
<td>40.78</td>
</tr>
<tr>
<td>*99203</td>
<td>Physicians typically spend 30 minutes</td>
<td>54.78</td>
</tr>
<tr>
<td>*99204</td>
<td>Physicians typically spend 45 minutes</td>
<td>80.79</td>
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<tr>
<td>*99205</td>
<td>Physicians typically spend 60 minutes</td>
<td>97.09</td>
</tr>
<tr>
<td></td>
<td><strong>Established Patient</strong></td>
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</tr>
<tr>
<td>*99211</td>
<td>Typically 5 minutes are spent supervising or performing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>these services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*99212</td>
<td>Physicians typically spend 10 minutes</td>
</tr>
<tr>
<td></td>
<td>*99213</td>
<td>Physicians typically spend 15 minutes</td>
</tr>
<tr>
<td></td>
<td>*99214</td>
<td>Physicians typically spend 25 minutes</td>
</tr>
<tr>
<td></td>
<td>*99215</td>
<td>Physicians typically spend 40 minutes</td>
</tr>
<tr>
<td></td>
<td><strong>Office Or Other Outpatient Consultations</strong></td>
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<tr>
<td></td>
<td><strong>New or Established Patient</strong></td>
<td></td>
</tr>
<tr>
<td>*99241</td>
<td>Physicians typically spend 15 minutes</td>
<td>28.43</td>
</tr>
<tr>
<td>*99242</td>
<td>Physicians typically spend 30 minutes</td>
<td>42.03</td>
</tr>
<tr>
<td>*99243</td>
<td>Physicians typically spend 40 minutes</td>
<td>52.51</td>
</tr>
<tr>
<td>*99244</td>
<td>Physicians typically spend 60 minutes</td>
<td>64.12</td>
</tr>
<tr>
<td>*99245</td>
<td>Physicians typically spend 80 minutes</td>
<td>71.24</td>
</tr>
<tr>
<td></td>
<td><strong>Confirmatory Consultations</strong></td>
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<td><strong>New or Established Patient</strong></td>
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</tr>
<tr>
<td>99271</td>
<td>Usually the presenting problem(s) are self limited or</td>
<td>23.98</td>
</tr>
<tr>
<td></td>
<td>minor</td>
<td></td>
</tr>
<tr>
<td>99272</td>
<td>Usually the presenting problem(s) are of low severity</td>
<td>32.01</td>
</tr>
<tr>
<td>99273</td>
<td>Usually the presenting problem(s) are of moderate</td>
<td>50.00</td>
</tr>
<tr>
<td></td>
<td>severity</td>
<td></td>
</tr>
<tr>
<td>99274</td>
<td>Usually the presenting problem(s) are of moderate to</td>
<td>48.00</td>
</tr>
<tr>
<td></td>
<td>high severity</td>
<td></td>
</tr>
<tr>
<td>99275</td>
<td>Usually the presenting problem(s) are of moderate to</td>
<td>69.98</td>
</tr>
<tr>
<td></td>
<td>high severity</td>
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XI. OBRA '89 OB/EDS COMPLIANCE REPORTS
NEW MEXICO MEDICAID PROGRAM

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>PRICE</th>
</tr>
</thead>
</table>

**Home Services**

**New Patient**
- 99341 Usually the presenting problem(s) are of low severity 27.43
- 99342 Usually the presenting problem(s) are of moderate severity 30.49
- 99343 Usually the presenting problem(s) are of high severity 42.84

**Established Patient**
- 99351 Usually the patient is stable, recovering or improving 22.00
- 99352 Usually the patient is responding inadequately to therapy or has developed a minor complication 30.29
- 99353 Usually the patient is unstable or has developed a significant complication or a significant new problem 40.97

**Prolonged Services**

**Prolonged Physician Service with Direct (Face-to-Face) Patient Contact**
- 99354 Prolonged physician service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour 54.34
- 99355 each additional 30 minutes 26.41

**Prolonged Physician Service without Direct (Face-to-Face) Patient Contact**
- 99358 Prolonged evaluation and management service before and/or after direct patient care; first hour Not covered by NM Medicaid
- 99359 each additional 30 minutes Not covered by NM Medicaid

**Preventive Medicine Services**

Codes 99381 - 99384 and 99391 - 99394 carry pricing on file, but are not billed to the Medicaid Program. All well child care is billed under the State assigned EPSDT codes.

- 0037W - EPSDT Screen IHS, with referral (encounter rate) 147.00
- 0039W - EPSDT Screen IHS, without referral (encounter rate) 147.00

EPSDT Screens for non-IHS providers are reimbursed under the following codes at $45.00.
Attachment 4.19-b
Page 14

X. OBRA '89 OBEPEDS COMPLIANCE REPORTS
NEW MEXICO MEDICAID PROGRAM

1997

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
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<tr>
<td>0040W</td>
<td>EPSDT Screen</td>
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<td>0017W</td>
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<tr>
<td>0018W</td>
<td>EPSDT Screen, Outpatient Hospital, without referral</td>
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</tr>
<tr>
<td>0019W</td>
<td>EPSDT Screen, Physician, with referral</td>
<td></td>
</tr>
<tr>
<td>0020W</td>
<td>EPSDT Screen, Physician, without referral</td>
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</tbody>
</table>

Counseling and/or Risk Factor Reduction Intervention

Codes 99401 - 99404, 99411, 99412, 99420 and 99429 represent services which are not covered by the New Mexico Medicaid program.

Newborn Care

99432 Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s) 61.56.

Medicine

Immunization Injections

Vaccines represented by codes 90700, 90702, 90703, 90707, 90712, 90713, 90716, 90720, 90730, 90737, 90744 and 90745 are provided free of charge to practitioners by the Vaccines for Children Program. New Mexico Medicaid reimburses providers $10.00 per administration.

*90701 diphtheria and tetanus toxoid and pertussis vaccine (DTP) 22.26
90704 mumps virus vaccine, live 21.00
90705 measles virus vaccine, live 19.00
90706 rubella virus vaccine, live 20.00
90708 measles and rubella virus vaccine, live 27.00
90709 rubella and mumps virus vaccine, live 28.00
90711 diphtheria, tetanus, and pertussis (DTP) and injectable poliomyelitis vaccine 70% of billed
90710 measles, mumps, rubella, and varicella vaccine 70% of billed
90714 typhoid vaccine 12.00
90717 yellow fever vaccine 9.00
90719 diphtheria toxoid 9.00
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<th>CODE</th>
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<tr>
<td>90721</td>
<td>diphtheria, tetanus toxoid, and acellular pertussis vaccine (DTaP) and Hemophilus influenza B (HIB) vaccine</td>
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<tr>
<td>90724</td>
<td>influenza virus vaccine</td>
<td>7.00</td>
</tr>
<tr>
<td>90725</td>
<td>cholera vaccine</td>
<td>11.03</td>
</tr>
<tr>
<td>90726</td>
<td>rabies vaccine</td>
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</tr>
<tr>
<td>90727</td>
<td>plague vaccine</td>
<td>4.00</td>
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<tr>
<td>90728</td>
<td>BCG vaccine</td>
<td>4.00</td>
</tr>
<tr>
<td>90732</td>
<td>pneumococcal vaccine, polyvalent</td>
<td>14.00</td>
</tr>
<tr>
<td>90733</td>
<td>meningococcal polysaccharide vaccine (any group[s])</td>
<td>14.00</td>
</tr>
<tr>
<td>90741</td>
<td>Immunization, passive; immune serum globulin, human (ISG)</td>
<td>4.00</td>
</tr>
<tr>
<td>90742</td>
<td>specific hyper immune serum globulin (e.g., hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, varicella-zoster)</td>
<td>6.60</td>
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<tr>
<td>90749</td>
<td>unlisted immunization procedure</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Attachment 4.19-B
Page 15

Item XII. Transportation

Transportation providers are reimbursed at the lesser of the following:

a. their usual and customary charge, not to exceed their tariff rates as approved by the state corporation commission; or

b. the Department fee schedule.

The fee schedule base rate for ground ambulance includes reimbursement for the initial fifteen (15) miles of transport, non-reusable supplies, IV solution, emergency drugs and oxygen.

Item XIII. Services for EPSDT Participants

a. Services Included in the State Plan.

Services included in the state plan are described in Attachment 3.1-A. Payment for these services for treating a condition identified during a screen or partial screen is made using the same methodology described in the corresponding section of the state plan.

b. Services Not Otherwise Included in the State Plan

Payment for services described in Attachment 3.1-A, Item 4.b. (EPSDT) and not otherwise covered under the state plan but reimbursed pursuant to OBRA 1983 provisions which require the state to treat a condition identified using a screen or partial screen, whether or not the service is included in the state plan, is made as follows:

1. The following services are considered to be professional services and a reimbursed on a fee for service basis according to the fee schedule in attachment 4.19-B, I.

   (a) Therapy by a speech-language therapist, physical therapist, or occupational therapist, not covered under the state plan.

   (b) Other rehabilitative services and therapy services not covered under the state plan because they are considered maintenance rather than restorative.

   State
   03-24-96
   DATE REC
   05-01-96
   DATE APPVD
   01-01-96
   DATE EFF
   96-02
   HCFA 179
(c) Private duty nursing services, Christian science nurse services, and personal care services.

(d) Services by licensed master’s level practitioners including psychologists, counselors, and social workers, and other individually licensed practitioners.

(e) Chiropractic services.

(f) Orthodontic services and other dental services not otherwise covered in the state plan.

(g) Services provided by school districts and local education agencies. Reimbursement will be at the same rate as other providers of the specific service rendered.

(h) Services provided by Licensed Alcohol and Drug Abuse Counselors (LADACs).

2. Inpatient Institutional Services

Inpatient services provided by JCAHO accredited institutions are reimbursed using the methodology for specialty hospitals according to the reimbursement principles of 4.19-A.

3. Outpatient Institutional Services

Outpatient services provided by JCAHO accredited institutions are reimbursed using the methodology for outpatient hospital according to the reimbursement principles of 4.19-B, III.

4. Rural Health Clinic and Federally Qualified Health Center Services

Services by these providers are reimbursed in accordance with the reimbursement methodology described in 4.19-B, Item VIII.

5. Durable Medical Equipment, Supplies, Prosthetics, and Orthotics

These items are reimbursed in accordance with the reimbursement methodology described in 4.19-B, Item VII.

6. Case Management

Case management services are reimbursed in accordance with the reimbursement methodology described in 4.19-B, Item X.
7. Psychosocial Rehabilitation

Reimbursement methodology for Psychosocial Rehabilitation services is determined by the setting/service. A multidisciplinary team establishes the level of need for each individual based upon acuity. Services provided are dependent upon the acuity level established. In residential settings, reimbursement is a daily rate based upon the acuity level. For non-residential services, the rate may be either hourly or daily, depending upon the service but does not differentiate by acuity level.

For all psychosocial rehabilitation services, provider cost information was analyzed in detail and total cost of service separated into categories associated with that service. To determine the percentage of total cost of service for each category, a range of percentages was derived from costs obtained from each provider and finally a weighted average applied.

Payment for Residential Treatment Centers and Group Homes is based on a resource model that defines the treatment and supervisory needs of the individuals served. This resource model was developed by the state in conjunction with a national consulting firm under contract to the Department. Rate setting decisions were made based upon the results of the consulting firm's reimbursement methodology study presented to the Department in February of 1994. Cost reports will be required from each provider in federal fiscal year 1996 and annually thereafter in order to determine appropriateness of reimbursement rates. The cost reports will be used to adjust provider rates as found necessary beginning in federal fiscal year 1997.

Provider cost information was analyzed in detail and total cost of service was separated into the following ten categories.

(1) Direct Service. These costs include all salaries, wages and benefits associated with personnel who provide daily face-to-face service to residents. Direct service staffing ratios were determined for each level of recipient for various times of day in each setting. The wage rate was based upon a Psychological Technician II classification in the New Mexico State Personnel System.
(2) Direct Supervision. Costs include all salaries, wages and benefits associated with personnel whose primary responsibilities are to oversee and coordinate the activities of the direct service staff and residents. A direct supervision wage rate and span of control was determined using a Psychological Counselor III in the State system.

(3) Therapy costs include all salaries, wages and benefits associated with personnel whose primary activities include providing face-to-face therapy services. This category only includes costs for therapy provided by personnel on the provider agency payroll. An average caseload for therapists was derived and the wage based upon that of a Clinical Social Worker.

(4) Admission/Discharge Planning. These costs include salaries, wages and benefits associated with personnel whose sole function is to serve as a liaison between the residential program and social workers, State agencies and other residential/foster care programs. Personnel performing these activities are paid at the Social Worker Range 21 level.

(5) Clinical support costs include all salaries, wages and benefits associated with personnel whose primary activities serve to support the residential program from a clinical/programmatic perspective as opposed to an administrative perspective. Included are clinical directors, assistant clinical directors, training directors, nurses and persons who perform other types of clinical program support and coordination activities. The wage level used was that of a Psychologist III with varying caseload factors for each level of client.

(6) Education related costs include salaries, wages and benefits for personnel who serve as teachers or teacher's aides in classroom setting for the residents. These costs were then excluded from consideration in the reimbursement rate for non-accredited Residential Treatment Centers and Group Homes.

(7) Non-personnel operating costs include expenses incurred for program related supplies, transportation, and training. These were derived using 8% of total cost for all service types and levels.
(8) Room & Board. This includes rent, depreciation, and utilities related to room and board, plus food, clothing, allowance, etc. Also included are wages, salaries and benefits associated with personnel whose primary activities are to support the room & board of the residents. These costs were then excluded from consideration in the reimbursement rate for Residential Treatment Centers and Group Homes.

(9) General administration costs include non-room and board related depreciation and interest or rent supporting this service, plus salaries, wages and benefits for central office personnel and other non-personnel costs. Also included are medical records, quality assurance and utilization review personnel costs. These are set at 15% of total costs.

(10) Consultation related costs include doctors, specialists and nurses who provide services to a residential program on a part-time "contract" or "consultative" basis. Consultation costs are a percentage of total costs which vary according to the setting and level of care provided to the client. Consultation service costs that are not billed directly to the provider, but rather to the State, are not included.

Payment for Treatment Foster Care and Behavioral Management services was derived from a model based on the resources required to meet the standards of the Department. This model was developed by the state in conjunction with a national consulting firm under contract to the Department. Rate setting decisions were made based upon the results of the consulting firm's reimbursement methodology study presented to the Department in May 1994. Rates do not duplicate costs reimbursed through foster care funds authorized by Title IV-E of the Social Security Act. Periodic rate studies will be performed to determine appropriateness of reimbursement rates. The rate studies will be used to adjust provider rates, as found necessary, beginning in federal fiscal year 1997.

Treatment Foster Care. Provider cost information was analyzed in detail and total cost of service was separated into the following categories.
(1) Family Payment. Reimbursement is made to the TFC agency which employs the families. Parent(s) in the Treatment Family are required to have the experience and training which allows them to participate in the therapy and treatment of the child. The daily reimbursement rate falls within the range of a state level Psychological Technician II.

(2) Room & Board. The amount allowed for this is based upon the rate Children, Youth and Families Department allows for its regular foster parents. These costs were then excluded from consideration in the reimbursement rate for Treatment Foster Care.

(3) Treatment Coordinators. Costs include all salaries, wages and benefits associated with personnel whose primary responsibilities are to oversee and coordinate the activities of the treatment family. A direct supervision wage rate and span of control was determined using a Psychological Counselor III in the State system.

(4) Therapy costs include all salaries, wages and benefits associated with personnel whose primary activities include providing face-to-face therapy services. This category only includes costs for therapy provided by personnel on the provider agency payroll. An average caseload for therapists was derived and the wage based upon a Clinical Social Worker.

(5) Clinical supervision and support costs include all salaries, wages and benefits associated with personnel whose primary activities serve to support the treatment foster care program from a clinical/programmatic perspective as opposed to an administrative perspective. Included are clinical directors, assistant clinical directors, training directors, nurses and persons who perform other types of clinical program support and coordination activities. The wage level used was that of a Psychologist III.

(6) Consultation related costs include doctors, specialists and nurses who provide services to individuals in treatment foster care on a part-time "contract" or "consultative" basis. Consultation costs are a percentage of total costs which vary according to the setting and level of care provided to the client. Consultation service costs that are not billed directly to the provider, but rather to the State, are not included.
(7) Non-personnel operating costs include expenses incurred for program related supplies, training, transportation, and costs related to office space. These were derived using a percentage of total cost.

(8) Administrative support costs include salaries, wages and benefits for agency personnel and other non-personnel costs. Also included are medical records, quality assurance and utilization review personnel costs.

(9) Alternate Care costs are for those days in which the child is placed with a temporary family. This family is required to have the training and experience of the regular Treatment Family and is reimbursed at the same rate.

Behavior Management Services. Providers of this service as well as staff in State agencies were interviewed in order to determine appropriateness of fee for service rates.

(1) Direct Service. These costs include the salary, wage and benefits associated with the Behavior Management Services Specialist who provides fact-to-face services to the individual. It was determined that there would be, on average, thirty billable hours per week. The BMS Specialist salary is comparable to that of a Psychological Technician II in the State system.

(2) Direct supervision costs include salaries, wages and benefits associated with personnel whose primary responsibilities are to oversee and coordinate the activities of the Behavior Management Services specialist staff and recipients. A direct supervision wage rate and span of control was determined using a Psychological Counselor III in the State system.

(3) Non-personnel operating costs include expenses incurred for program related supplies, training, transportation, and costs related to office space. These were derived using a percent of total cost.

(4) General administration costs include salaries, wages and benefits for central office personnel and other non-personnel costs. Also included are medical records, quality assurance and utilization review costs. These are set at a percentage of total costs.
Payment for Day Treatment services was derived from a model based on the resources required to meet the standards of the Department. The model was developed by the state in conjunction with a national consulting firm and applied by the Department of Health to address "Psychosocial Rehabilitation-Integrated Program Model", services similar in terms of activities, providers, and location to Day Treatment. Rate setting decisions were made based upon the results of a methodology study completed by the Department of Health. Periodic rate studies will be performed to determine appropriateness of reimbursement. The rate studies will be used to adjust provider rates, as found necessary, beginning in federal fiscal year 1997.

Day Treatment. Provider cost information was analyzed and total cost of service was separated into the following categories:

(1) Direct Service. These costs include all salaries, wages and benefits associated with personnel who provide daily face-to-face service to the recipient. Direct service staffing ratios were determined. The wage rate was based upon a Vocational Rehabilitation Counselor 2 in the State Personnel system.

(2) Direct Supervision. Costs include all salaries, wages and benefits associated with personnel whose primary responsibilities are to oversee and coordinate the activities of the direct service staff. A span of control was set and a wage rate determined using a Social Worker Supervisor 2 in the State system.

(3) Clinical supervision and support costs include all salaries, wages and benefits associated with personnel whose primary activities serve to support the day treatment program from a programmatic and clinical perspective as opposed to an administrative perspective. Included are clinical directors, assistant clinical directors, training directors, nurses and persons who perform other types of clinical program support and coordination activities. The wage level used was that of a Psychologist III.

(4) Consultation related costs include doctors, specialists and nurses who provide services to a day treatment program on a part-time "contract" or "consultative" basis. Consultation costs are a
percentage of total costs. Consultation service costs that are not billed directly to the provider, but rather to the State are not included.

(5) Non-personnel operating costs include expenses incurred for program related supplies, transportation, and training. These were derived using a percentage of total cost.

(6) General administration costs include salaries, wages and benefits for central office personnel and other non-personnel costs. Also included are medical records, quality assurance and utilization review personnel costs. These are set at 10% of total costs.

8. Special Rehabilitation Services

Development of Fee Schedule:
To establish a fee schedule amount, the Department uses cost studies developed by a consulting firm to determine the average actual costs to providers to perform special rehabilitation services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration.

Using these factors, an amount was determined that was further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to special rehabilitation services with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examines rates being charged by providers who are already rendering services to other agencies and payers; and, (2) evaluates the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee is also verified by comparing the fees to those paid by several other state Medicaid programs for similar services.

Reimbursement for special rehabilitation services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined the rates are in conformance with OMB Circular A-87.

The fee schedule rate is re-evaluated every two years. In all cases, when making changes to the fee schedule, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.
percentage of total costs. Consultation service costs that are not billed
directly to the provider, but rather to the State are not included.

(5) Non-personnel operating costs include expenses incurred for
program related supplies, transportation, and training. These were
derived using a percentage of total cost.

(6) General administration costs include salaries, wages and benefits
for central office personnel and other non-personnel costs. Also included
are medical records, quality assurance and utilization review personnel
costs. These are set at 10% of total costs.

8. Special Rehabilitation Services

Development of Fee Schedule:
To establish a fee schedule amount, the Department uses cost studies developed by a
consulting firm to determine the average actual costs to providers to perform special
rehabilitation services. Allowable costs included salaries plus fringe benefits, costs for
supervision, costs for direct operating expenses, facility related costs, and staff costs for
indirect administration.

Using these factors, an amount was determined that was further evaluated for
reasonableness considering prevailing charges and the existing fee schedule for services
similar to special rehabilitation services with regards to complexity, time, and level of
responsibility. Specifically, the Department (1) examines rates being charged by
providers who are already rendering services to other agencies and payers; and, (2)
evaluates the reasonableness of the rates by comparing the complexity of the task and the
necessary training and experience of staff who carry out the task with payment levels for
comparable tasks. The reasonableness of the fee is also verified by comparing the fees to
those paid by several other state Medicaid programs for similar services.

Reimbursement for special rehabilitation services is consistent with the requirements of
Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for
services must be consistent with efficiency, economy, and quality of care. It was also
determined the rates are in conformance with OMB Circular A-87.

The fee schedule rate is re-evaluated every two years. In all cases, when making
changes to the fee schedule, there is no differentiation between public and private
providers with regards to reimbursement for the same service. The fees are
available in a published fee schedule.
9. Rehabilitative Services – Assertive Community Treatment

Development of Fee Schedule:
To establish a fee schedule amount, the Department uses cost studies to determine the average actual costs to providers to perform Assertive Community Treatment services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. The rates do not include room and board.

Using these factors, an amount is determined that is further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to Assertive Community Treatment services with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examines rates being charged by providers who are already rendering services to other agencies and payers; and, (2) evaluates the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee is also verified by comparing the fees to those paid by other state Medicaid programs for similar services.

Reimbursement for Assertive Community Treatment services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It is also determined the rates are in conformance with OMB Circular A-87.

The fee schedule rate is re-evaluated every two years. The payment rates result in public and private providers receiving the same payment for the same service. The fees are available in a published fee schedule.
REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

For service covered by the OMB rate provided to Native Americans by a qualified facility operated by the Indian Health Service, the applicable rate will be paid as published and specified in the the Federal Register.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item A of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item of this attachment (see 3. above).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **NEW MEXICO**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinurance

QMBs:  

- **Part A**  SP Deductibles  SP Coinurance
- **Part B**  SP Deductibles  SP Coinurance

Other Medicaid Recipients:  

- **Part A**  SP Deductibles  SP coinurance
- **Part B**  SP Deductibles  SP coinurance

Dual Eligible (QMB Plus):  

- **Part A**  SP Deductibles  SP Coinurance
- **Part B**  SP Deductibles  SP Coinurance

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STATE: New Mexico  
DATE REC'D: 7-22-04  
DATE APPVD: 6-22-04  
DATE EFF: 5-1-04  
HCFA 179: 04-03

TN No. **CA-03**  6-22-04  
Supersedes Approval Date  Effective Date 5-1-04  
TN No. **91-19**  HCFA ID: 7982E

**SUPERSEDES: IN- 91-19**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

A. Payment of coinsurance and deductibles for Medicare services not covered by Medicaid will be at the Medicare rate.
Attachment 4.19-C
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF NEW MEXICO

ATTACHMENT 4.19-C  RESERVE BEDS

Six reserve bed days per calendar year will be covered for every long term care resident for hospitalization without prior approval. Three reserve bed days per calendar year will be covered for a brief home visit without prior approval.

Six reserve bed days will be allowed with prior approval for visits which enable the recipient to adjust to a new environment as part of the discharge plan.
Attachment 4.19-D
The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.
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.

I. GENERAL REIMBURSEMENT POLICY:

The Human Services Department will reimburse Nursing Facilities (effective October 1, 1990, the SNF/ICF distinction is eliminated; see section VIII.) the lower of the following, effective July 1, 1984:

A. Billed Charges;

B. The prospective rate as constrained by the ceilings (Section V) established by the Department as described in this plan.

II. DEFINITIONS

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.

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.

Governmental Institution. -- A provider of services owned and operated by a federal, state or local governmental agency.

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.

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.

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 Department shall be the usual and customary rate charged to all patients.

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.

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.

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.

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.

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.

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.

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.

Facility -- The actual physical structure in which services are provided.

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 twenty-five years old and has been in continuous use as a Skilled Nursing or Intermediate Care facility for at least twenty-five years or which facility has been destroyed by catastrophic occurrence and rendered unusable and irreparable, or condemned by eminent domain.

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.

Replaced Facility -- The facility replaced by a replacement facility as defined above.

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).

Imputed Occupancy -- The level of occupancy attributed for the purpose of calculating the reimbursement rate.

Owner -- The entity holding legal title to the facility.
III. 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 90 days after the close of the provider's cost reporting year. Failure to file a report within the 90-day limit,
unless an extension is granted prior to the due date, will result in termination of Title XIX payments. Extensions must be requested in writing from the Medical Assistance Division prior to the due date of the cost report.

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 Department will withhold the last month's payment to the previous provider as security against any outstanding obligations to the Department. The provider must notify the Department 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 not less than four 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 not less than three years following the date of final settlement of such reports.

E. Audits

1. Audits will be performed in accordance with 42 CFR 447.202.

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.

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 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;
   
   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.

a. Operating Costs include such things as:

(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, incontinency care, tray service and enemas.

(6) Items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans.

(7) 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, bandages, laxatives and fecal softeners, aspirin, antacids, OTC ointments, and tongue depressors.

(8) 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, oxygen administration equipment, and other durable equipment.

(9) Special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician.

(10) Laundry services including basic personal laundry.
(11) Oxygen for emergency use -- The Department will allow two options for the purchase of oxygen for patients for whom the attending physician prescribes oxygen administration on a regular or on-going basis:

a) The long term care facility may purchase the oxygen and include it as a reimbursable cost in its cost report. This is the same as the method of reimbursement for oxygen administration equipment; or

b) The Department will make payment directly to the medical equipment provider in accordance with procedures outlined in Medical Assistance Manual Section 310.08, Medical Supplies, and subject to the limitations on rental payments contained in section 310.0805 (B).

(12) Managerial, administrative, professional, and other services related to the providers operation and rendered in connection with patient care.

b. Facility costs, for purpose of specific limitations included in this plan, include only depreciation, lease costs, and long-term interest.

(1) 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.

a) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.

b) Historical cost is the actual cost incurred in acquiring and preparing an asset for use.

c) 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 Department.

d) 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.

e) 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.

(2) 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.

(3) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

c. 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.
d. 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.

e. 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 Medical Assistance Manual Section 307.

6. Any civil monetary penalties levied in connection to intermediate sanctions, licensure, certification, or fraud regulations.

IV. 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 1, Year 2, and Year 3. Because rebasing is done every three years, operating year 4 will again become Year 1, etc.

Cost incurred, reported, audited and/or desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year 1 will be used to re-base the prospective per diem rate. Rebasing of costs in excess of 110% 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 1 (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 report. The rate period January 1, 1996, through June 30, 1996, will be considered Year 1. The rate period July 1, 1996, through June 30, 1997, will be considered Year 2, and the rate period July 1, 1997, through June 30, 1998, will be considered Year 3. The rebasing cycle will resume for rates effective July 1, 1998, and continue as described in the first paragraph of this section.

B. **Inflation factor to recognize economic conditions and trends during the time period covered by the provider's prospective per diem rate.**

The index used to determine the inflation factor will be the Health Care Financing Administration Nursing Home Market Basket Index (NHI).

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 1. For the out of cycle rebasing occurring for rates effective January 1, 1996,
through June 30, 1996, the mid-year point for indexing for operating Year 1 will be 3/31.

The inflation factor for the period July 1, 1996, through June 30, 1997, will be the percentage change in the NHI for the previous year plus 2 percentage points. For each rate period thereafter, the inflation factor will be the change in the NHI for the previous year.

C. Incentives to Reduce Increase in Costs

As an incentive to reduce the increases in the costs of operation, the Department will share with the provider...
in accordance with the formula described below the savings below the operating cost ceiling in effect during the state's fiscal year.

\[ I = \left( \frac{1/2(M - N)}{2} \right) \leq 2.00 \]

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 1**

\[ PR = BYOC \times (1 + NHI) + I + FC \]

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 NHI as described in B above
- \( I \) = Allowable incentive per diem
- \( FC \) = Allowable facility costs per diem

**Years 2 and 3**

\[ PR = (OP + I) \times (1 + NHI) + FC \]

Where
- \( PR \) = Prospective per diem rate
- \( OP \) = Allowable operating costs per diem
- \( I \) = Allowable incentive per diem
- \( NHI \) = The change in the NHI 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

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:

1. The applicable facility cost ceiling.
2. The operating cost ceiling.

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:

1. The lower of allowable facility costs or the applicable facility cost ceiling
2. The lower of allowable operating costs or the operating cost ceiling

Such providers will not be eligible for incentive payments until the next operating Year 1, after rebasing.

G. Changes of provider by sale of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

1. The lower of allowable facility costs determined by using the Medicare principles of reimbursement, or the facility cost ceiling.
2. The operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

Such providers will not be eligible for incentive payments until the next operating Year 1, after rebasing.
H. Changes of provider by lease of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

1. The lower of allowable facility costs or the facility cost ceiling, as defined by this plan.

2. The operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

Such providers will not be eligible for incentive payments until the next operating Year 1, 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.

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

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:

1. The median operating cost for its category.

2. The lower of allowable facility costs or the applicable facility cost ceiling.
Such providers will not be eligible for incentive payments until the next operating year 1, 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 G or H, which ever is applicable, will apply.

2. When a facility has been closed and re-enters the Medicaid program within 12 months of closure under the same ownership, 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 more than 12 months after closure, under the same ownership, the provider's prospective rate will be the sum of:

   a) the median operating cost for its category
   b) the lower of allowable facility costs or the applicable facility cost ceiling.

Providers of such facilities will not be eligible for incentive payments until the next operating year 1, after rebasing.

V. ESTABLISHMENT OF CEILINGS

The following categories are used to establish ceilings used in calculating prospective per diem rates:

1. State-owned and operated NF
2. Non-state-owned and operated NF

The Department determines the status of each provider for exclusion 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 1. For Years 2 and 3, 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 2 beginning July 1, 1985, by NHI minus 1 percentage point and then annually by the NHI.

A. Operating Costs

The ceiling for operating costs will be established at 110% 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 1. 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 which are 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 1 and 2 above.

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 section IV, B, of these regulations.

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 Department the name of the appraiser, a copy of his/her certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the Department.

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 movable 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, 110% 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 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 which are in the same category.

VI. 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 90% occupancy rate. This provision will apply to:

1. Any new facility certified for participation in the Medicaid program on or after January 1, 1988.

2. 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.

3. 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.
4. Any replaced facility which re-enters the Medicaid program on or after January 1, 1988, either under the same ownership or different ownership.

5. Any closed facility which re-enters the Medicaid program on or after January 1, 1988.

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.

VII. ADJUSTMENTS TO BASE YEAR COSTS

Since rebasing of the prospective per diem rate will take place every three years, the Department recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:

A. 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.)

B. Additional costs incurred as a result of uninsurable losses from catastrophic occurrences.

C. Additional costs of approved expansion, remodeling or purchase of equipment.

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 Department 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.
At no time will rebasing in excess of the applicable operating or facility cost ceilings be allowed, unless the Department 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.

VIII. 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.

   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 ICFs, the Low NF rate will be the provider's ICF rate in effect on September 30, 1990.

5. 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 (i.e. the average difference) of the operating component of current SNF/ICF rates.

6. 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 (i.e. the average difference) 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

IX. 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 50% of the regular payment rate.

X. 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
Human Services Department
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 his/her designee, within 5 days after the closing date for final submittals.

H. The Secretary, or his/her designee, may secure all information and call on all expertise he/she believes necessary to decide the issues.

I. The Secretary, or his/her 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 him. 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.

XI. 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.

XII. SEVERABILITY

If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.
## COMPARISON IN CERTIFICATION REQUIREMENTS

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Cost/Effect</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nurse aide continuing education/inservice</td>
<td>$0.11</td>
<td>for continuing education and inservice</td>
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<tr>
<td>2. Supplies</td>
<td>$0.04</td>
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<tr>
<td>3. RN-8hr.*</td>
<td>$0.39</td>
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<tr>
<td>4. 24 hour nursing*</td>
<td>$0.18</td>
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<tr>
<td>5. Physician Involvement*</td>
<td>$0.06</td>
<td></td>
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<tr>
<td>6. Social services and elimination of ICF/SNF distinction*</td>
<td>$0.64</td>
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<tr>
<td>7. Wage adjustment for trained aides</td>
<td>$0.90</td>
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<td>8. Overtime staff costs due to aide training</td>
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<td>9. PASAAR screen</td>
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<td>10. Pharmacy &amp; dietary consulting</td>
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<td>11. Resident rights</td>
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<td>12. Interest bearing accounts/surety bonds</td>
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<tr>
<td>13. Increased aide staffing for restraints and individualized needs</td>
<td>$1.11</td>
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**Supercedes:** TN-94-06
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Cost</th>
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<tbody>
<tr>
<td>14</td>
<td>Increased social services/activities staff for individual resident needs</td>
<td>$0.72</td>
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<tr>
<td>15</td>
<td>Resident assessment</td>
<td>$0.31</td>
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</table>

**TOTAL COST PER PATIENT DAY** $4.96

- Increases do not apply to existing SNFs as these requirements already built into SNF cost report.
SUPERSEDES: TN - 9.25-96

6.11 ASSUME A STANDARDS OF 24 HOURS OF IN-SERVICE TRAINING PER AIDE

This category has two components: (1) the cost of maintaining
staffing level while ade are receiving in-service training and the
cost of the in-service instruction. The first component is calculated
as follows: additional costs of providing in-service training to aides
not at the 24 hour level divided by the number of patient days
in those facilities. 107/254 = 0.42 (the cost for the in-service
instructor is based on the salary level of an aide as in the
number of hours needed to achieve the standards divided by the number
of patient days in the affected facility. 107/254 = 0.42)

6.04 THIS COST IS BASED ON THE PROVISION OF INSERVICE INSTRUCTORS AT AN AVERAGE COST OF
$20.00, FREQUENTLY AT AN AVERAGE COST OF $20.00 PER FACILITY AND STUDENT
STUDENT INSTRUCTORS AT AN AVERAGE COST OF $20.00 PER FACILITY. INCIDENTAL COSTS SUCH AS
PAPER, PENS, ETC. ARE ALSO INCLUDED. A TEACHER RATE IS CALCULATED FOR EACH
FACILITY USING TOTAL U-25 TIMES CURRENT AIDE LEVEL. 107/254 = 0.42
THE DIVIDER IS EQUAL TO RELEVANT PATIENT DAYS.
PHARMACY & DISCOUNT
CONSULTANT

RESIDENT RIGHTS
REQUIREMENTS

INTEREST BEARING ACCOUNTS
SUCURITY DEPOSITS

ACTIVITIES/SOCIAL SERVICES
INCREASED STAFF FOR INDIVIDUALIZED SERVICES

INCREASED AIDE STAFFING FOR INDIVIDUALIZED SERVICES

TOTAL LTC '07 LTC COST
PEF PATIENT DAY

NOTE:


SUPERSEDES: TN 94-06
COST RELATED REIMBURSEMENT OF ICF/MR FACILITIES

The New Mexico Title XIX Program makes reimbursement for appropriately licensed and certified Intermediate Care Facilities for the Mentally Retarded as outlined in this material.

I. GENERAL REIMBURSEMENT POLICY

The Human Services Department will reimburse ICF/MR facilities the lower of the following, effective for services rendered on or after September 1, 1990:

A. Billed charges;

B. The prospective per diem rate as constrained by the ceilings (Section V) established by the Department as described in this plan.

II. DEFINITIONS

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.

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.

Governmental Institution — A provider of services owned and operated by a federal, state or local governmental agency.

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.
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. If amounts are received from the Federal Government to finance hospital activities or service operations that are covered by the Medicaid program, then these amounts must be treated as applicable credits.

Charges --The regular rates established by the provider for services rendered to both Medicaid recipients and to other paying patients whether inpatient or outpatient. The rate billed to the Department shall be the usual and customary rate charged to all patients.

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.

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.

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 center are allocated to other cost centers on the basis of services rendered.

Special Service Cost Centers --Commonly referred to as Ancillary Cost Center. Such centers usually provide direct identifiable services to individual patients, and include departments such as the physical therapy and supply departments.
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.

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 recipient charges to total charges on a departmental basis.
2. ratio of recipient 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.

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.

Facility --The actual physical structure in which services are provided.

Owner --The entity holding legal title to the facility.

III. DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS

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 ICF/MR 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 cost 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 ICF/MR 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 90 days after the close of the provider's cost reporting year. Failure to file a report within the 90 day limit, unless an extension is granted prior to the due date, will result in suspension of Title XIX payments. Extensions must be requested in writing from the Medical Assistance Division prior to the due date of the cost report.

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 Department will withhold the last month's payment to the previous provider as security against any outstanding obligations to the Department. The provider must notify the Department 60 days prior to any change of ownership.
D. Retention of Records

1. Each ICF/MR provider shall maintain financial and statistical records of the period covered by such cost report for a period of not less than four years following the date of submittal of the N.M. 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 not less than three years following the date of final settlement of such report.

E. Audits

Audits will be performed in accordance with 42 CFR 447.202.

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.

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 HHS no later than 60 days following the discovery.

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;
   d. Cost incurred to meet requirements for licensing under state law which are necessary to provide ICF/MR 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.
   a. Operating costs include such things as:
      (1) Regular room
      (2) Dietary and nursing services
      (3) Medical and surgical supplies (including but not limited to
syringes, catheters, ileostomy, and colostomy supplies).

(4) Use of equipment and facilities

(5) General services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas.

(6) Items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans.

(7) 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, OTC ointments, and tongue depressors.

(8) 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, oxygen administration equipment, and other durable equipment.

(9) Special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician.

(10) Laundry services other than for personal clothing.

(11) Oxygen for emergency use--The Department will allow two options for the purchase of oxygen for patients for whom the attending physician prescribes oxygen administration on a regular or on-going basis:
a) The provider may purchase the oxygen and include it as a reimbursable cost in its cost report. This is the same as the method of reimbursement for oxygen administration equipment; or

b) The Department will make payment directly to the medical equipment provider in accordance with procedures outlined in Medical Assistance Manual Section 310.08, Medical Supplies, and subject to the limitations on rental payments contained in that section.

(12) All services delivered in relation to active treatment, such as physical therapy, occupational therapy, speech therapy, psychology services, recreational therapy, etc.

(13) Managerial, administrative, professional and other services related to the providers operation and rendered in connection with patient care.

b. Facility cost, for the purpose of specific limitations included in this plan, include only depreciation, lease costs, and long term interest.

(1) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated life of the assets.

a) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.

b) Historical cost is the actual
cost incurred in acquiring and preparing an asset for use.

c) 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 Department.

d) In determining the historical cost of assets where an on-going facility is purchased, the provisions of Medicare Provider Reimbursement Manual (HIM-15) will apply.

e) 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.

(2) 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.

(3) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.
c. Gains and Losses on Disposition

Gains or losses on the disposition of depreciable assets used in the program are calculated in accordance with the 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.

d. Depreciation, interest, lease cost, or other costs are subject to limitations stated in the HIM-15.

e. 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 Medical Assistance Manual Section 307.

6. Any civil monetary penalties levied in connection with licensure, certification, or fraud regulations.

IV. 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 any applicable ceiling:

A. Base Year

For implementation Year 1 (effective September 1, 1990), the providers base year will be for cost reports filed for base year periods ending no later than June 30, 1990. Since these cost reports will not be audited at the time of implementation, an interim rate will be calculated and once the audited cost report is settled, a final prospective rate will be determined. Retrospective settlements of over or under payments resulting from the use of the interim rate will be made.

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 1, Year 2, and Year 3. Since rebasing is done every three years, operating year 4 will again become Year 1, etc.

Costs incurred, reported, audited and/or desk reviewed for the provider's last fiscal year which ends in the calendar year prior to year 1 will be used to re-base the prospective per diem rate. Rebasing costs in excess of 110% of the previous year's reported cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.
B. Inflation factor to recognize economic conditions and trends during the time period covered by the facility's prospective per diem rate.

The index used to determine the inflation factor will be the Health Care Financing Administration Nursing Home Market Basket Index (MBI)- Without Capital and Medical Fees.

Each provider's operating costs will be indexed to a mid-year point of February 28 for operating Year 1.

The inflation factor will be the percentage change in the most current available actual or forecast MBI for the previous calendar year.

C. Incentive to Reduce Increases in Cost

As an incentive to reduce the increases in the Administrative and General (A&G) and Room and Board (R&B) cost center, the Department will share with the provider the savings below the A&G/R&B ceiling in accordance with the formula described below:

\[ A = \frac{1}{2} (B - C) \leq 1.00 \]

Where:
- \( A \) = Allowable Incentive per diem
- \( B \) = A&G/R&B ceiling per diem
- \( C \) = Allowable A&G/R&B per diem from the base year's cost report

D. Cost Centers for Rate Calculation

For the purpose of rate calculation, costs will be grouped into four major cost centers. These are:

1. Direct Patient Care (DPC)
2. Administration and General (A&G)
3. Room and Board (R&B)
4. Facility costs (FC)
E. Case-Mix Adjustment

In assuring the prospective reimbursement system addresses the needs of residents of ICF/MR facilities, a case-mix adjustment factor will be incorporated into the reimbursement system. The case-mix index will be used to adjust the reimbursement levels in the Direct Patient Care cost center. The key objective of the case-mix adjustment is to link reimbursement to the acuity level of residents in a facility. To accomplish this objective, the Department utilizes level of care criteria which classify ICF/MR residents into one of three levels, with Level I representing the highest level of need. Corresponding to each level of care, the relative values are as follows:

<table>
<thead>
<tr>
<th>Level</th>
<th>Relative Value</th>
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<tbody>
<tr>
<td>Level I</td>
<td>1.077</td>
</tr>
<tr>
<td>Level II</td>
<td>0.953</td>
</tr>
<tr>
<td>Level III</td>
<td>0.768</td>
</tr>
</tbody>
</table>

Using these level specific relative values, a provider specific base year case-mix index (CMI) will be derived. The CMI represents the weighted average of the residents' level of care divided by the total number of residents in the facility. The CMI is calculated as follows:

\[
\frac{[(A \times 1.077) + (B \times 0.953) + (C \times 0.768)]}{N} = \text{CMI}
\]

WHERE:  
A = Number of Level I residents  
B = Number of Level II residents  
C = Number of Level III residents  
N = Total number of provider's residents

F. Calculation of the Prospective Per Diem Rate

A prospective per diem rate for each of the three levels of ICF/MR classification will be determined for each provider. Payment will be made based on the rate for the level of classification of the recipient.

The provider's Direct Patient Care (DPC) allowable cost per diem will be divided by the provider's case-mix index to determine the cost at a value of 1.00 for the base year. The adjusted DPC is then multiplied by the relative value of the level of
classification to determine the DPC component of the rate. To this, will be added the allowable cost per diem A & G and R & B amount (as constrained by the ceiling described in Section V.,B.) and the allowable facility cost per diem. The formula for the rates will be as follows:

The formula for Year 1 is:

\[(A_1 \times RV) + C_1 + D + E = PR \text{ (Year 1)}\]

The formula for Year 2 is:

\[[(A_1 \times RV) + C_1] \times (1 + MBI)] + D + E = PR \text{ (Year 2)}\]

The formula for Year 3 is:

\[[(A_2 \times RV) + C_2] \times (1 + MBI)] + D + E = PR \text{ (Year 3)}\]

Where:

- **A** = Allowable DPC per diem adjusted to a value of 1.00
- **B** = The relative value of the level of classification.
- **C** = Allowable A&G and R&B per diem
- **D** = Allowable incentive per diem
- **E** = Allowable facility cost per diem
- **MBI** = Market Basket Index
- **PR** = Prospective rate
- **RV** = the relative value for the level

"1" = The numerical subscript means the date of the data used in the formula. For example, "A1" means the base direct patient care costs established in the base year, while "A2" would refer to the base direct patient care costs adjusted by the MBI.

Each provider will have three prospective rates, one for each of the three levels of care (I, II, and III.)

G. Effective dates of prospective rates

Rates will be effective September 1 of each year for each facility. In addition, the case mix index for
each facility will be reviewed at the mid point of each year. At that time, the rate will be readjusted to reflect the current case mix index.

H. Calculation of rates for existing providers that do not have actuals as of June 30, 1990, and for new providers entering the program after September 1, 1990

For existing and for new providers entering the program that do not have actuals, the provider's interim prospective per diem rate will become the sum of:

1. The state wide average patient care cost per diem for each level plus;
2. The A&G and R&B ceiling (as described in Section V.B.) per diem plus;
3. Facility cost per diem as determined by using the Medicare principles of reimbursement.

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 cost report must be submitted no later than 90 days after the completion of the six month period or the fiscal year end, whichever comes later. This will be audited to determine the actual allowable and reasonable cost for the provider. A final prospective rate will be established at that time, and retroactive settlement will take place.

I. Changes of provider by sale of an existing facility

When a change of ownership occurs, the provider's prospective rate per diem will become the sum of:

1. The patient care cost per diem for each level, established for the previous owner plus;
2. The A&G and R&B per diem established for the previous owner; plus
3. Allowable facility costs determined by using the Medicare principles of reimbursement.
J. Changes of ownership by lease of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

1. The patient care cost per diem for each level established for the previous owner; plus

2. The A&G and R&B per diem established for the previous owner; plus

3. The lower of allowable facility cost or the ceiling on lease cost as described by this plan.

K. Sale/Leaseback of and exiting facility

When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

V. ESTABLISHMENT OF CEILINGS

Ceilings on the four major cost centers will be established as follow:

A. Direct Patient Care

No ceiling will be imposed on this cost center.

B. A&G and R&B

The per diem costs for administration and general and for room and board will be grouped together for the establishment of a ceiling. This ceiling will be calculated at 110% of the median of allowable costs for the base year, indexed (using the index described in Section IV.B.) to 12/31 of the base year. The ceiling will then be indexed (using the index described in Section IV.B.) to the mid-point of year 1 and set. For years 2 and 3, the ceiling will not be recalculated, but rather will be indexed forward using the appropriate inflation factor described earlier in these regulations.

C. Facility Cost

No ceiling will be imposed on this cost center, except in relation to leases.
Effective for leases executed and binding on both parties on or after September 1, 1990, 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 and annual rate of return on the fair market value of the facility equal to one times 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 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 Section IV, B of these regulations.

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 geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the Department the name of the appraiser, a copy of his/her certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the Department.

VI. ADJUSTMENTS TO BASE YEAR COSTS

Since rebasing of the prospective per diem rate will take place every three years, the Department recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:
A. Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g., minimum staffing requirements, minimum wage change, property tax increases, etc.)

B. Additional costs incurred as a result of uninsurable losses from catastrophic occurrences.

C. Additional costs of approved expansion, remodeling or purchase of equipment.

Such additional costs must reach minimum of $5,000 for facilities with 16 or more beds and $1000 for facilities with 15 or less beds, of 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 Department 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 receipt of the request if retroactive approval was obtained. At no time will rebasing in excess of any applicable ceilings be allowed.

VII. RESERVE BED DAYS

Reserve bed days will be paid using the provider's Level III rate.

VIII. RECONSIDERATION PROCEDURES FOR BASE YEAR DETERMINATIONS

A. A provider who is dissatisfied with the base year rate determination or the final settlement (in the case of a change of ownership) may request a reconsideration of the determination by addressing a Request for Reconsideration to:

Director
Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504
Attachment 4.19-E
State Plan for Medical Assistance
Under Title XIX SSA
New Mexico

Attachment 4.19E

Definition of timely payment requirement for the State of New Mexico

The New Mexico State Plan will define a claim as all services for one recipient within a bill.
18 Dental: Dental claim form, dental services
19 EPSDT: EPSDT claim form, EPSDT screening services
20 Long Term Care: Turnaround document for long term care
21 (not assigned)
22 Institutional Cross Over: institutional cross over coinsurance and deductible
23 Professional Cross Over: professional cross over coinsurance and deductible
24 System Generated Claim: a system generated payment, primary care network administrative fee
SUPPLEMENT TO ATTACHMENT 4.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE COVERAGE, ELIGIBILITY AND CLAIMS DATA

1902(A)(25)(l) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(l) of the Social Security Act.

TN No. 08-06 Approval Date 9-2-08 Effective Date 7-1-08

SUPERSEDES: NONE - NEW PAGE
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE COVERAGE, ELIGIBILITY AND CLAIMS DATA

1902(A)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.
Attachment 4.22-A
This attachment specifies guidelines which the Department applies in determining whether to seek reimbursement from liable third parties.

For cases in which a third party has already been identified, all claims pertinent to the type of coverage will be routinely returned to the provider for filing with the third party. For cases in which a liable third party is newly identified, the Human Services Department will not seek reimbursement for claims already filed with the Department when the amount to be recovered from the third party would be less than $50. The Department has determined that recovery of payments made for less than this amount would not be cost effective because of the staff time, reproducing and mail costs involved. If, after a claim has been paid, the Department learns of the existence of a liable third party, it will seek reimbursement from the third party within 30 days after the end of the month in which it learned of the existence of the liable third party. Claims accumulated for a particular provider up to this point will be applied in establishing whether such collection is cost effective.

In cases of potential liability, such as an accident or work-related injury, the Human Services Department may choose not to pursue tort liability when the amount to be recovered would be less than $200.

For claims in which a liable third party has been identified, the Department will pay the amount remaining, under the Title XIX payment schedule, after the amount of the third party's liability has been established. Payment will not be withheld if third party liability or the amount of liability cannot be currently established or is not currently available. For claims involving tort liability, the Department will pay the full amount allowed under the Title XIX payment schedule and seek reimbursement from any liable third party to the limit of legal liability.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

Requirements for Third Party Liability
Identifying Liable Resources

This attachment describes the measures taken by the New Mexico Human Services Department to determine the liability of third parties to pay for all or part of the cost of services furnished under the New Mexico Medicaid state plan.

1. Obtaining Health Insurance Information

A. Medicaid eligibility for all individuals other than those individuals eligible for the Supplemental Security Income Program, Foster Care and Adoptions is determined by the New Mexico Human Services Income Support Division (IV-A Agency)

At the time of application and at each redetermination of eligibility for AFDC or any other program that would include Medicaid eligibility, the eligibility worker obtains information from the applicant or recipient as to whether he/she has other health insurance or is covered by a health insurance policy owned by someone else.

(2) If the applicant/recipient is covered by another health insurance policy the eligibility worker obtains:

(a) name and address of insurance company,

(b) name, social security number, and dates of birth of covered recipients,

(c) type of coverage,

(d) the policy number and/or group number,

(e) name and address of policy holder's employer,

(f) policy holder's name and social security number,

(g) dates of coverage.

TN No. ______ Supersedes ______ Approval Date ______ Effective Date ______

TN No. ______

HCFA ID: 1076P/0019P
B. Medicaid eligibility because of eligibility for SSI is determined by the Social Security District Offices.

(1) The New Mexico Human Services Department has an agreement with the Social Security Administration to determine whether the applicant/recipient has other health insurance at the time of initial application or redetermination.

(2) If other insurance exists the Social Security office obtains the:

(a) name and address of the insurance company,
(b) policy holder's name and Social Security number,
(c) policy numbers and/or group numbers.

(3) The agreement with SSA also includes a provision for SSA to obtain the appropriate assignment of medical support rights and payments.

C. Transmittal of Information

(1) For AFDC and all other Medicaid categories other than SSI, the other insurance information is transmitted to the Medicaid TPL unit VIA computer.

(2) TPL information form Social Security District Offices os transmitted to the Medicaid TPL Unit via form SSA-8019U2 through the U.S. Mail Service.

(3) If the SSN of an absent parent is available at the time of application for AFDC the name and SSN of the absent parent is maintained in the state's ISD2 eligibility system and can be readily accessed by the Medicaid TPLU. The names and SSN's of absent parents that are maintained in the Child Support Enforcement Data System (COLTS) are available to the MAD-TPLU and if the case has been investigated by the IV-D agency, the information can be utilized to identify whether or not the absent parent is employed and if so, the name and address of the employer can also be obtained.
(4) Names and SSN's of custodial parents are maintained in the ISD-2 system or in the Social Services ADAPT system. The Social Services "ADAPT" system includes only the names of the parents of children eligible for Medicaid benefits by virtue of placement in a foster home and having met AFDC income and resource standards. At such time as Social Security number for both absent and custodial parents are obtained, these numbers will be available to the Third Party Liability Unit of the Medical Assistance Division.

D. Use of Data by Medicaid Agency

(1) When information is received by the Title XIX TPL Unit either via computer system or mail, the following takes place,

(a) information verified
(b) action taken to include other insurance information in files of Medicaid fiscal agent (name and address of insurance company, policy holder's name and social security number, coverage codes, dates of coverage, policy numbers),
(c) updates to the fiscal agent's files will be accomplished within 60 days of receipt of the information.

(2) After fiscal agent incorporates information into their files all claims for payment of medical services are passed against these files,

(a) if a claim comes in for a recipient who's file indicates other insurance coverage, the following occurs:

(1) system compares date of service to coverage date,

(2) checks type of service to coverage,

(3) if date of service is within coverage dates and service is included in the insurance coverage, the claim is denied and a facsimile claim is produced that
includes all of the information that was on the original claim plus the name and address of the etc. This claim is returned to the provider and can then be filed by the provider of service with the appropriate insurance company for payment. The amount that would have been paid by medicaid is then stored for future retrieval as a cost avoidance.

2. Exchange of Data

A. State wage information collection agency (SWICA)

(1) The Data Exchange with the State Labor Department (SWICA) is carried out by way of the HSD eligibility computer system ISD-2 having direct access to the data included in the State Labor Department's computer files.

(a) at the time of application or redetermination for any program that carries Medicaid eligibility other than SSI, Foster Care or Adoptions, the parents, (either absent or custodial) SSN's are passed against the Labor Department files. If a match occurs, the information is utilized in the eligibility determination and included in the case and system file for future use by both the IV-A agency and the Medical Assistance Division TPL Unit. A positive match would require the eligibility worker to again inquire about the existence of a health insurance policy.

(b) the MAD-TPLU will perform a data match of Medicaid eligibles and absent parents of Medicaid eligible children with the state WDX information on a quarterly basis. A positive match will result in a follow-up to the employer to determine if health insurance exists, if children are covered and the source and amount of the coverage. If coverage is found to exist, the TPL data is input into the Medicaid fiscal agents eligibility files within
60 days to accomplish cost avoidance.

B. State Workers Compensation

(1) The new Mexico Medical Assistance Division has attempted to secure an agreement with the New Mexico Workers Compensation Commission to match Medicaid Eligibility files (name and SSN) with theirs to identify potential medical resources resulting from employment related accidents. Because the workers compensation agency does not have the resources to perform the data matches, they agreed to provide information to the Department so the Department could perform the matches. The Department is currently exploring ways to perform these matches.

(2) These data matches would take place at least two times a year.

(3) A positive match would result in the MAD/TPL Unit forwarding an inquiry to the recipient to determine the nature of the injury, the dates, employer, attorney, insurance company, and other related information that could be used to identify funds that could be recouped or cost avoided.

(4) All communications will be maintained to document failure to reach agreement.

C. State Motor Vehicle Accident Report Files

(1) The New Mexico Medical Assistance Division TPL Unit will attempt to secure an agreement with the New Mexico Highway and Transportation Department to match the New Mexico Medicaid eligibility file (including all individuals either currently eligible or those that were eligible within the last year) against their files of individuals that were involved in accidents.

(2) The agreement would provide for carrying out data matches twice a year.

 TN No. ______  Approval Date ______  Effective Date ______

 TN No. ______  HCPA ID: 1076P/0019P
(3) A positive match would result in the MAD/TPL Unit following up with an inquiry to obtain the specifics of the accident, (date, other parties, insurance coverage who caused accident, attorneys involved, etc). This information would then be used to determine if funds could be recouped.

(4) All correspondence and communication will be maintained to document failure to reach an agreement.

D. Data Exchange with Private Insurance Carriers

(1) The New Mexico Medical Assistance Division TPL Unit will attempt to secure agreements with the larger insurance carriers to perform computer matches of states Medicaid eligibility files with their subscriber files.

(2) All communication and correspondence will be maintained.

E. MAD TPL Unit on yearly basis Accomplishes a Data Exchange with CHAMPUS

3. Diagnosis and Trauma Code Edits

A. The New Mexico Medicaid program currently subjects all claims with a dollar amount over $100 to an edit that compares the diagnosis and procedure codes on the claim with identified trauma diagnoses and procedure codes (ICD-9-CM codes 800 thru 999 and selected procedure codes).

B. A positive hit from this edit results in the production and forwarding of an inquiry letter to the recipient identified on the claim to ascertain the specifics of the accident.

(1) dates, names, insurance
(2) who was at fault
(3) type of accident, attorneys involved
(4) other party insurance.
C. Failure to respond to the inquiry within 30 days results in a follow-up inquiry. Failure to respond after 90 days results in termination of Medicaid benefits.

D. This edit is on-going in the claims processing system and inquiry letters are produced and mailed once a month.

E. MAD/TPL Unit will work with Medicaid fiscal agent to identify those codes that yield the highest third party collection.

4. Frequency of Data Exchange and Trauma Code Edits

A. The comparing of AFDC, etc., applicants SSN against the SWICA (State Labor Department) file occurs at the time the applicant applies for assistance (a positive match of this information results in the caseworker making further inquiry as to the existence of other insurance. The existence of other health insurance is then reported via the ISD-2 system to the MAD/TPL Unit.

B. Other data exchange programs, such as Highway and Transportation Department, Workers Comp, and private insurance will take place at least two times a year, but not more often than every quarter.

5. Follow-ups Procedures for Identifying Legally Liable Third Party Resources

A. The MAD/TPL Unit immediately verifies information received concerning the existence of potential third party resources.

(1) Follow-ups on positive hits from Workers Comp or Highway and Transportation Department files would occur in the form of an inquiry letter within 2 weeks of receipt of information.

(2) If inquiry results in the identification of a resource action is taken to prepare a file for interim follow-up (tort) or update fiscal agent files with appropriate information for cost avoidance.
(3) If a positive match occurs in the data exchange with private insurance carriers, action is taken within 10 working days to verify the insurance coverage and update the Medicaid fiscal agent files.

B. Inquiry letters that are generated as a result of a positive hit in the trauma code edit are mailed once a month. Follow-up inquiries are mailed every 30 days thereafter. Inquiry letters that are returned that indicate potential tort liability result in the creation of a case file and the forwarding of communication to attorney and/or insurance company of the state's subrogation right. Recipient histories are ordered to determine the amount paid by the Medicaid program as a result of the accident. Information in the recipient history is shared with the attorney involved if a proper release of medical information is executed by the recipient. Subsequent follow-ups are directed to the involved parties as required.

6. Safeguarding Information

A. All information received by the MAD/TPL Unit is held in strict confidence.

B. Provisions for confidentiality are included in all data exchange agreements.

C. Specific information is not divulged unless a properly executed release is provided.

Use of TPL Information

A. If information received and verified indicates the existence of a health insurance policy, specific information is incorporated into the Medicaid fiscal agents files to prevent the payment of a claim that could be paid by the other insurance except as follows:

(1) prenatal or preventative services
(2) services provided to an individual on whose behalf child support enforcement is being carried out by the title IV-D agency and communicated to the Medicaid agency.
B. If information received reveals potential tort liability, files are prepared and maintained, attorneys and insurance companies are informed of subrogation rights and communication maintained until case is settled.

8. Cooperative Agreements with Other Agencies

A. The New Mexico MAD/TPL Unit is in the process of entering into agreements with the New Mexico Income Support Division to carry out the required TPL activities related to obtaining TPL information and Child Support Enforcement.

B. The New Mexico MAD/TPL Unit is in the process of preparing and entering into an agreement with the Social Services Division to obtain TPL information and assignments of medical Support and payment rights for individuals that are eligible for Medicaid by virtue of foster care or adoptions.

9. Reports

A. In addition to reports routinely produced to document TPL activities, the Medical Assistance Division will produce reports that the Secretary deems necessary to determine compliance with the regulation.
Attachment 4.22-B
1. THE NEW MEXICO MEDICAID PROGRAM WILL "PAY & CHASE" IN SITUATIONS AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (42 U.S.C. 1396a(a)(25))

A. Claims for prenatal or preventive pediatric care (including early and periodic screening and diagnosis & treatment services), based on diagnosis codes provided by HCFA.

(1) Inpatient and outpatient hospital claims and pharmacy claims are excluded from this provision and will continue to be "cost avoided".

Services provided to individuals on whose behalf Child Support Enforcement is being carried out by the N.M. IV-D agency, if payment for these services is not made by the third party within 30 days after the services are furnished;

(1) Failure of the third party to pay for the services within 30 days must be certified in writing with each claim submitted by the provider seeking Medicaid payment.

(2) The provider must certify in writing with each claim submitted that if payment for the services being billed to Medicaid are subsequently paid by the third party, the lower of the third party payment or the Medicaid payment will be immediately refunded to the New Mexico Human Services Department.

2. METHOD USED BY THE NEW MEXICO MEDICAID PROGRAM TO DETERMINE PROVIDER COMPLIANCE WITH THE THIRD PARTY BILLING REQUIREMENTS

A. Individuals on whose behalf medical support is being enforced by Child Support Enforcement are identified to the Medicaid fiscal agent.

B. Based on information referred to in 2.A., the Medicaid fiscal agent adds a child support indicator in the recipients eligibility file. Claims filed are edited against the eligibility file. The presence of the child support indicator causes the claims to suspend for manual review for the following:

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TN No. _____
Supersedes _____
Approval Date ________
Effective Date ________
*TN No. _____
HCFA ID: 1076P/0019P
(1) Is the certification form attached to the claim? If not, the claim is denied (cost avoided).

(2) If certification form is attached it is checked to see if the 30 day requirement has been met.

(3) If the 30 day requirement has been met and the certification is otherwise in order the claim is paid. A facsimile claim is produced for the Medicaid program to use in billing the recipients Health Insurance carrier.

3. THRESHOLDS

A. For cases in which a third party has already been identified, all claims pertinent to the type of coverage will be routinely returned to the provider for filing with the third party. For cases in which a liable third party is newly identified, the Human Services Department will not seek reimbursement for claims already filed with the Department when the amount to be recovered from the third party would be less than $50. The Department has determined that recovery of payments made for less than this amount would not be cost effective because of the staff time, reproducing and mail costs involved. If, after a claim has been paid, the Department learns of the existence of a liable third party, it will seek reimbursement from the third party within 30 days after the end of the month in which it learned of the existence of the liable third party. Claims accumulated for a particular provider up to this point will be applied in establishing whether such collection is cost effective. Pursuant to section 3904.5 of the State Medicaid Manual, thresholds under $100 do not require justification.

B. In cases of potential liability, such as an accident or work-related injury, the Human Services Department may choose not to pursue tort liability when the amount to be recovered would be less than $200. Pursuant to section 3904.5 of the State Medicaid Manual, thresholds under $250 do not require justification.
C. For claims in which a liable third party has been identified, the Department will pay the amount remaining, under the Title XIX payment schedule, after the amount of the third party's liability has been established. Payment will not be withheld if third party liability or the amount of liability, the Department will pay the full amount allowed under the Title XIX payment schedule and seek reimbursement from any liable third party to limit of legal liability. In personal injury cases where liability has been established, claims related to the injury will be cost-avoided.

4. ASSURANCE THAT MEDICAID PROVIDERS FOLLOW RESTRICTIONS SPECIFIED IN 42 CFR 447.20

A. Sanction of providers who seek payment from Medicaid recipients for balances due after payment from an insurance company when the insurance payment was at least equal to what Medicaid would have paid for the same service.

(1) Upon determination by the Director of the Medical Assistance Division that a provider has sought payment for a service from a Medicaid recipient after receiving payment for that service from that recipient's health insurance company or other third party in an amount at least equal to the amount that Medicaid would have allowed for that same service, an amount equal to three times the amount sought from the recipient will be deducted from the provider's next Medicaid payment. This provision is included in Section 1902 of the Social Security Act (42 U.S.C. 1396a).

B. Providers refusing to furnish services covered under the plan on account of a third party's potential liability for the service(s) are subject to termination of their provider agreement.

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Supersedes Approval Date Effective Date
TN No. 1076P/0019P
Attachment 4.22-C
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

The New Mexico Medicaid Agency receives information from the Wage Data Exchange tape and the Unemployment Compensation Benefit tape from the State Employment Security Department.

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other states. The information that is requested will be exchanged with states and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

SUPERSEDES: TN-86-11

STATE New Mexico
DATE REC'D. 8-9-10
DATE APP'ED. 9-27-10
DATE EFF. 7-1-10
HCFA 179 10-10

TN No. 10-10
Approval Date 9-27-10
Effective Date 7-1-10

Supersedes
TN No. 86-11

HCFA ID: 0123P/0002P
Attachment 4.30
Sanctions for MCOs and PCCMs

(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:

(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

(c) The State’s contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.
Attachment 4.32-A
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

The New Mexico Medicaid Agency receives information from the Wage Data Exchange tape and the Unemployment Compensation Benefit tape from the State Employment Security Department.

APPROVED BY DHHS/HCFA/DPO:
DATE: 12-5-86
TRANSMITTAL NO: 86-11

TN No. 86-11
Supersedes
TN No. [Redacted]

Approval Date 12-5-86
Effective Date 07-30-86

HCFA ID: 0123P/0002P
Attachment 4.33-A
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

The Department makes every effort to assure that eligible homeless individuals receive their cards. Arrangements are made on a case by case basis, and would include arrangements such as sending the card to the home of a friend, relative, or public or private shelter.

STATE: NM
DATE REC'D: 7-2-87
DATE APP'V'D: 8-14-87
DATE EFF: 5-5-87
HCFA 179: 8-9-12

TN No. 37-1
Supersedes Approval Date 8-14-87 Effective Date 5-5-87
TN No. new
HCFA ID: 1080P/0010P
Attachment 4.34-A
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State of New Mexico concerning advance directives. The state statutes are silent on the question of whether a health care provider may object, on the basis of conscience, to the implementation of advance directives.

A. Living will

New Mexico Statutory Act 24-7-1 through 24-7-11 is cited as the "Right to Die Act" and defines a living will as a document, executed by an individual of sound mind and having reached the age of majority, directing that if he is ever certified as suffering from a terminal illness or being in an irreversible coma, maintenance medical treatment shall not be utilized for the prolongation of his life.

The same statute discusses a variety of limitations of living will declaration. They are valid documents only if executed in the same process as a valid will under provisions of the Probate Code. Certification of terminal illness or irreversible coma must be done in writing by two physicians presumed to be acting in good faith. Revocation of the living will can be accomplished by destroying the document or by contrary indication expressed to any one witness over the age of majority.

The statute also defines proxy designation for the benefit of minors who are terminally ill or in irreversible coma. Substituted consent may also be given by all family members who can be contacted through reasonable diligence and who choose to forego treatment for their member.

Attachment 4.34-A (1) contains the "New Mexico Living Will and Declaration Under the Right to Die Act".

B. Durable Power of Attorney

New Mexico Statutory Act 45-5-501 through 45-5-502 defines durable power of attorney as a written document in which a principal designates another person as his attorney-in-fact or agent by a power of attorney containing the words, "This power of attorney shall not be affected by the incapacity of the principal".
or "This power of attorney shall become effective upon the incapacity of the principal" or similar language showing the principal's intent that the authority conferred shall be exercised notwithstanding his capacity.

The second section of this statute explains that other powers of attorney are not revoked or terminated if the attorney in-fact, agent or other person acts in good faith without actual knowledge of the death or disability of the principle.

NEW MEXICO LIVING WILL

AND

DECLARATION UNDER THE RIGHT TO DIE ACT

, being of sound mind and age 18 or older, willfully and voluntarily make known my will and directive that my life shall not be prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time I should be certified in writing by two physicians, one of whom is in charge of my care, to have a terminal illness or be in an irreversible coma, I direct that maintenance medical treatment be withheld or withdrawn, and that I be permitted to die.

2. By maintenance medical treatment, I mean any medical treatment that is designed solely to sustain the life process, but I do not mean medication administered for the purpose of easing pain and discomfort.

3. In the absence of my ability to give directions regarding the use of maintenance medical treatment, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical treatment, and I accept the consequences of such refusal.

4. If my attending physician declines to participate in the withholding or withdrawal of maintenance medical treatment, she/he must take steps to transfer me to another physician who will honor my wishes.

5. I understand the full import of this directive, and I am emotionally and mentally competent to make this directive.

6. I understand that I may revoke this directive at any time by destroying it or saying so in the presence of someone over age 18.

7. I will keep the original of this document at:

__________________________
(name the place or person who will have the original document)

I will give copies of this document to:

__________________________
(name the place or person who will have copies of the document)

Revised 10/91
NEW MEXICO DURABLE POWER OF ATTORNEY
FOR
HEALTH CARE DECISIONS

The powers granted by this document are broad and sweeping. The document is prepared in accordance with NMSA 1978, §45-5-502, and should be interpreted consistently with that statute.

I, ________________________________________, reside in __________________________ County, New Mexico. I appoint ________________________________________ to serve as my legally-authorized decision maker(s).

If any decision maker appointed above is unable to serve, then I appoint ________________________________________ to serve as my decision maker in place of the person who is unable to serve.

Check and initial the following paragraph only if more than one person is appointed to act on your behalf and you want any one of them to have the power to act alone without the signature of the other(s). If you do not check and initial the following paragraph and more than one person is named to act on your behalf, then they must act jointly.

( ) If more than one person is appointed to serve as my decision maker, then each may act alone and independently of each other.

My decision maker shall have the power to act in my name, place and stead in any way which I myself could do with respect to the following matters to the extent permitted by law:

Initial the box opposite each authorization which you desire to give to your decision maker. Your decision maker shall be authorized to engage only in those activities which are initialed. Cross out those authorizations you do not desire to give to your decision maker.

1. Decisions regarding lifesaving and life prolonging medical treatment

2. Decisions relating to medical treatment, surgical treatment, nursing care, medication, and hospitalization

Revised 10/91
Attachment 4.35-A
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

NA
Attachment 4.35-B
Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)
Attachment 4.35-C
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☐ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

New Mexico

STATE

DATE REC'd: SEP 26 1995
DATE APPL'D: OCT 2 7 1995
DATE EFF: JUL 0 1 1995
HCFA 179

A

TN No. 95-13
Supersedes Approval Date: OCT 2 7 1995 Effective Date: JUL 0 1 1995
TN No.
Attachment 4.35-D
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

- Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

- Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

New Mexico

STATE RECEIVED: SEP 26 1995
DATE REC'D: OCT 2 7 1995
DATE APPV'D: JUL 01 1995
HCFA 179 95-13

TN No. 95-13
Supersedes Approval Date: OCT 2 7 1995 Effective Date: JUL 01 1995
Check box if alternative remedy is the appropriate
Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

_____ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE: New Mexico

DATE RECEIVED: SEP 2 6 1995
DATE AMENDED: OCT 27 1995
DATE APPROVED: OCT 27 1995
DATE EFFECTIVE: JUL 1 1995

HCFA 179

TN No. 25-13
Supersedes Approval Date: OCT 2 7 1995 Effective Date: JUL 0 1 1995
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

New Mexico
STATE
DATE REC'D: SEP 26 1995
DATE APPR'D: OCT 2 7 1995
DATE EFF: JUL 01 1995
HCFA 179 95-13

TN No. 95-13
Supersedes Approval Date: OCT 2 7 1995
TN No. Effective Date: JUL 0 1 1995
Attachment 4.35-H
Additional Remedies: Describe the criteria (as required at $1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

NA
Attachment 4.38
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

STATE

DATE REC'D: AUG 18 1992
DATE APP'D: SEP 15 1992
DATE EFF: JUL 01 1992
HCFA 179

TN No: 98-12
Supersedes Approval Date: SEP 15 1992 Effective Date: JUL 01 1992

HCFA ID:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

COLLECTION OF ADDITIONAL REGISTRY INFORMATION
483.156 (C) REQUIREMENTS

Above and beyond the registry requirements in 42 CFR 483.156(C), The New Mexico Nurse Aide Registry for Long Term Care includes current employer, Medicaid provider number, date of hire, date of decertification, certification number, and recertification date.
Specialized Services, Definitions

(1) For mental illness, specialized services means the services specified by the State which, combined with the services provided by the NF, results in the continuous and aggressive implementation of an individualized plan of care.

(2) For mental retardation, specialized services means the services specified by the State which, combined with the services provided by the NF or other service providers, results in treatment which meets the requirements of 483.440(a)(1).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: New Mexico
CATEGORICAL DETERMINATIONS

STATE Review
DATE REC'D AUG 19 1993
DATE APP'D SEP 20 1993
DATE EFF JUL 01 1993
HCFA 179 93-17

TN No. 32-17
Superseded Approval Date SEP 20 1993 Effective Date JUL 01 1993

Attachment 4.42
State Plan under Title XIX of the Social Security Act

State: New Mexico

Citation
1902(a)(68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries.

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental...
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity’s responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An “employee” includes any officer or employee of the entity.

(C) A “contractor” or “agent” includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.
(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity’s policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State’s provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.
EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will reassess compliance on an ongoing basis.

1. Entities who meet the $5,000,000 annual payment threshold as of September 30th of each year will be deemed to be "qualifying entities."

   By January 1st of each year, the Department will issue a notification to each qualifying entity reminding the entity of their responsibilities regarding Employee Education About False Claims Recoveries. The initial letter informing qualifying entities of their responsibilities regarding Employee Education About False Claims Recoveries was sent on December 26, 2006, and will occur annually prior to January 1st of each year.

   By July 1st of each year, the Department will provide each qualifying entity with a certification document on which the entity must certify they understand and are meeting their responsibilities regarding Employee Education About False Claims Recoveries.

   By September 1, 2007, regarding compliance for calendar year 2007, and by October 1, 2007 and each October 1st thereafter, regarding compliance for calendar year 2008 and each year thereafter, the entity must complete the certification document and return it to the Department. In addition to certifying they understand and are meeting their responsibilities regarding Employee Education About False Claims Recoveries, the certification document will require the entity to state if they have written policies, educational programs, handbooks, or other documentation used by the entity to meet the requirements regarding Employee Education About False Claims Recovery.

   A response will be deemed inadequate if the entity does not certify they understand and are meeting their responsibilities regarding Employee Education About False Claims Recoveries; if they fail to identify any forms of documentation used by the entity; or, if they fail to respond to a second follow-up request from the Department after not responding to the initial request.

   An inadequate response will be followed by an audit of the entity’s compliance by the Department. Any time a qualifying entity is subject to an onsite review for any other reason, their compliance will be verified not to exceed once annually. Additionally, qualifying entities may be selected randomly for audit.

2. No later than December 31, 2007, the requirements of this law will be incorporated into the agreements entities sign to participate in the Medicaid Program.

3. No later than July 1, 2007, the requirements of this law will be incorporated into entity contracts including managed care organization contracts and audited annually in an onsite visit conducted by the Department.
Attachment 4.43
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

New Mexico

State/Territory: 

Citation 1902(a)(69) of the Act, P.L. 109-171 (section 6034) 4.43 Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

SUPERSEDES: NONE - NEW PAGE

TN No. 08-04 Approval Date: 6/12-08 Effective Date: 4-1-08

STATE New Mexico DATE REC 5-30-08
DATE APPVD 6-12-08
DATE EFF 1-1-08
HCFA 179 0.8-04
4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Citation
Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)

X The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

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<td>DATE REC'D</td>
<td>7-25-11</td>
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TN No. 11-02
Supersedes
TN No. SUPERSEDES: NONE - NEW PAGE
Effective Date: 6-1-11
Approval Date: 5-17-11
A. officials elected by popular vote or appointed to fill vacancies in elective offices;
B. members of boards and commissions and heads of agencies appointed by the governor;
C. heads of agencies appointed by boards or commissions;
D. directors of department divisions;
E. those in educational institutions and in public schools;
F. those employed by state institutions and by state agencies providing educational programs and who are required to hold valid certificates as certified school instructors as defined in Section 22-1-2 NMSA 1978 issued by the state board of education;
G. those in the governor's office;
H. those in the state militia or state police;
I. those in the judicial branch of government;
J. those in the legislative branch of government;
K. not more than two assistants and one secretary in the office of each official listed in Subsections A, B and C of this section, excluding members of boards and commissions in Subsection B of this section;
L. those of a professional or scientific nature which are temporary in nature;
M. those filled by patients or inmates in charitable, penal or correctional institutions;
N. state employees, if the personnel board, in its discretion, decides that the position is one of policy making;
O. disadvantaged youth under twenty-two years of age regularly enrolled or to be enrolled in a secondary educational institution approved by the state board of education or in an accredited state institution of advanced learning or vocational training and who are to be employed for not more than seven hundred twenty hours during any calendar year.

(1) The term "disadvantaged youth" shall be defined for purposes of this exemption by regulation duly promulgated by the board.

(2) The board shall:
   (a) require that all of the above criteria have been met;
   (b) establish employment lists for the certification of the highest standing candidates to the prospective employers; and
   (c) establish the pay rates for such employees.


The 1977 amendment added present Subsections D and E, redesignated former Subsections D through M as "P" through "O", deleted "New Mexico state personnel" preceding "board" near the end of Subsection O(1) and deleted "state personnel" preceding "board" in the introductory language of Subsection O(2).


Due process requirements. — New Mexico has recognized that nonpolicy-making officials are entitled to due process before they may be dismissed, but members of boards and commissions and heads of agencies appointed by the governor are not entitled to the State Personnel Act's notice and hearing requirements preceding dismissal of state employees. Mitchell v. King, 537 F.2d 385 (10th Cir. 1976).

Constitutionality of option feature. — The option feature of the Personnel Act, granting to exempt officials the right to place their department or agency under the act, is clearly enabling legislation and not an unconstitutional delegation of legislative power. 1961-62 Op. Att'y Gen. No. 62-79.

Purposes underlying exemptions. — The purposes underlying the exemption of certain classes of employees are not to preclude them from benefits such as vacation and sick leave. 1969 Op. Att'y Gen. No. 69-47.
10-9-5. Public officers and public employees; executive branch; annual exempt-salaries plan.

A. The department of finance and administration shall prepare, by May 1 of each odd-numbered year, an exempt-salaries plan for the governor's approval. The plan shall specify salary ranges for the following public-officer and public-employee positions of the executive branch of government:

(1) members of boards and commissions appointed by the governor;
(2) heads of agencies appointed by the governor;
(3) heads of agencies appointed by the respective boards and commissions of the agencies;
(4) employees in the governor's office;
(5) positions in the state militia and the state police;
(6) the assistants and secretaries in the offices of each official covered by Paragraphs (1), (2) and (3) of this section who are excluded from Personnel Act coverage by the provisions of Subsection I [Subsection K] of Section 10-9-4 NMSA 1978;
(7) positions of a professional or scientific nature which are temporary in nature; and
(8) state employees whose positions the personnel board has classified as policy-making positions, and exempt employees of elective public officials.

B. Excluded from the provisions of this section are employees of the state board of educational finance and employees of state educational institutions named in Article 12, Section 11 of the constitution of New Mexico.

C. Upon the governor's approval, the plan shall take effect at the beginning of the subsequent fiscal year.


1977 amendments. — Laws 1977, ch. 246, § 42, amending this section by combining Paragraphs (1) and (2) of Subsection B in a single paragraph, was approved April 7, 1977. Laws 1977, ch. 247, § 46, amending this section by inserting a new Paragraph (4) in Subsection A, redesignating Paragraphs (5) through (8) of Subsection A as (6) through (9) and substituting "Subsection K" for "Subsection I" in present Paragraph (6) of Subsection A, was also approved April 7, 1977. However, Laws 1977, ch. 365, § 1, amended this section by adding "the" at the beginning of Paragraph (6) of Subsection A, substituted "who are excluded from Personnel Act coverage by the provisions of" for "excluding those positions covered by the Personnel Act according to" in Paragraph (6) of Subsection A and incorporated the changes made by the first 1977 amendment but not those of the second, and was approved April 8, 1977. The section is set out as amended by Laws 1977, ch. 365, § 1.


Board of educational finance administratively attached. — Laws 1977, ch. 246, § 42, administratively attaches the board of educational finance to the educational finance and cultural affairs department. See 21-1-28 NMSA 1978.


10-9-6. Certified school instructors previously employed under the provisions of the Personnel Act.

Certified school instructors who were employed as certified school instructors by state institutions or state agencies under the provisions of the Personnel Act prior to July 1, 1974, may elect to continue to be employed under the Personnel Act. Certified school instructors who elect to continue under the Personnel Act shall file a notice of such election with the personnel director prior to the effective date of this act.


Effective date. — Laws 1975, ch. 182, § 3, makes the act effective on July 1, 1975.


10-9-7. Payment by covered agencies to the personnel board for services of state personnel office.

Each agency whose personnel are covered by the Personnel Act shall budget for and pay to the personnel board as directed by the department of finance and administration an

The personnel board is created, and shall be composed of five members appointed by the governor, who shall serve staggered terms of five years each with one board member’s term expiring each year. No person shall be a member of the board or eligible for appointment to the board who is an employee in the service, holds political office or is an officer of a political organization.

10-9-9. Board members; pay; meetings.

Each board member shall be paid per diem and mileage according to the Per Diem and Mileage Act [10-8-1 to 10-8-7 NMSA 1978] when traveling on board business. The board shall meet at the call of the chairman but in the absence of such call, at least once every two months.


The board shall:

A. promulgate regulations to effectuate the Personnel Act;
B. hear appeals and make recommendations to employers;
C. hire, with the approval of the governor, a director experienced in the field of personnel administration;
D. review budget requests prepared by the director for the operation of the personnel program and make appropriate recommendations thereon;
E. make investigations, studies and audits necessary to the proper administration of the Personnel Act;
F. make an annual report to the governor at the end of each fiscal year;
G. establish and maintain liaison with the department of finance and administration; and
H. represent the public interest in the improvement of personnel administration in the system.
10-9-11. Board and office administratively attached to department of finance and administration.

The board and the state personnel office are administratively attached, as defined in the Executive Reorganization Act (9-1-1 to 9-1-10 NMSA 1978), to the department of finance and administration.

History: 1953 Comp., § 5-4-34.1, enacted by Laws 1977, ch. 247, § 47.

10-9-12. Director duties.

The director shall:
A. supervise all administrative and technical personnel activities of the state;
B. act as secretary to the board;
C. establish, maintain and publish annually a roster of all employees of the state, showing for each employee his division, title, pay rate and other pertinent data;
D. make annual reports to the board;
E. recommend to the board rules he considers necessary or desirable to effectuate the Personnel Act; and
F. supervise all tests and prepare lists of persons passing them to submit to prospective employers.


10-9-13. Rules; adoption; coverage.

Rules promulgated by the board shall be effective when filed as required by law. The rules shall provide, among other things, for:
A. a classification plan for all positions in the service;
B. a pay plan for all positions in the service;
C. competitive entrance and promotion tests to determine the qualifications, fitness and ability of applicants to perform the duties of the position for which they apply, and such rules shall also provide for the awarding to those applicants having a passing grade of one preference point for each year of consecutive residency in New Mexico, immediately prior to taking the test, not to exceed a total of five preference points;
D. exemption from competitive entrance tests for those professional persons applying for classified positions in the service who possess recognized registration or certification by another state agency;
E. a period of probation of one year during which a probationer may be discharged or demoted or returned to the eligible list without benefit of hearing;
F. the establishment of employment lists for the certification of the highest standing candidates to the prospective employers, and procedure to be followed in hiring from the lists;
G. hours of work, holidays and leave;
H. dismissal or demotion procedure for employees in the service, including presentation of written notice stating specific reasons and time for the employees to reply thereto, in writing, and appeals to the board;
 I. the rejection of applicants who fail to meet reasonable requirements as to age, physical condition, training, experience or moral conduct; and
 J. employment of any apparently qualified applicant for a period of not more than ninety days when an emergency condition exists and there are no applicants available on an appropriate employment list as provided in Subsection F of this section. The applicant, if employed shall be paid at the same rate as a comparable position covered by the Personnel Act.


Generally, as to employment termination and pay. — Terminal leave pay is available to involuntarily terminated employees at the discretion of the appointing authority. Terminal leave pay is available to voluntarily resigning employees as a matter of right. The only limitations upon the power of the appointing authority to dismiss are that notice must be given in writing to the dismissed employees and an authorized reason for dismissal must be stated therein. The only limitation on the right of the voluntarily resigning employee to terminal pay is the requirement that he must give 14 days’ notice to the appointing authority. 1959-60 Op. Att’y Gen. No. 69-213.

Physician dismissal by miners’ hospital board. — The miners’ hospital board may dismiss a physician in their employment for not abiding by the rules and regulations of the hospital board, but the physician has the right to appeal the dismissal to the personnel board. 1964 Op. Att’y Gen. No. 64-130.

Dismissal of employees. — The miners’ hospital board has power to remove or discharge any employee, but it must exercise this power in accordance with the rules promulgated by the personnel board. 1964 Op. Att’y Gen. No. 64-130.

Right to board hearing. — An employee covered by Personnel Act has a right to a personnel board hearing on his dismissal when the reason for the dismissal is administrative change and a reduction in personnel. 1961-62 Op. Att’y Gen. No. 68-158.

Requiring physical examination. — The state personnel board has the authority to require a physical examination of all applicants for employment. 1963-64 Op. Att’y Gen. No. 64-22.

Harmonization with other act. — The Personnel Act can be harmonized with the provision in the General Appropriation Act that “insurance department personnel shall have qualifications as established by the superintendent of insurance.” 1964 Op. Att’y Gen. No. 64-121.

Granting overtime pay or time-off. — There is no prohibition against the cattle sanitary board (now N.M. livestock board) paying its employees engaged in inspecting meat overtime pay or granting compensatory time-off for the extra hours worked. 1967 Op. Att’y Gen. No. 67-20.

Generally, as to specific work hours. — There is no requirement contained in the New Mexico constitution or statutes that work be done at any specific hours of the day. 1967 Op. Att’y Gen. No. 67-89.

And eight-hour days. — There is no specific requirement, either constitutional or statutory, requiring that employees of the state work an eight-hour day. 1967 Op. Att’y Gen. No. 67-89.

Classification under rule-making authority. — Under the rule-making authority of this section and 10-9-10 NMSA 1978, the state personnel board has a limited and restricted right to classify as confidential certain portions of an individual’s personnel file which would not otherwise be made available to the state unless on a confidential or restricted basis. 1963-64 Op. Att’y Gen. No. 64-19.


So is test score and position. — A job applicant’s test score and position on an eligibility list under this section, possessed by the state personnel office, is a public record under 14-3-1 NMSA 1978. 1968 Op. Att’y Gen. No. 68-110.

But not medical and employment histories. — The medical history and employment history solicited from an applicant’s previous employer, under this section, are not public records under 14-3-1 NMSA 1978. 1968 Op. Att’y Gen. No. 68-110.


10-9-14. Blind not barred from competitive examination; method of testing.

A. No agency or officer of the state or any of its political subdivisions shall prohibit, prevent, disqualify or discriminate against any blind person, otherwise qualified, from registering, taking or competing in a competitive entrance or promotion test for any position for which the blind person makes application.

B. The state personnel board and all political subdivisions of the state which require competitive or promotion tests for any position shall provide an adequate and equal test by an appropriate method for any blind person requesting such a test at the time of submitting his application.
10-9-15. Duties of state officers and employers.

All officers and employers of the state shall comply with the Personnel Act. All employers shall hire employees only from employment lists of applicants who meet prescribed minimum requirements and have passed the prescribed tests, provided by the director. All officers and employers shall furnish any records or information which the director or the board requests.


All employees of the state holding positions brought into the classified service by the Personnel Act shall be continued in their positions and become regular employees without original examinations, if they have held the position for at least one year immediately prior to the effective date of the Personnel Act. All other employees of the state holding positions brought into the service by the Personnel Act shall be continued in their positions as probationers until they have, not later than one year from the effective date of the Personnel Act, taken and passed a qualifying test prescribed by the director for the position held. An employee who fails to qualify shall be dismissed within thirty days after the establishment of an employment or promotion list for his position. Nothing in the Personnel Act shall preclude the reclassification or reallocation of any position held by an incumbent.

This section shall not apply to employees of the grant-in-aid agencies whose status as employees or probationers shall be recognized under rules to be promulgated by the board.

10-9-17. Certification of payroll.

No person shall make or approve payment for personnel services to any person in the service, unless the payroll voucher or account of the pay is certified by the director that the person being paid was employed in accordance with the Personnel Act.

10-9-18. Appeals by employees to the board.

Any employee who is dismissed or demoted, or who is suspended, may, within thirty days after the dismissal, demotion or suspension, appeal to the board. The appealing employee and the appointing authority whose action is reviewed have the right to be heard publicly and to present facts pertinent to the appeal. Any applicant denied permission to take an examination, or who is disqualified, may appeal to the board. Technical rules of evidence shall not apply. If the board finds the ground for the action is not substantiated, then it shall make written findings and recommendations to the employer, who shall reinstate,
within thirty days after notice, the employee, with pay, from the date of suspension, demotion or discharge. Any decision made by the board is final. The board may designate a hearing officer who may be a member of the board or any qualified state employee to preside over and take evidence at any hearing held pursuant to this section.


Whenever an employee is terminated by an employer in a reduction in force by the employer, the terminated employee shall be rehired by that employer if the same or a comparable position becomes available in an increase of force within six months after the termination.


10-9-20. Oaths; testimony; records; refusal.

The board has the power to administer oaths, subpoena witnesses and compel the production of books and papers pertinent to any investigation or hearing authorized by the Personnel Act. Refusal to testify before the board on matters pertaining to personnel is grounds for dismissal from the service.


A. No employer shall dismiss an employee for failure or refusal to pay or promise to pay any assessment, subscription or contribution to any political organization or candidate; however, nothing herein contained shall prevent voluntary contributions to political organizations.

B. No person in the personnel office, or employee in the service, shall hold political office or be an officer of a political organization during his employment. For the purposes of the Personnel Act, being a member of a local school board shall not be construed to be holding political office, and being an election official shall not be construed to be either holding political office, or being an officer of a political organization. Nothing in the Personnel Act shall deny employees the right to vote as they choose or to express their opinions on political subjects and candidates.

C. Any employee who becomes a candidate for public office must, upon filing or accepting the nomination and during the campaign, take a leave of absence. This subsection does not apply to those employees of a grant-in-aid agency, whose political activities are governed by federal statute.

D. The director shall investigate any written charge by any person, that this section has been violated and take whatever steps deemed necessary.

E. No person shall be refused the right of taking an examination, or from appointment to a position, from promotion or from holding a position, because of political or religious opinions or affiliation, or because of race or color.

F. No employee or probationer shall engage in partisan political activity while on duty.

Existing personnel rules, policies and pay plans for employees of the state shall govern until new rules, policies and pay plans are established under the Personnel Act.


10-9-25. Federal funds and assistance.

When the provisions of any laws of the United States, or any rule, order, or regulation of any federal agency or authority providing federal funds for use in New Mexico, either directly or indirectly or as a grant-in-aid, to be matched or otherwise, impose as a condition for the receipt of such funds, other or higher personnel standards or different classifications than are provided for by the Personnel Act, the board has the authority and is directed to adopt rules and regulations to meet the requirements of such law, rule, order or regulation.


G. With respect to employees of federal grant-in-aid agencies, the applicable personnel standards, regulations and federal laws limiting activities shall apply and shall be set forth in rules promulgated by the board.


Cross-reference. — For definition of incompatible office, see 10-6-5 NMSA 1978.


Constitutionality. — Subsection B does not violate the first amendment guarantee of freedom of speech in requiring that certain state employees not hold public office, nor does it deny equal protection by exempting some state employees from its provisions. State ex rel. Gonzalez v. Manzogal, 87 N.M. 230, 531 P.2d 1203 (1975).

Legislative power. — The legislature had the constitutional power under N.M. Const., art. VII, § 2B, to enact this section and to thereby provide, as a qualification or standard for continued employment by the state in a position covered by the State Personnel Act, that the employee not hold "political office." State ex rel. Gonzalez v. Manzogal, 87 N.M. 230, 531 P.2d 1203 (1975).


Scope of prohibition in Subsection B. — The words "be an officer of a political organization" are relatively clear. The prohibition (in Subsection B) is without restriction and the legislative intent of these words applies with equal force to the highest and lowest office in a political party or organization. Since there is no restriction, all officers of the party or organization are included within the prohibition, from the state chairman to membership in the central committee or executive committee on down the line to precinct officers and division officers. 1961-62 Op. Att'y Gen. No. 61-53.

Effect of election to public office. — Under the theory advanced by a Kentucky court, any person who is elected by the voters to a public office would be deemed holding a political office within the intent of Laws 1961, ch. 240, §§ 5 and 15. This would be so even if the election were conducted along what is commonly known as nonpartisan lines rather than political party lines. The term "political office" applies to every elected public office within the state including, but not limited to state elected positions, county elected positions and municipal elected positions, even if conducted along nonpartisan lines (decided prior to 1963 amendment). 1961-62 Op. Att'y Gen. No. 51-53.

Example of political office. — The office of city councilman clearly falls within the definition of a "political office" and petitioner who held such office could properly be discharged from his classified state job under this section. State ex rel. Gonzalez v. Manzogal, 87 N.M. 230, 531 P.2d 1203 (1975).


On candidate for delegate to constitutional convention. — A candidate for the position of delegate to the constitutional convention, which is both a temporary and occasional position, is not a candidate for "public office" and need not take a leave of absence. 1969 Op. Att'y Gen. No. 69-28.

On the delegate. — The position of delegate to a constitutional convention is not a "political office" within the meaning of Subsections B or C of this section. 1969 Op. Att'y Gen. No. 69-28.


It is unlawful to:

A. make any false statement, certificate, mark or rating with regard to any test, certification or appointment made under the Personnel Act;
B. directly or indirectly give, pay, offer, solicit or accept any money or other valuable consideration or secure or furnish any special or secret information for the purpose of affecting the rights or prospects of any person with respect to employment in the service.

History: 1953 Comp., § 5-4-43; enacted by Laws 1961, ch. 240, § 16.


10-9-23. Penalties.

Any person willfully violating any provision of the Personnel Act or the rules of the board is guilty of a misdemeanor. In addition to the criminal penalties, a person found guilty of a misdemeanor under the Personnel Act is ineligible for appointment to or employment in a position in the service, and forfeits his office or position.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF NEW MEXICO

NONTDISCRIMINATION

This Division has received assurance from the Licensure Division of the State Health Agency that currently approved methods of administration under the civil rights requirements are on file in the Regional Office.