STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: New Mexico

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: NEW MEXICO

Citation
42 CFR
430.10

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the

HUMAN SERVICES DEPARTMENT
(Single State Agency)

submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

TN No. 91-19
Supersedes Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. 78-7

HCFA ID: 7982E

STATE New Mexico
DATE RECEIVED DEC 1 7 1991
DATE APPROVED JAN 15 1992
DATE EFF OCT 01 1991
HCFA I/9 91-19
SECTION 1       SINGLE STATE AGENCY ORGANIZATION

1.1 Designation and Authority

(a) The NEW MEXICO HUMAN SERVICES DEPARTMENT is the single State agency designated to administer or supervise the administration of the Medicaid program under title XV of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.
Item 1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

☐ Yes. The State agency so designated is

This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

☐ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).
Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

☐ Yes. ATTACHMENT I.1-B describes these waivers and the approved alternative organizational arrangements.

☐ Not applicable. Waivers are no longer in effect.

☐ Not applicable. No waivers have ever been granted.

TN 78-7
Supersedes
TN 78-7

Approval Date 5-31-78
Effective Date 4-1-78
The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan.

Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.
Revision: HCPA-AT-30-38 (BPP)
May 22, 1980

State: NEW MEXICO

Citation
42 CFR 431.10
AT-79-29

1.1(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.

TN # 76-25
Supersedes
TN #

Approval Date 2-18-77
Effective Date 9-3-76
1.2 Organization for Administration

(a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the MEDICAL ASSISTANCE BUREAU has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

\[\text{Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.}\]
1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

☐ The plan is State administered.

☐ The plan is administered by the political subdivisions of the State and is mandatory on them.

TN 78-7
Supersedes
TN ____ Approval Date 5-31-78 Effective Date 4-1-78
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.

1.4a Tribal Consultation Requirements

Section 1902(a)(73) of the Social Security Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA).

Consultation is required concerning Medicaid matters having a direct impact on Indian health programs and Urban Indian organizations.

Please describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Please include information about the frequency, inclusiveness and process for seeking such advice.

- The tribal consultation process is based on a government-to-government relationship with each tribal or pueblo government and their healthcare providers.

- The state agency evaluates all proposed changes to reimbursement to determine whether the changes will have a direct effect on federally-recognized tribes, Indian Health Programs (including Indian Health Service programs, tribal health programs and urban Indian organizations) and facilities and whether it will impact payments.
to those facilities. The state agency will employ the consultation process when reductions in reimbursement for those providers are proposed.

- "Direct impact" is defined as any change that will result in any decrease in payment levels to IHS or other tribal healthcare providers or any decrease in covered benefits, frequency of benefits, or limitation on benefits that will affect a Native American recipient, or an IHS facility or other tribal healthcare provider.

- When changes in coverage or eligibility are made that limit or decrease benefits, payments, or eligibility in the Medicaid program or the state Children's Health Insurance Program (CHIP) that affect Native American groups, the state agency will employ the consultation process.

- Prior to the submission to the federal government of a CHIP or Medicaid state plan amendment (SPA) or waiver, extension, amendment and renewal, or proposal for a demonstration project, the state agency will employ the consultation process.

- The consultation process begins with a written notification to the governor of each tribe or pueblo or their designee, to IHS facilities and other tribal healthcare providers, and to inter-tribal councils and inter-pueblo councils.

An updated list of all these entities is maintained by the state agency and is verified by the Native American liaison staff of the state agency.

This notification describes the purpose and anticipated impact of the SPA or waiver, amendment, extension, or renewal, or proposed demonstration project, and the method for each tribal or pueblo government, IHS facility, or other tribal healthcare to obtain more information and to make comments.

The notification is sent at least 60 days before the date of the state agency's submission to CMS and will allow a reasonable amount of time for response to the notification which will be, at a minimum, 30 days. This will allow a tribal or pueblo government, IHS facility, or other tribal healthcare provider to make comments or to ask questions within a time frame that allows adequate time for the state agency to consider any issues raised and time for any necessary further discussion between the state agency and the tribal or pueblo government, IHS facility, or other tribal healthcare providers responding to the notification.
Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Initial notification of the proposed state plan amendment was provided to all tribes, pueblos, to IHS, and to all other tribal or pueblo health providers, by letter on October 29, 2010. The state agency allowed more than 30 days for written comment. No comments were receiving either in writing or verbally.
1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.
2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:
   - State Medicaid Agency
   - State Public Health Agency
SECTION 2 - COVERAGE AND ELIGIBILITY

2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.
Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.

For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1902 of the Act. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

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DATE AMENDED: 12-18-03
DATE EFFECTIVE: 7-1-03
NOTE: 179 03-03

TN #: 03-03
Supersedes TN #: 97-02
Effective Date: 7-1-03
Approval Date: 12-18-03
2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

☐ Mandatory categorically needy and other required special groups only.

☐ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

☒ Mandatory categorically needy, other required special groups, and specified optional groups.

☐ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(i)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.
2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.
2.4 Blindness

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.
Citation 2.5 Disability
42 CFR 435.121,
435.540(b)
435.541

All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.
2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.
2.7 Medicaid Furnished Out of State

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.
SECTION 3 - SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration, and Scope of Services

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

(1) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, as provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(x) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Not applicable. Nurse-midwives are not authorized to practice in this State.
Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10), clause (VII) of the matter following (F) of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(I)(IV) and 1902(a)(10)(A)(II)(IX) of the Act.
(vi) Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.

(vii) Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

(viii) Respiratory care services are provided to "ventilator dependent individuals as indicated in item 3.1(h) of this plan.

(ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.

(x) 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.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and for conditions that may complicate the pregnancy.
State: NEW MEXICO

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, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services for conditions that may complicate the pregnancy.
This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

- If services in an institution for mental diseases or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1903, and 1915 of the Act.

- Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

- Prenatal care and delivery services for pregnant women.
(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

(vii) Services in an institution for mental diseases for individuals over age 65.

(viii) Services in an intermediate care facility for the mentally retarded.

(ix) Inpatient psychiatric services for individuals under age 21.
3.1(a)(2)  Amount, Duration, and Scope of Services:  
Medically Needy (Continued)

(x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

(xi) 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.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.
State: NEW MEXICO

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically 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-B identifies services provided to each covered group of the medically needy; specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services for conditions that may complicate the pregnancy.
3.1 Amount, Duration, and Scope of Services - (continued)

(a)(3) Other Required Special Groups: Qualified Medicare Beneficiaries

Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.

(a)(4)(i) Other Required Special Groups: Qualified Disabled and Working Individuals

Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.

(ii) Other Required Special Groups: Specified Low-Income Medicare Beneficiaries

Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(F)(ii) of the Act are provided as indicated in item 3.2 of this plan.

(iii) Other Required Special Groups: Qualifying Individuals - 1

Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv) (I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

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Supersedes 93-05
Approval Date 4-21-98 Effective Date 1-1-98
(iv) **Other Required Special Groups: Qualifying Individuals - 2**

The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(a)(10)(E)(iv) (II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

**Other Required Special Groups: Families Receiving Extended Medicaid Benefits**

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

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**TN No. 98-02**

**Supersedes** Approval Date 4-21-98, Effective Date 1-1-98
1925 of the Act

(a)(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

Citation
Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(1) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(5)(1)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.
Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.

Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.

Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.

The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.
42 CFR 431.53  (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-B.

42 CFR 483.10  (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c)(8)(i).
Methods and Standards to Assure Quality of Services

The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.
Citation: 42 CFR 441.20
AT-78-90

3.1(e) Family Planning Services

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.
3.1 (f) (1) **Optometric Services**

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

\[\checkmark\] Yes.

\[\checkmark\] No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

\[\checkmark\] Not applicable. The conditions in the first sentence do not apply.

(2) **Organ Transplant Procedures**

Organ transplant procedures are provided.

\[\checkmark\] No.

\[\checkmark\] Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.
3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who—

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of—

   — 30 consecutive days;
   — __ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

   Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

☐ Yes. The requirements of section 1902(e)(9) of the Act are met.

☐ Not applicable. These services are not included in the plan.
3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

_ X Part A   _ Part B

The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.
1902(a)(10)(E)(ii) and 1905(u) of the Act

(ii) Qualified Disabled and Working Individual (QDWI)

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-A, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act

(iii) Specified Low-Income Medicare Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iv)(I), 1905(p)(3)(h)(ii), and 1933 of the Act

(iv) Qualifying Individual-1 (QI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.
Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

- All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); (b) receiving State supplements under title XVI; or (c) within a group listed at 42 CFR 431.625(d)(2).

- Individuals receiving title II or Railroad Retirement benefits.

- Medically needy individuals (FFP is not available for this group).

Other Health Insurance

The Medicaid agency pays insurance premiums for medical or any other type of residential care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).
Revision: HCPA-PM-93-2 (MB)
MARCH 1993

State: New Mexico

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905(a), and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

(i) Qualified Medicare Beneficiaries (QMBs)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

X For the entire range of services available under Medicare Part B.

Only for the amount, duration, and scope of services otherwise available under this plan.

(iii) Dual Eligible—QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).
1906 of the Act

(c) **Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations**

The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.

When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).

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1902(a)(10)(F) of the Act

(d) **xx**

The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A who were participating in the Health Insurance Premium Payment (HIPPP) program as of July 1, 1998 and who have continued to maintain their eligibility for the program.

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**TN No. 98-26**

Supercedes Approval Date 10.29.98 Effective Date 7-1-98

**TN No. 91-19**

HCFA ID: 7983E
Citation: 42 CFR 441.101, 42 CFR 431.620(c) and (d) AT-79-29

State: NEW MEXICO

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☐ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☒ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Approval Date: 3-20-78 Effective Date: 1-1-78
3.4 Special Requirements Applicable to Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F are met.
Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

☑ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

☐ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

☑ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☐ Medical or remedial care provided by licensed practitioners.

☐ Home health services.
Families Receiving Extended Medicaid Benefits (Continued)

☐ Private duty nursing services.
☐ Physical therapy and related services.
☐ Other diagnostic, screening, preventive, and rehabilitation services.
☐ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
☐ Intermediate care facility services for the mentally retarded.
☐ Inpatient psychiatric services for individuals under age 21.
☐ Hospice services.
☐ Respiratory care services.
☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

Supersedes Approval Date JAN 15 1992 Effective Date OCT 1 1991

HCFA ID: 7982E
Families Receiving Extended Medicaid Benefits
(Continued)

(c) The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance—

☐ 1st 6 months ☐ 2nd 6 months

The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

☐ 1st 6 mos. ☐ 2nd 6 mos.

(d) (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

☐ Enrollment in the family option of an employer's health plan.

☐ Enrollment in the family option of a State employee health plan.

☐ Enrollment in the State health plan for the uninsured.

☐ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).
Families Receiving Extended Medicaid Benefits
(Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency—

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

(ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).
\/

Enrollment in an eligible health maintenance organization (HMO) that has an enrollment of less than 50 percent of Medicaid recipients who are not recipients of extended Medicaid.

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

(ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).
Revision: HCFA - Region VI
DECEMBER 1990

State/Territory: New Mexico

Sec 1905(o)(3) of the Act. (Sec 6408(c) of P.L. 100-239 and Sec 4705 of P.L. 101-508)

3.8 Additional amounts for Nursing Facility Residents

When hospice care is furnished to an individual residing in a nursing facility or intermediate care facility for the mentally retarded, the hospice is paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility or intermediate care facility for the mentally retarded equals at least 95 percent of the per diem rate that would have been paid to the facility for that individual in that facility under this State Plan.
SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.
4.2 Hearings for Applicants and Recipients

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.
4.3 Safeguarding Information on Applicants and Recipients

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

All other requirements of 42 CFR Part 431, Subpart F are met.
4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

☐ Yes.

☐ Not applicable. The State has an approved Medicaid Management Information System (MMIS).
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.
Citation  
42 CFR 455.12 
AT-78-90 
48 FR 3742

4.5 Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13-455.21 for prevention and control of program fraud and abuse.
### PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

#### 4.5 Medicaid Recovery Audit Contractor Program

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| Section 1902(a)(42)(B)(i) of the Social Security Act | **X** The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.  
**☐** The State is seeking an exception to establishing such program for the following reasons:  
| Section 1902(a)(42)(B)(ii)(I) of the Act | **X** The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.  
**☐** Place a check mark to provide assurance of the following:  
| Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act | **X** The State will make payments to the RAC(s) only from amounts recovered.  
**X** The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.  
The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):  
Specifically, the New Mexico agency will pay a contingency fee for overpayments.  
|  | **X** The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to the Medicare RACs, as published in the Federal Register.  
|  | **☐** The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to the Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.  
|  | **☐** The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.  

SUPERSEDES: NONE - NEW PAGE
| Section 1902(a)(42)(B)(ii)(II)(bb) of the Act | □ X □ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):
Percentage of the contingency fee |
| Section 1902(a)(42)(B)(ii)(III) of the Act | □ X □ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s). |
| Section 1902(a)(42)(B)(ii)(IV)(aa) of the Act | □ X □ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan. |
| Section 1902(a)(42)(B)(ii)(IV)(bb) of the Act | □ X □ The State assures that the recovered amounts will be subject to a State’s quarterly expenditure estimates and funding of the State’s share. |
| Section 1902(a)(42)(B)(ii)(IV)(cc) of the Act | □ X □ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program. |

**SUPERSEDES:** NONE - NEW PAGE
Revision: HCFA-Region VI
June 21, 1991

State: New Mexico

Citation
42 CFR 431.16
AT-79-29,
Section 1927 of the
Social Security Act

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met. The Medicaid agency will comply with the reporting requirements for State drug utilization information and on restrictions to coverage. The Medicaid agency will keep the drug unit rebate amount confidential and will not disclose it for purposes other than rebate invoicing and verification. All reporting and confidentiality requirements of Section 1927 of the Social Security Act are met.
4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.
4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.
Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

TN # 74-5
Supersedes
TN #

Approval Date 6-24-74
Effective Date 1-19-74
Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual—

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act.

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).
4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is the HEALTH AND ENVIRONMENT DEPARTMENT.

(b) The State authority(ies) responsible for establishing and maintaining standards other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): the HEALTH AND ENVIRONMENT DEPARTMENT.

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.
Citation
42 CFR 431.610
AT-78-90
AT-89-34

4.11(d) The HEALTH AND ENVIRONMENT DEPARTMENT (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.
4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

X Yes, as listed below:

INTERMEDIATE CARE FACILITIES

☐ Not applicable. Similar services are not provided to other types of medical facilities.
Revision: HCFA-PM-91-4  (BPD)  AUGUST 1991
State/Territory: NEW MEXICO

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107  (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483  (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart D  (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act  (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

☐ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

TN No. 91-19  Supersedes 7778  Approval Date JAN 15 1992  Effective Date OCT 1 1999

89-05, pg. 72, item 4.24 (a)
For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

1. Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

   a. Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

   b. Provide written information to all adult individuals on their policies concerning implementation of such rights;

   c. Document in the individual's medical records whether or not the individual has executed an advance directive;

   d. Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

   e. Ensure compliance with requirements of State Law (whether
(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

Not applicable. No State law or court decision exist regarding advance directives.
Citation  4.14  Utilization/Quality Control
42 CFR 431.60 (a)  A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

____X____ Directly

By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO—

(1) Meets the requirements of §434.6(a):

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

1932(c)(2) and 1902(d) of the ACT, P.L. 99-509 (section 9431)

____X____

A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation.
Citation 4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

☐ All hospitals (other than mental hospitals).

☐ Those specified in the waiver.

☐ No waivers have been granted.
The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

All mental hospitals.

Those specified in the waiver.

No waivers have been granted.
(d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

- Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

- Utilization review is performed in accordance with 42 CFR Part 456, Subpart K, that specifies the conditions of a waiver of the requirements of Subpart E for:
  - All skilled nursing facilities.
  - Those specified in the waiver.

- No waivers have been granted.
4.14 (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

- Facility-based review.
- Direct review by personnel of the medical assistance unit of the State agency.
- Personnel under contract to the medical assistance unit of the State agency.
- Utilization and Quality Control Peer Review Organizations.
- Another method as described in ATTACHMENT 4.14-A.
- Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

Not applicable. Intermediate care facility services are not provided under this plan.
For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.

Not applicable.
4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases

All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

☐ Not applicable with respect to intermediate care facility services; such services are not provided under this plan.

☒ Not applicable with respect to services for individuals age 65 or over in institutions for mental diseases; such services are not provided under this plan.

☒ Not applicable with respect to inpatient psychiatric services for individuals under age 22; such services are not provided under this plan.
Citation
42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

Superscedes______ Approval Date 5-26-78 Effective Date 5-1-78
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

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) (1) (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 APPV'D 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)-(f).

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

TN No.: 10-06
Supersedes
TN No.: 83-04
Approval Date: 8-11-10  Effective Date: 4-1-10

SUPERSEDES: TN- 83-04
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.

STATE: New Mexico
DATE REC'D: 5-17-10
DATE APP'VD: 8-11-10
DATE EFF: 4-1-10
HCFA 179: 10-06

TN No.: 10-06
Supersedes: SUPERSEDES: NONE - NEW PAGE
Approval Date: 8-11-10
Effective Date: 4-1-10
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

Citation(s)

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.

STATE New Mexico
DATE RECD 5-17-10
DATE APPVD 8-11-10
DATE EFF 4-1-10
HCFA 179 10-06

TN No.: 10-06
Supersedes: NONE - NEW PAGE
Approval Date: 8-11-10
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
DATE APP'D: 8-11-10
DATE EFF: 4-1-10
HCFA 179

TN No.: 10-06
Supersedes Approval Date: 8-11-10 Effective Date: 4-1-10
TN No.: SUPERSEDES: NONE - NEW PAGE
(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 PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

LIENS AND ADJUSTMENT OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

   At this time we take the client/client representative's statement that; either they intend to return home or do not. A utilization review contractor reviews the long term care abstract submitted to them by the nursing home which indicates if a client requires long term care in a nursing facility.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR 433.36(f): We take the client/clients representative's statement as to whether the son or daughter provided care in the two years prior to the institutionalization. This care provided the applicant the opportunity to reside at home rather than in a medical facility or nursing home. The caseworker may obtain collateral statements to verify the living and care situation from neighbors, doctors or clergy etc.

3. The State defines the terms below as follows:

   - Estate—Includes the property of the decedent, trust or other person whose affairs are subject to the Uniform Probate Code [45-1-101 NMSA 1978] as originally constituted and as it exists from time to time during administration
   - Individual's home—A home is any shelter used by an applicant/recipient or his/her spouse as the principal place of residence.
   - Equity interest in the home—(Also known as equity value.) The value of a home minus the total amount owed on it in mortgages, liens and other encumbrances
   - Residing in the home for at least one or two years on a continuous basis—we take client/clients representative’s statement as to whether or not the client lived in their primary residence prior to entering a facility.
   - Lawfully residing—an applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have demonstrated intent to remain in the state.

4. The State defines undue hardship as follows:

   Hardship provision: The Human Services Department or its designee may waive recovery because recovery would work an undue hardship on the heirs. The following are deemed to be causes for hardship.
   (a) deceased recipient's heir(s) would become eligible for a needs-based assistance program (such as medicaid or temporary assistance to needy families (tanf) or be put at risk of serious deprivation without the receipt of the proceeds of the estate;
   (b) deceased recipient's heir(s) would be able to discontinue reliance on a needs-based program (such as medicaid or tanf) if he/she received the inheritance from the estate;

   TN # 10-06
   Supersedes TN #
   Date Approved: 8-11-85
   Effective Date: 4-1-10

   SUPERSEDES: NONE - NEW PAGE
A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.

For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.

A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

(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
DATE EFF: 4-1-10
HCFA 179: 10-06

TN No.: 10-06
Supersedes: SUPERSEDES: NONE - NEW PAGE

Approval Date: 8-11-10
Effective Date: 4-1-10
42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

\[\checkmark\] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

447.51 through 447.58

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

\[\checkmark\] Not applicable. No such charges are imposed.
Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

X Not applicable. No such charges are imposed.

(1) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

☐ 18 or older
☐ 19 or older
☐ 20 or older
☐ 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.
State/Territory: New Mexico

Citation 4.18(c)(3) (Continued)

447.51 through (iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

447.56

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

☐ Not applicable. There is no maximum

447.57

4.18(d) The Medicaid agency does not increase the payment it makes to any provider to offset uncollected amounts for deductibles, coinsurance, copayments or similar charges that the provider has waived or are uncollectable, except as permitted under 42 CFR 447.57(b).
42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of
42 CFR Part 447, Subpart C, and sections
1902(a)(13) and 1923 of the Act with respect to
payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and
standards used to determine rates for payment for
inpatient hospital services.

☑ Inappropriate level of care days are not covered.
In addition to the services specified in paragraphs 4.19(a), (d), (k), (i), and (m), the Medicaid agency meets the following requirements:

(1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).

(2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and facilities in intermediate care facilities for the mentally retarded that are described in other attachments.

SUPPLEMENT 1 TO ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.
State: NEW MEXICO

Citation: 42 CFR 447.40
AT-78-90

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☑ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☐ No.

Amendment 80-12
T. L. 80-12
December 22, 1980

Approval Date: FEB 2 1981
Effective Date: 12-1-80
4.19 (d)

(1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for nursing facility services and intermediate care facility services for the mentally retarded.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for nursing facility services and intermediate care facility services for the mentally retarded.

(2) The Medicaid agency provides payment for routine nursing facility services furnished by a swing-bed hospital.

- At the average rate per patient day paid to NFs for routine services furnished during the previous calendar year.

- At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

- Not applicable. The agency does not provide payment for NF services to a swing-bed hospital.
Revision: HCFA-Region VI  
March 1991

State: New Mexico

Citation  
42 CFR 447.45  
AT-79-50  
Sec. 1915(b)(4),  
(Sec. 4742 of  
P.L. 101-508)

4.19(e)  
The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

STATE:  
DATE REC'D: 4/19/91  
DATE APP'V'D: 4/19/91  
DATE EFF: 1/1/91  
HCFA 179

TN# 91-08  
Supersedes  
TN# 79-12  
Approval Date: 4/19/91  
Effective Date: 1/1/91
The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

STATE: NM
DATE REC'D: 8-21-87
DATE APP'D: 1-13-88
DATE EFF: 4-1-87
HCFA 179

Supersedes TN No. 83-9
Approval Date: 1-13-88 Effective Date: 4-1-87

HCFA ID: 1010P/0012P
State: NEW MEXICO

Citation: 419(g) The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Supersedes: IN # 79-9
Approval Date: 10-26-79
Effective Date: 8-6-79
4.19(h) The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.
The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.
Citation

42 CFR 4.19(j) The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.

447.201 and 447.205 (k) The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.
Citation 4.19(k) Payments to Physicians for Clinical Laboratory Services
42 CFR 447.342
46 FR 42669

For services performed by an outside laboratory for a physician who bills for the service, payment does not exceed the amount that would be authorized under Medicare in accordance with 42 CFR 405,515(b), (c) and (d).

☐ Yes

X Not applicable. The Medicaid agency does not allow payment under the plan to physicians for outside laboratory services.

Supersedes
 Approval Date DEC 22 1981 Effective Date JUL 1 1981
4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

- sets a payment rate at the level of the regional maximum established by the DHHS Secretary.
- is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.
- sets a payment rate below the level of the regional maximum established by the DHHS Secretary.
- is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

$10 per injection

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

Other: (It is our understanding the access methodology is pending, subject to further federal guidelines.)
4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services

☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.
4.21 Prohibition Against Reassignment of Provider Claims

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.
Revision: HCFA-PM-94-1
FEBRUARY 1994

State/Territory: NEW MEXICO

Citation

4.22 Third Party Liability

42 CFR 433.137
(a) The Medicaid agency meets all requirements of:
(1) 42 CFR 433.138 and 433.139.
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433.151 through 433.154.
(4) Sections 1902(a)(25)(H) and (I) of the Act.

42 CFR 433.138(f)
(b) ATTACHMENT 4.22-A --

(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3), and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii) and (2)(ii)
(2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i)
(3) Describes the methods the agency uses for following up on information obtained through the state motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i) through (iii)
(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

STATE

DATE REC'D 3-29-94
DATE APPVD 4-4-94
DATE EFF 10-1-93
HCFA 179 A

TN No. 94-02
Supersedes Approval Date 4/4/94 Effective Date 10/1/93
TN No. 90-10
Citation

42 CFR 433.139(b)(3)(ii)(A) X (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

(d) ATTACHMENT 4.22-B specifies the following:

42 CFR 433.139(b)(3)(ii)(C) (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).

42 CFR 433.139(f)(2) (2) The threshold amount or other guidelines used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3) (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20 (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.
42 CFR 433.151(a) (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

- State title IV-D agency. The requirements of 42 CFR 433.152(h) are met.
- Other appropriate State agency(ies)...
- Other appropriate agency(ies) of another State...
- Courts and law enforcement officials.

1902(a)(60) of the Act (g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

- The Secretary's method as provided in the State Medicaid Manual, Section 3910.
- The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.
Revision: NM-AT-84-2 (BERC)  
September 2003

State/Territory: New Mexico

Citation 4.23 Use of Contracts

42 CFR 434.4
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

☐ Not applicable. The State has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):

☐ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2

X a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2

☐ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.

☐ Not applicable.

TN # 03-03  
Supersedes TN # A0-03  
Effective Date 7-1-03  
Approval Date 12-18-03

New Mexico  
9-30-03  
12-18-03  
7-1-03  
03-03
4.24 Standards for Payments for Skilled Nursing and Intermediate Care Facility Services

42 CFR 442.10 and 442.100
AT-78-90
AT-79-18
AT-80-25
AT-80-34

(a) With respect to skilled nursing and intermediate care facilities, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.

(b) Not applicable to intermediate care facilities, such services are not provided under this plan.

1919(e)(1)
1919(e)(2)
(b) With respect to the nurse aide training and competency evaluation programs, and to nurse aide competency evaluation programs; and to the nurse aide registry, the requirements of 1919(e)(1) and (2) are met.

1919(e)(7)
(c) With respect to preadmission screening and resident review, the requirements of 1919(e)(7) are met.

 STATE: NM
 DATE REC'D: 3-31-89
 DATE APPVD: 4-21-89
 DATE EFF: 1-1-89
 HCFA 177: 89-05

TN# 89-05
Supersedes Approval Date 4-21-89 Effective Date 1-1-89

TN# 80-06
State: NEW MEXICO

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

Approval Date: 4-23-74
Effective Date: 12-26-73
Drug Utilization Review Program

The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

The DUR program assures that prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results

The DUR program is designed to educate physicians and pharmacist to reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacist, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug interactions
- Incorrect drug dosage or duration
- Drug allergy interactions
- Clinical abuse/misuse

The DUR program shall assess data against predetermined standards consistent with:

- The peer reviewed medical literature
- Three compendia specified by the statute

DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. DUR is required for drugs dispensed to residents of nursing facilities which are not in compliance with 42 CFR 483.60.

The DUR program includes prospective review of drug therapy at the point of sale before each prescription is filled or delivered to the Medicaid recipient.
Prospective DUR includes screening for potential drug therapy problems due to:

- Therapeutic duplication
- Drug disease contraindications
- Drug interactions
- Incorrect dosage or duration
- Drug allergy interactions
- Clinical abuse/misuse

Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care

The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug interactions
- Incorrect dosage/duration
- Clinical abuse/misuse

The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

The DUR program has established a State DUR Board either:

- Directly
- Contract with a private organization

STATE: New Mexico

DATE REC'D: APR 5 1993
DATE APPV'D: MAY 03 1993
DATE EFF: JAN 01 1993

HCFA 179

SUPERSEDS: 23-27

TN No.: 23-27

Approval Date: MAY 03 1993
Effective Date: JAN 01 1993
The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacist and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in:

--- Clinically appropriate prescribing and dispensing of covered outpatient drugs.
--- Monitoring of covered outpatient drugs.
--- Drug use review, evaluation and intervention.
--- Medical quality assurance.

The activities of the DUR Board include:

--- Retrospective DUR
--- Application of Standards
--- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR
--- Interventions include in appropriate instances:
   - Information dissemination
   - Written, oral, and electronic reminders
   - Face to Face discussions
   - Intensified monitoring/review of providers/dispensers

An annual report is submitted to the secretary, including a report from its DUR Board, on the DUR program.
Citation 42 CFR 431.115(c)
AT-78-90
AT-79-74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.
Citation

42 CFR 431.152;
42 U.S.C. 1396m-79-18
52 FR 22444;
Secs.
1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act; P.L. 100-203 (Sec. 4211(c)).

4.28 Appeals Process

(a) The Medicaid agency has
established appeals procedures
for NFs as specified in 42 CFR
431.153 and 431.154.

(b) The State provides an appeals system
that meets the requirements of 42 CFR
431 Subpart E, 42 CFR 483.12, and
42 CFR 483 Subpart E for residents who
wish to appeal a notice of intent to
transfer or discharge from a NF and for
individuals adversely affected by the
preadmission and annual resident review
requirements of 42 CFR 483 Subpart C.
Conflict of Interest

State: New Mexico

Citation

1902(a)(4)(C) of the Social Security Act P.L. 105-33

4.29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

1902(a)(4)(D) of the Social Security Act P.L. 105-33

The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

1932(d)(3) 42 CFR 438.58

New Mexico

9-30-03

12-11-03

7-1-03

03-03

TN # 02-03

Supersedes TN # 80-17

Effective Date 7-1-03

Approval Date 12-18-03
4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42.CFR.455.104 through 455.106 and sections 1128 (b) (9) and 1902 (a) (38) of the Act.

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (Section 1137 of the Act and 42 CFR 435.940 through 435.960)

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948 (a) (6), the information that will be Requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.
4.31 Disclosure of Information by Providers and Fiscal Agents
The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128 (b) (9) and 1902 (a) (38) of the Act.

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (Section 1137 of the Act and 42 CFR 435.940 through 435.960)

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948 (a) (6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.
4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) [Attachment 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.]
4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.
Revision: Region VI
September 1989
State/Territory: NEW MEXICO

Citation
1137 of
the Act

P.L. 99-403
(sec. 121)

P.L. 100-360
(Sec. 411(k)(13))

4.34 Systematic Alien Verification for Entitlements
The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1980, except for aliens seeking medical assistance for treatment of emergency medical conditions under Section 1903(v)(2) of Social Security Act.

☐ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

☐ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

☐ Total waiver
☐ Alternative system
☐ Partial implementation

STATE: New Mexico
DATE REC'D: 11-3-90
DATE APP'ED: 2-2-90
DATE EFF: 1-1-89
HCFA 179 89-17

TW No. (not visible) Effective Date (not visible)
4.35 Enforcement of Compliance for Nursing Facilities

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

1. nature of noncompliance,
2. which remedy is imposed,
3. effective date of the remedy, and
4. right to appeal the determination leading to the remedy.

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy’s effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy’s effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

The State considers additional factors. Attachment 4.35-A describes the State’s other factors.
c) Application of Remedies

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF’s provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

(v) When immediate jeopardy does not exist, the State terminates an NF’s provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR §488.412(a) are not met.

(d) Available Remedies

(i) The State has established the remedies defined in 42 CFR §488.406(b).

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<tr>
<th>State</th>
<th>New Mexico</th>
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<tr>
<td>Date Re-D.</td>
<td>SEP 2 6 1995</td>
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<td>HCFA 179</td>
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X (1) Termination
X (2) Temporary Management
X (3) Denial of Payment for New Admissions
X (4) Civil Money Penalties
X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
X (6) State Monitoring

Attachments 4.35-B through 4.35-7 describe the criteria for applying the above remedies.

Under State Statutes NMSA 1978 Section 24-1-5.2, NMSA 1978 Section 24-1-5, and NMSA 1978 27-2-12.4, we have the authority to impose the Federal enforcement rules mandated by OBRA1987.
Citation

42 CFR
$488.406(b)
§1919(h)(2)(B)(ii)
of the Act.

(ii) The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

(1) Temporary Management
(2) Denial of Payment for New Admissions
(3) Civil Money Penalties
(4) Transfer of Residents; Transfer of Residents with Closure of Facility
(5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR
$488.303(b)
1910(h)(2)(F)
of the Act.

(e) X State Incentive Programs

X (1) Public Recognition
X (2) Incentive Payments

STATE
NEW MEXICO
DATE REC'D SEPT 2 6 1995
DATE APPV'D OCT 2 7 1995
DATE EFF JUL 0 1 1995
HCFA 179

TN No. 95-13
Supersedes Approval Date: OCT 2 7 1995 Effective Date: JUL 0 1 1995
4.36 Required Coordination Between the Medicaid and WIC Programs

1902(a)(11)(C) and 1902(a)(53) of the Act

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.
Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities

(a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.

(b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).

(c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.

(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.

(e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.

(f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

STATE: [Signature]
DATE REC'D: AUG 18 1992
DATE APRVD: SEP 15 1992
LATE E: JUL 01 1992
HCFA E: [Signature]

TN No. [Signature]
Supercede Approval Date: SEP 15 1992 Effective Date: JUL 01 1992

New Page
Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

(k) For program reviews other than the initial review, the State visits the entity providing the program.

(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).
The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.

The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.

The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).

The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).

The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.

The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.
When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.

The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.

The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.

The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.

Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.

The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).

The State has a standard for successful completion of competency evaluation programs.
Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

X (z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.

(aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).

(bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.

(cc) The State includes home health aides on the registry.

(dd) The State contracts the operation of the registry to a non-State entity.

(ee) ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.155(c)(1)(iii) and (iv).

X (ff) ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).
Citation
Secs.
1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act;
P.L. 100-203
(Sec. 4211(c));
P.L. 101-508
(Sec. 4801(b)).

4.39 Preadmission Screening and Annual
Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a
written agreement with the State mental
health and mental retardation authorities
that meet the requirements of 42 (CFR)
431.621(c).

(b) The State operates a preadmission and
annual resident review program that meets
the requirements of 42 CFR 431.100-138.

(c) The State does not claim as "medical
assistance under the State Plan" the cost
of services to individuals who should
receive preadmission screening or annual
resident review until such individuals are
screened or reviewed.

(d) With the exception of NF services
furnished to certain NF residents defined
in 42 CFR 431.118(c)(1), the State does
not claim as "medical assistance under the
State plan" the cost of NF services to
individuals who are found not to require
NF services.

(e) ATTACHMENT 4.39 specifies the State's
definition of specialized services.
Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFSs and that a more appropriate placement should be utilized.

The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.
SECTION 5 PERSONNEL ADMINISTRATION

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 203 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☐ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan.

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.
State: NEW MEXICO

5.2. [Reserved]
Training Programs: Subprofessional and Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.
6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.
6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.
6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

\[\text{State funds are used to pay all of the non-Federal share of total expenditures under the plan.}\]

\[\text{There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.}\]

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

Approval Date 7-16-76   Effective Date 7-1-76
SECTION 6 FINANCIAL ADMINISTRATION

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.
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[ ] State funds are used to pay all of the non-Federal share of total expenditures under the plan.

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(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.
SECTION 6  FINANCIAL ADMINISTRATION

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☑ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

☐ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

Approval Date  7-16-76  Effective Date  7-1-76
SECTION 7 - GENERAL PROVISIONS

Citation 7.1 Plan Amendments

42 CFR 430.12(c) The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

TN No. 91-19 Supersedes Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. 77-20

NEW MEXICO

STATE DEC 17 1992
DATE REC'D JAN 15 1992
DATE A.M.VD JAN 15 1992
DATE EFF OCT 1 1991
HCFA ID: 7982E
Citation 7.2 Nondiscrimination

45 CFR Parts 80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.
Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

☒ Not applicable. The Governor--
☐ Does not wish to review any plan material.
☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

The New Mexico Human Services Department
(Designated Single State Agency)

Date: December 12, 1991

Bruce Weidner
(Signature)

Director
(Title)

Supersedes Approval Date JAN 15 1992

Effective Date OCT 1 1991

HCFA ID: 7982E