

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

Attachment 2.1-A
Page 1

STATE PLAN DEFINITION OF HMO

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

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*Forms Provided

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*Forms Provided

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*Forms Provided

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May 4, 1978

~~Attachment 1.1-A~~
~~STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT~~
~~MEDICAL ASSISTANCE PROGRAM~~

~~Amendment 78-7 TL 78-7~~
~~Attachment 1.1-A~~

~~State of NEW MEXICO~~

~~ATTORNEY GENERAL'S CERTIFICATION~~

I certify that:

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

☒ ~~administering the plan.~~

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

~~Section 13-17-15, New Mexico Statutes Annotated, 1953 Compilation
(statutory citation)~~

☒ ~~supervising the administration of the plan by local
political subdivisions.~~

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

~~(statutory citation)~~

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

~~(statutory citation)~~

~~4/26/78~~
DATE

~~ATNEY ANAYA~~

~~Attorney General by~~

~~Signature -~~

APPROVED by DHEW/HCFR/MS
DATE: ~~MAY 31 1978~~

TRANSMITTAL NO: ~~78-7~~

~~Assistant Attorney General~~
~~Title~~

~~State Plan for Medical Assistance
under Title XIX, SSA
New Mexico~~

~~Attachment 1.2 A~~

~~ORGANIZATION AND FUNCTION OF STATE AGENCY~~

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

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

~~SECTION I~~

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

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

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

- ~~A. the Medical Assistance Division;~~
- ~~B. the Income Support Division;~~
- ~~C. the Child Support Enforcement Division;~~
- ~~D. the Office of Inspector General;~~
- ~~E. the Administrative Services Division; and,~~
- ~~F. the Office of General Counsel.~~

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~~77-11; 78-19; 81-13; 84-2~~
~~SUPERSEDES: TN 78-200-15-12~~

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Amendment 95-02
March 6, 1995

~~Secretary of Human Services~~ The administrative head of the human services department is the "secretary of human services," who is appointed by the governor with the consent of the senate and who serves in the executive cabinet. The appointed secretary shall serve and have all the duties, responsibilities and authority of that office during the period of time prior to final action by the senate confirming or rejecting his appointment.

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

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

~~SECTION II~~

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

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

~~Child Support Enforcement Division~~ The mission of the Child Support Enforcement Division is

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

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

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

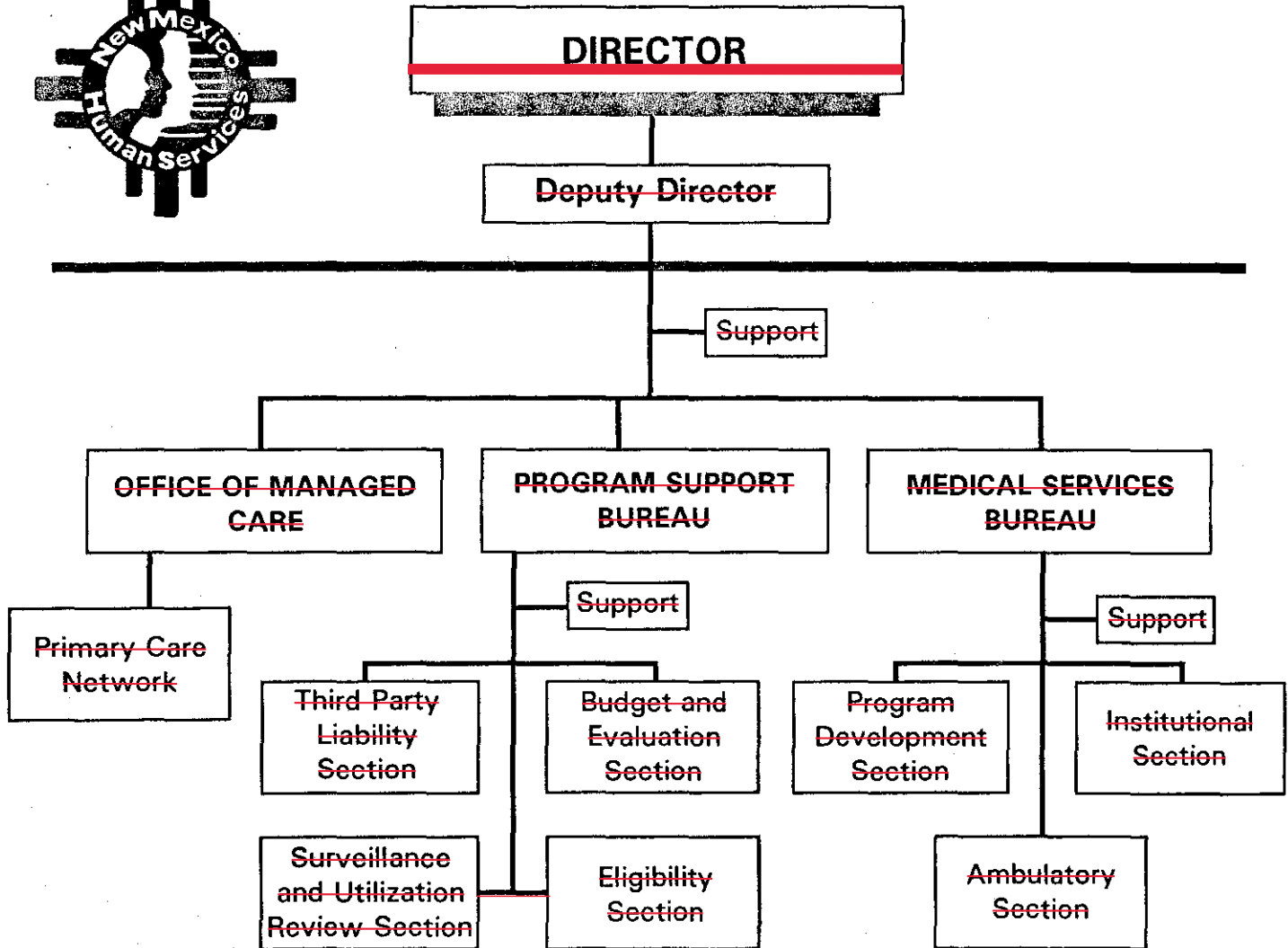
~~Office of General Counsel The Office of General Counsel provides legal advice and intervention and litigation services. The office reports directly to the Cabinet Secretary. Other offices under the umbrella of the Office of the Secretary are the Hearings Bureau, which provides administrative arbitration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

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~~SECTION III~~

~~MEDICAL ASSISTANCE DIVISION~~



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~~State Plan for Medical Assistance
under Title XIX, SSA
New Mexico~~

~~Attachment 1.2-B~~

~~ORGANIZATION AND FUNCTION UNDER MEDICAL ASSISTANCE DIVISION~~

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

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

~~SECTION I~~

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

~~SECTION II~~

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

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

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

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

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

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

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

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

~~B. Ambulatory Care Section - The Ambulatory Care Section is responsible for developing~~

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

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

~~Office of Managed Care The Office of Managed Care includes the Primary Care Network, a statewide primary care, case-management system which requires Medicaid recipients to enroll with primary physicians, clinics and pharmacies. These primary care providers serve as gatekeepers into the health care system and are responsible for monitoring the patient's use of health care services and eliminate the inefficient or inappropriate use of resources. The Office of Managed Care also oversees the division's transition from traditional fee-for-service Medicaid programs to managed Medicaid programs.~~

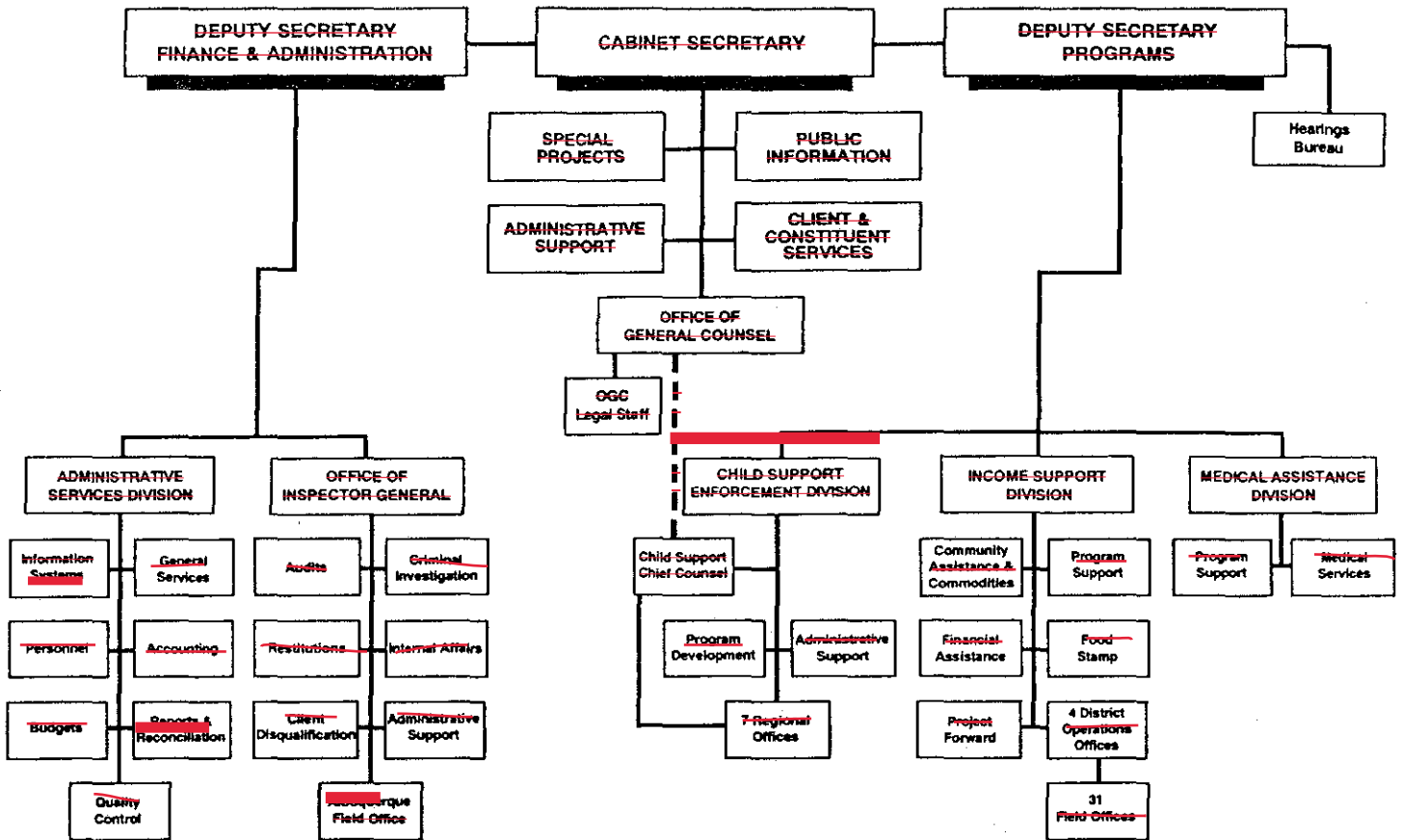
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~~SECTION III~~



~~New Mexico~~
~~HUMAN SERVICES DEPARTMENT~~



HSD Secretary

2/6/95

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on: HCFA-AT-80-38 (BPP)
May 22, 1980

State NEW MEXICO

Citation
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431.12(b)
AT-78-90

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.

74-13

per sedes
TN #

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This plan includes the medically needy

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Supplement 1

Supplement 3

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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The following groups are covered under this plan.
IV-A

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

42 CFR 435.110

1. Recipients of AFDC

The approved State AFDC plan includes:

- ☒ Families with an unemployed parent for the mandatory 6-month period and an optional extension of ___ months.
- ☒ Pregnant women with no other eligible children.
- ☒ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

42 CFR 435.115

2. Deemed Recipients of AFDC

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

*Agency that determines eligibility for coverage.

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Approval Date JAN 15 1992

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TN No. 90-24

HCFA ID: 7983E

STATE	<u>New Mexico</u>
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A

State: NEW MEXICO

Agency* Citation(s) Groups Covered

IV-A

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

2. Deemed Recipients of AFDC.

~~1902(a)(10)(A)(i)(I)
of the Act~~

Text stricken here is
superseded by SPA TN
13-22 submitted via MMDL.

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

~~402(a)(22)(A)
of the Act~~

~~c. Individuals whose AFDC payments are
reduced to zero by reason of recovery
of overpayment of AFDC funds.~~

406(h) and
1902(a)(10)(A)
(i)(I) of the Act

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

1902(a) of
the Act

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

*Agency that determines eligibility for coverage.

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Supersedes

Approval Date JAN 15 1992

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TN No. 90-24 page 1 Item 2, b

HCFA ID: 7983E

90-17 page 2 Item 2, c, d, f

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A

State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

~~IV-A
407(b), 1902
(a)(10)(A)(i)
and 1905(m)(1)
of the Act~~

~~3. Qualified Family Members~~

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

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

~~IV-A
1902(a)(52)
and 1925 of
the Act~~

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

Text stricken here is
superseded by SPA TN
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*Agency that determines eligibility for coverage.

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TN No. 90-17

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90-24 page 4a item 8 & b

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State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

~~IV-A~~

~~42 CFR 435.113~~

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

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

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

~~(2) Grandparents;~~

~~(3) Legal guardians; and~~

~~(4) Individual alien sponsors (who are not
spouses of the individual or the
individual's parent);~~

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

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

~~*Agency that determines eligibility for coverage.~~

~~TN No. 91-19~~

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~~Effective Date~~

~~OCT 1 1991~~

~~Supersedes~~

~~TN No. 87-2~~

~~posed item 4~~

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HCFA 179	<u>91-19</u>

A

State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

IV-A 42 CFR 435.114

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

~~x~~

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

~~x~~

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

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

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

~~7. Qualified Pregnant Women and Children.~~

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

IV-A

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

*Agency that determines eligibility for coverage.

TN No. ~~92-02~~

Superseded

TN No. ~~91-19~~

Approval Date ~~MAR 10 1992~~

Effective Date ~~JAN 01 1992~~

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency* Citation(s)

Groups Covered

IV-A

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

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

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

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

~~Children born after~~

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

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

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>APR 03 1992</u>	
DATE APPV'D	<u>APR 29 1992</u>	
DATE EFF	<u>JAN 01 1992</u>	
HCFA 179	<u>9204</u>	

* ~~Agency that determines eligibility for coverage.~~

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

State: NEW MEXICO

~~COVERAGE AND CONDITIONS OF ELIGIBILITY~~

~~Agency*~~ Citation(s)

~~Groups Covered~~

~~IV-A~~

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

~~1902(a)(10)(A)
(i)(IV) and
1902(l)(1)(A)
and (B) of the
Act~~

~~8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.~~

~~X The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.~~

~~IV-A~~

~~9. Children:~~

~~1902(a)(10)(A)
(i)(VI)
1902(l)(1)(C)
of the Act~~

~~a. who have attained 1 year of age but have not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.~~

~~1902(a)(10)(A)(i)
(VII) and 1902(l)
(1)(D) of the Act~~

~~b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.~~

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

STATE	<u>New Mexico</u>	A
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DATE APP'VD	<u>APR 29 1992</u>	
DATE EFF	<u>JAN 01 1992</u>	
HCFA 179	<u>92-04</u>	

* Agency that determines eligibility for coverage.

TN No. 92-04 Approval Date APR 29 1992 Effective Date JAN 01 1992
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TN No. 91-19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency* Citation(s)

Groups Covered

Text stricken here is
superseded by SPA TN
13-22 submitted via MMDL.

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

~~10. Reserved~~

IV-A 1902(e)(5)
of the Act

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

IV-A 1902(e)(6)
of the Act

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

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DATE APPV'D	<u>APR 29 1992</u>	
DATE EFF	<u>JAN 01 1992</u>	
HCFA 179	<u>92-04</u>	

* Agency that determines eligibility for coverage.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

IV-A

X a. Individuals receiving SSI.

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

X Aged
X Blind
X Disabled

STATE	NM
DATE REC'D	9/30/09
DATE APPVD	11/16/09
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HCFA 179	09-07

*Agency that determines eligibility for coverage.

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State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

435.121

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

1619(b)(1)
of the Act

☐ Aged
☐ Blind
☐ Disabled

The more restrictive categorical eligibility criteria are described below:

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

*Agency that determines eligibility for coverage.

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Agency* Citation(s) Groups Covered

Social Security

Administration A.

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

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

14. Qualified severely impaired blind and disabled individuals under age 65, who--
- a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or
- b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--
- (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
- (2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;
- (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

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Agency* Citation(s)

Groups Covered

Social Security
Administration

A.

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

- (4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
- (5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

☒

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

*Agency that determines eligibility for coverage.

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Agency* Citation(s)

Groups Covered

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

1619(b)(3)
of the Act

☒

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

*Agency that determines eligibility for coverage.

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State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

1634(c) of
the Act

15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--
- a. Are at least 18 years of age;
 - b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.
 - ☐ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.
 - ☐ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.

IV-A

42 CFR 435.122

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

42 CFR 435.130

17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

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

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

☐ Aged ☐ Blind ☐ Disabled

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

*Agency that determines eligibility for coverage.

OCT 1 1991

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State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

- 42 CFR 435.132 19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--
- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and
 - b. Remain institutionalized; and
 - c. Continue to need institutional care.
- 42 CFR 435.133 20. Blind and disabled individuals who--
- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and
 - b. Were eligible for Medicaid in December 1973 as blind or disabled; and
 - c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

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State: NEW MEXICO

Agency* Citation(s) Groups Covered

IV-A

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

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

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

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

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

*Agency that determines eligibility for coverage.

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State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

42 CFR 435.135

22. Individuals who --

- a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and
- b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

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

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

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

*Agency that determines eligibility for coverage.

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TN No. 88-09

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HCFA ID: 7983E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APPE'D	<u>JAN 15 1992</u>
DATE EFF.	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

A

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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Page 9
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State: NEW MEXICO

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634 of the Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

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

☐ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

TN No. 91-19
Supersedes
TN No. 91-01

Approval Date JAN 15 1992

Effective Date

OCT 1 1991

HCFA ID: 7983E

STATE	<u>NEW MEXICO</u>
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A

State/Territory: New Mexico

Agency* Citation(s)

Groups Covered

1634(d) of the
Act

IV-A

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

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

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

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

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

— In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual.

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DATE EFF	<u>1-1-92</u>	
HCFA 179	<u>92-01</u>	

*Agency that determines eligibility for coverage.

TN No. 92-01
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TN No. 91-19

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency * Citation (s)

Groups Covered

IV-A

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

1902 (a) (10)(E)(i)
And 1905 (p)
1860 D-14 (a)(3)(d)
of the Act

*HSD

25. Qualified Medicare beneficiaries--

- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);
- b. Whose income does not exceed 100 percent of the Federal poverty level, and
- c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI).

1902 (a)(10)(E) (ii),
1905 (s) and
1905 (p) (3) (A) (i)
of the Act

*HSD

26. Qualified disabled and working individuals--

- a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;
- b. Whose income does not exceed 200 percent of the Federal poverty level; and
- c. Whose resources do not exceed three times the maximum standard under SSI.
- d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.

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DATE APP'D	<u>8-30-10</u>
DATE EFF	<u>1-1-10</u>
HCFA 179	<u>10-03</u>

TN No. 10-03
Supersedes
TN No. 93-05

Approval Date 8-30-10 Effective Date 1-1-10

SUPERSEDES: TN- 93-05

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency * Citation (s)

Groups Covered

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

1902 (a) (10)(E)(iii),
1905 (p)(3)(A)(ii) and
1860 D-14(a)(3)(D)
of the Act

*HSD

27. Specified low-income Medicare beneficiaries--

- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);
- b. Whose income is at least 100 percent, but does not exceed 120 percent of the Federal poverty level.
- c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the Consumer Price Index (CPI).

(Medical assistance for this group is limited to Medicare Part A premiums under section 1839 of the Act.)

1902(a)(10)(E)(iv)
1905(p)(3)(A)(ii)
1860D-14(a)(3)(D)
of the Act

*HSD

28. Qualifying Individuals

- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under 1818A of the Act);
- b. Whose income is at least 120 percent, but does not exceed 135 percent of the Federal Poverty level;
- c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the Consumer Price Index (CPI).

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HCFA 179 <u>10-03</u>	

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SUPERSEDES: TN- 93-05

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency * Citation (s)

Groups Covered

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

1634 (e) of
the Act

29. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611 (e)(3)(A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month.
- b. The State applies more restrictive eligibility standards than those under SSI.

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

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DATE APP'D.	<u>8-30-10</u>	
DATE EFF.	<u>1-1-10</u>	
HCFA 179	<u>10-03</u>	

*Agency that determines eligibility for coverage.

TN No. 10-03
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SUPERSEDES: TN- 96-02

Revision: HCFA REGION VI
NOVEMBER 1991

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PAGE 9bb

State: NEW MEXICO

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

* Agency that determines eligibility for coverage.

TN NO. 91-19 Approval Date: JAN 15 1992 Effective Date: OCT 1 1991

Supersedes TN NO. New Page

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>DEC 17 1991</u>	
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HCFA 179	<u>91-19</u>	

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)

ATTACHMENT 2.2-A
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OMB No.: 0938-

State: NEW MEXICO

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy

42 CFR ☐ 1. Individuals described below who meet the
435.210 income and resource requirements of AFDC, SSI, or an
1902(a) optional State supplement as specified in 42
(10)(A)(ii) and CFR 435.230, but who do not receive cash
1905(a) of assistance.
the Act

☐ The plan covers all individuals as described above.

☐ The plan covers only the following group or groups of individuals:

☐ Aged
☐ Blind
☐ Disabled
☐ ~~Caretaker relatives~~
☐ Pregnant women

Text stricken here is
superseded by SPA TN
13-22 submitted via MMDL.

IV-A 42 CFR ☒ 2. Individuals who would be eligible for AFDC, SSI
435.211 or an optional State supplement as specified in 42
CFR 435.230, if they were not in a medical
institution.

*Agency that determines eligibility for coverage.

TN No. 91-19 Approval Date JAN 15 1992 Effective Date OCT 1 1991
Supersedes
TN No. 88-09 *Page 9a thru 51 + B2* HCFA ID: 7983E
87-10 Page 10 Paragraph

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APP'D	<u>JAN 15 1992</u>
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HCFA 177	<u>91-19</u>

A

Revision: NM-PM-91-10 (BPD)

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State: New Mexico

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

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

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

X The State elects not to guarantee eligibility.

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

The State measures the minimum enrollment period from:

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

*Agency that determines eligibility for coverage.

SUPPRESSED: NONE - NEW PAGE

TN # 03-03

Supersedes TN # 03-03

Effective Date 7-1-03
Approval Date 12-18-03

STATE	<u>New Mexico</u>
DATE REC'D	<u>9-30-03</u>
DATE APP'VD	<u>12-18-03</u>
DATE EFF	<u>7-1-03</u>
HCPA 179	<u>03-03</u>

State: New Mexico

Agency*	Citation(s)	Groups Covered
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1932(a)(4) of Act	B. Optional Groups Other Than Medically Needy(continued)	
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The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

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

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

 No restrictions upon disenrollment rights.

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

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

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

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

SUPERSEDES: NONE - NEW PAGE

* Agency that determines eligibility for coverage.

STATE	<u>New Mexico</u>
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DATE APPVD	<u>12-18-03</u>
DATE EFF	<u>7-1-03</u>
HOFA 179	<u>0303</u>

A

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Supersedes TN # 00-07 Approval Date 12-18-03
NEW PAGE

State/Territory: New Mexico

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

STATE <u>New Mexico</u>	A
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HCFA 179 <u>92-01</u>	

*Agency that determines eligibility for coverage.

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AUGUST 1991

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Agency* Citation(s) Groups Covered

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

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

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

☒ The State covers all individuals as described above.

☒ The State covers only the following group or groups of individuals:

☐ Aged
☐ Blind
☐ Disabled
☐ Individuals under the age of--
 ☐ 21
 ☐ 20
 ☐ 19
 ☐ 18
☐ Caretaker relatives
☐ Pregnant women

*Agency that determines eligibility for coverage.

TN No. 91-19

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A

State: NEW MEXICO

Agency* Citation(s)

Groups Covered

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

42 CFR 435.220



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

This page is superseded by SPA
TN 13-22 submitted via MMDL.



~~The State covers all individuals as described above.~~

1902(a)(10)(A)
(ii) and 1905(a)
of the Act



~~The State covers only the following group or groups of individuals:~~

- ~~— Individuals under the age of—~~
 - ~~— 21~~
 - ~~— 20~~
 - ~~— 19~~
 - ~~— 18~~
- ~~— Caretaker relatives~~
- ~~— Pregnant women~~

42 CFR 435.222
1902(a)(10)
(A)(ii) and
1905(a)(i) of
the Act

7. ☒

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

- ~~— 20~~
- ~~— 19~~
- ~~— 18~~

TN No. 92-02

Superseded 9/1/9

TN No. 92-02

Approval Date MAR 10 1992

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DATE EFF <u>JAN 01 1992</u>	
HCFA 179 <u>92-02</u>	

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AUGUST 1991

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State: NEW MEXICO

Agency* Citation(s)

Groups Covered

~~Social Services~~
~~and IV-A~~

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

~~42 CFR 435.222~~

~~X b. Reasonable classifications of individuals described in (a) above, as follows:~~

~~X (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:~~

~~X (a) In foster homes (and are under the age of 18).~~

~~X (b) In private institutions (and are under the age of 18).~~

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

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

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

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

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Supersedes

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TN No. 87-02 page 12 item 7 (4)(1)
87-03 page 13 item 7 (4)(a)

HCFA ID: 7983E

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State: NEW MEXICO

Agency* Citation(s)

Groups Covered

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

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

*CYFD

X (6) ~~Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.~~

TN No. 9313

Superseded 9119

TN No. 9119

Approval Date 01/24/95

Effective Date 08/01/94

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STATE <u>New Mexico</u>	A
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DATE APPV'D <u>01-04-95</u>	
DATE EFF <u>08-01-94</u>	
HCFA 179 <u>93-13</u>	

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AUGUST 1991

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Agency* Citation(s) Groups Covered

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

~~1902(a)(10)
(A)(ii)(VIII)
of the Act~~

~~✓~~

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

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

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

~~The State covers individuals under the age of--~~

~~___ 21
___ 20
___ 19
___ 18~~

TN No. ~~91-19~~

Supersedes

TN No. ~~87-3~~

Approval Date

~~JAN 15 1992~~

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~~OCT 1 1991~~

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STATE	New Mexico	A
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HCFA 179	91-19	

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AUGUST 1991

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Agency* Citation(s) Groups Covered

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

~~42 CFR 435.223~~ ☒

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

~~1902(a)(10)
(A)(ii) and
1905(a) of
the Act~~

~~Individuals under the age of--
 21
 20
 19
 18
Caretaker relatives
Pregnant women~~

TN No. 91-19

Supersedes

TN No. 87-3

Approval Date JAN 15 1992

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87-3 page 15 Paragraph

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DATE APP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>9/17/9</u>

State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

42 CFR 435.230 ☒ 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

435.120

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

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in the State.
- d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.
 - (1) All aged individuals.
 - (2) All blind individuals.
 - (3) All disabled individuals.

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DATE EFF	<u>APR 19 1991</u>
HCFA 177	

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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State: NEW MEXICO

Agency*	Citation(s)	Groups Covered
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**B. Optional Groups Other Than the Medically Needy
(Continued)**

42 CFR 435.230

- | | | |
|---|-----|---|
| — | (4) | Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| — | (5) | Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| — | (6) | Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI. |
| — | (7) | Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| — | (8) | Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| — | (9) | Individuals in additional classifications approved by the Secretary as follows: |

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TN No. 87-3 *page 15 Item 10 d 4*
87-3 page 16 Items 5-9

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Agency* Citation(s)

Groups Covered

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

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

 Yes.

 No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

TN No. 91-19 Approval Date JAN 15 1992 Effective Date OCT 1 1991
Supersedes 87-3 *pages 16 last 2 paragraphs* HCFA ID: 7983E
TN No. 87-3

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>DEC 17 1991</u>	
DATE APP'D	<u>JAN 15 1992</u>	
DATE EFF	<u>OCT 01 1991</u>	
HCFA 179	<u>91-19</u>	

State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

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

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

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

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in each classification and available on a Statewide basis.
- d. Paid to one or more of the classifications of individuals listed below:

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

TN No. 92-02
Supersedes 91-19
TN No. 91-19 Approval Date MAR 10 1992

Effective Date JAN 01 1992

HCFA ID: 7983E

STATE <u>New Mexico</u>	A
DATE REC'D <u>FEB 18 1992</u>	
DATE APPV'D <u>MAR 10 1992</u>	
DATE EFF <u>JAN 01 1992</u>	
HCFA 179 <u>92-02</u>	

Revision: HCFA Region VI
July 1991

(BERC)

ATTACHMENT 2.2-A
Page 17a

Agency*	Citation(s)	Group Covered
	1902(a)(10)(A)(ii) <u>x</u> 13. (IX) and 1902(1) of the Act, P.L. 100-203 (Section 4101)	<p>The following individuals who are not described in section 1902(a)(10)(A)(i) of the Act whose income level (established at an amount not more than 185 percent of the Federal poverty line) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:</p> <p>Woman during pregnancy (and during the 60-day period beginning on the last day of pregnancy) and infants under one year of age.</p> <p>Infants who are receiving inpatient services on the date they reach the maximum age for coverage under the approved plan will continued to be eligible for inpatient services until the end of the stay for which the inpatient services are furnished.</p>

*Agency that determines eligibility for coverage.

TN No. <u>91-15</u>	Approval Date <u>OCT 23 1991</u>	Effective Date <u>JUL -1 1991</u>						
Supersedes TN No. <u>90-17</u>	<table><tr><td>STATE <u>New Mexico</u></td><td rowspan="5">A</td></tr><tr><td>DATE REC'D <u>SEP 27 1991</u></td></tr><tr><td>DATE APP'D <u>OCT 23 1991</u></td></tr><tr><td>DATE EFF <u>JUL -1 1991</u></td></tr><tr><td>HCFA 179 <u>91-15</u></td></tr></table>		STATE <u>New Mexico</u>	A	DATE REC'D <u>SEP 27 1991</u>	DATE APP'D <u>OCT 23 1991</u>	DATE EFF <u>JUL -1 1991</u>	HCFA 179 <u>91-15</u>
STATE <u>New Mexico</u>	A							
DATE REC'D <u>SEP 27 1991</u>								
DATE APP'D <u>OCT 23 1991</u>								
DATE EFF <u>JUL -1 1991</u>								
HCFA 179 <u>91-15</u>								

Agency* Citation(s) Groups Covered

Text stricken here is
superseded by SPA TN
13-22 submitted via MMDL.

~~The payment levels under the approved State AFDC plan are no lower than the AFDC payment levels in effect under the approved AFDC plan on April 17, 1986.~~

☒ Yes.

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

1902(a)
(10)(A)
(ii)(X)
and 1902(m)
(1) and (3)
of the Act,
P.L. 99-509
(Section
9402(a) and
(b))

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

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

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

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

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

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

___ Under SSI;

___ Under the State's more restrictive financial criteria; or

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

STATE	New Mexico
DATE REC'D	3-17-88
DATE APP'D	4-8-88
DATE EFF	1-1-88
HCFA 177	88-05

A

*Agency that determines eligibility for coverage.

TN No. 88-05
Supersedes
TN No. 87-18

Approval Date 4-8-88

Effective Date 1-1-88

HCFA ID: 1036P/0015P

Revision: HCFA-PM-87-4 (BERC)
March 1987

ATTACHMENT 2.2-A
Page 17c
OMB NO. 0938-0193

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

Text stricken here is
superseded by SPA TN
13-22 submitted via MMDL.

C. Optional Coverage of the Medically Needy

435.301

This plan includes the medically needy.

X No.

— Yes. This plan covers:

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

STATE	<u>MM</u>	A
DATE REC'D	<u>05-23-89</u>	
DATE APP'D	<u>12-04-89</u>	
DATE EFF	<u>04-01-89</u>	
HCFA 179	<u>8407</u>	

*Agency that determines eligibility for coverage.

TN No. _____
Supersedes _____ Approval Date _____ Effective Date _____
TN No. _____

HCFA ID: 1036P/0015P

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991
State: NEW MEXICO

ATTACHMENT 2.2-A
Page 18
OMB NO.: 0938-

Agency* Citation(s) Groups Covered

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

- (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
- (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
- (9) Individuals in additional classifications approved by the Secretary as follows:

TN No. 91-19 Approval Date JAN 15 1992
Supersedes
TN No. 87-3 *pages 15 Item 10 d 4*
87-3 page 14 Items 5-9

Effective Date OCT 1 1991
HCFA ID: 7983E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

A

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 2.2-A
Page 18a
OMB NO.: 0938-

State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

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

___ Yes

___ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

TN No. 91-19
Supersedes
TN No. 87-3

Approval Date JAN 15 1992

Effective Date OCT 1 1991

HCFA ID: 7983E

page 16 last 2 paragraphs

STATE	<u>NEW Mexico</u>	A
DATE REC'D	<u>DEC 17 1991</u>	
DATE APP'D	<u>JAN 15 1992</u>	
DATE EFF	<u>OCT 01 1991</u>	
HCFA 179	<u>91-19</u>	

State: NEW MEXICO

Agency* Citation(s) Groups Covered

IV-A

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

42 CFR 435.231 ☒
1902(a)(10)
(A)(ii)(V)
of the Act

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

☒ The State covers all individuals as described above.

☐ The State covers only the following group or groups of individuals:

1902(a)(10)(A)
(ii) and 1905(a)
of the Act

☐ Aged
☐ Blind
☐ Disabled
☐ Individuals under the age of--
 ☐ 21
 ☐ 20
 ☐ 19
 ☐ 18
☐ Caretaker relatives
☐ Pregnant women

TN No. 91-19

Supersedes

TN No. 87-17

Approval Date JAN 15 1992

Page 17 Item 11

Effective Date

OCT 1 1991

HCFA ID: 7983E

STATE	<u>NEW MEXICO</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APY'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 1/9	<u>91-19</u>

A

Revision: HCFA Region VI
December 1990

Attachment 2.2-A
Page 19a

STATE: New Mexico

Agency*	Citation	Groups Covered
	Section 4723 of P.L. 101-508 and Section 1903(f)(2)(B) of the Act	The State agency allows medically needy individuals and families to pay an amount to the State, which when combined with incurred medical costs in prior months, is sufficient when excluded from the family's income, to reduce such family's income below the applicable income limitation described in Section 1903(f)(1) of the Act.

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>1-18-91</u>	
DATE APP'D	<u>1-28-91</u>	
DATE EFF	<u>11-5-90</u>	
HCFA 179	<u>90-26</u>	

* Agency that determines eligibility for coverage

TN NO.	<u>90-26</u>	Effective Date:	<u>11/5/90</u>
Superseded	<u>New Page</u>	Approval Date:	<u>1/28/91</u>
TN NO.			

State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

1902(e)(3)
of the Act

☐

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

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

IV-A

1902(a)(10)
(A)(ii)(IX)
and 1902(1)
of the Act

☒

14. ~~The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6 A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6 A:~~
- a. ~~Women during pregnancy (and during the 60 day period beginning on the last day of pregnancy); and~~
 - b. ~~Infants under one year of age.~~

Text stricken here is
superseded by SPA TN
13-22 submitted via MMDL.

TN No. 92-02
Supersedes
TN No. 91-19

Approval Date MAR 10 1992

Effective Date JAN 01 1992

HCFA ID: 7983E

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>FEB 18 1992</u>	
DATE APPV'D	<u>MAR 10 1992</u>	
DATE EFF	<u>JAN 01 1992</u>	
HCFA 179	<u>92-02</u>	

Revision: HCFA REGION VI
NOVEMBER 1991

ATTACHMENT 2.2-A
PAGE 21

State: NEW MEXICO

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

(RESERVED FOR FUTURE USE)

* Agency that determines eligibility for coverage.

TN NO. 91-19 Approval Date JAN 15 1992 Effective Date: OCT 1 1991
Supersedes TN NO. 96-20

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>DEC 17 1991</u>	
DATE APPV'D	<u>JAN 15 1992</u>	
DATE LFF	<u>OCT 01 1991</u>	
HCFA 179	<u>91-19</u>	

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)

ATTACHMENT 2.2-A
Page 22
OMB NO.: 0938-

State: NEW MEXICO

Agency* Citation(s) Groups Covered

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

1902(a) ☒
(11)(X)
and 1902(m)
(1) and (3)
of the Act

16. Individuals--

- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.
- b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
- c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

TN No. 91-19
Supersedes
TN No. 88-05 for 17 & Item 14

Approval Date

JAN 15 1992

Effective Date

OCT 1 1991

HCFA ID: 7983E

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>DEC 17 1991</u>	
DATE APPV'D	<u>JAN 15 1992</u>	
DATE EFF	<u>OCT 01 1991</u>	
HCFA 179	<u>91-19</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency^A Citation(s)

Groups Covered

QUALIFIED
P/E PROVIDERS

1902(a)(47)
and 1920 of
the Act

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

X

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

This page is superseded by SPA
TN 13-22 submitted via MMDL.

STATE <u>New Mexico</u>	A
DATE REC'D <u>APR 03 1992</u>	
DATE APP'D <u>APR 29 1992</u>	
DATE EFF <u>JAN 01 1992</u>	
HCFA 179 <u>92-04</u>	

* Agency that determines eligibility for coverage.

TN No. 92-04
Supersedes
TN No. 91-19
Approval Date APR 29 1992 Effective Date JAN 01 1992

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 2.2-A
Page 23a
OMB NO.:

State/Territory: NEW MEXICO

Citation

Groups Covered

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

1906 of the
Act

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

1902(a)(10)(F)
and 1902(u)(1)
of the Act

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

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

A

TN No. 91-19

Supersedes

Approval Date

JAN 15 1992

Effective Date

OCT 1 1991

TN No. New Page

HCFA ID: 7982E

~~ATTACHMENT 2.2-A~~

~~Page 23b~~

Citation

Groups Covered

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

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

~~20. Optional Targeted Low Income Children who:~~

- ~~a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability);~~
- ~~b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on April 15, 1997 (other than because of the age expansion provided for in 1902(n)(2)(D));~~
- ~~c. are not covered under a group health plan or other group health insurance (as such terms are defined in 2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no Federal funds for the program;~~
- ~~d. have family income at or below:

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

~~TN No. 09-04
Supersedes
TN No. 04-04~~

~~Approval Date 11-16-09 Effective Date 10-1-09
HCFA ID: 7982E~~

~~SUPERSEDES. TN. 04-04~~

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>9-30-09</u>	
DATE APPV'D	<u>11-16-09</u>	
DATE EFF	<u>10-1-09</u>	
HCFA 179	<u>09-04</u>	

Citation

Groups Covered

~~The State covers:~~

~~— All children described above who are under age 19 (18, 19) with family income at or below 235 percent of the Federal poverty level.~~

~~X The following reasonable classifications of children described above who are under age 6 with family income at or below 235 percent of the percent of the Federal poverty level:~~

Text stricken here is
superseded by SPA TN
13-22 submitted via MMDL.

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

1902(e)(12) of the Act

X

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

~~1920 A of the Act~~

~~X~~

~~22. Children under age 19 who are determined by a "qualified entity" as defined in 1920A(b)(3)(A) based on preliminary information, to meet the highest applicable income criteria specified in this plan.~~

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

TN No. 13-10
Supersedes:
TN No. 93-13

Approval Date 10/25/13 Effective Date 7/1/13

HCFA ID: 7982E

Revision:

ATTACHMENT 2.2-A
PAGE 23d
OMB NO.:

State/Territory: NEW MEXICO

Citation		Groups Covered
B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)		
1902(a)(10)(A) (ii)(XIII) of the Act	<input checked="" type="checkbox"/>	23. BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A
1902(a)(10)(A) (ii)(XV) of the Act	<input type="checkbox"/>	24. TWWIIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.
1902(a)(10)(A) (ii)(XVI) of the Act	<input type="checkbox"/>	25. TWWIIA Medical Improvement Group - Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A.
NOTE: If the State elects to cover this group, it MUST also cover the Basic Coverage Group described in no. 24 above.		

TN No. 01-01

Supersedes

Approval Date 04/17/01

Effective Date 01-01-01

TN No. **SUPERSEDES: NONE - NEW PAGE**

HCFA ID:

STATE <u>New Mexico</u>	A
DATE REC'D <u>01-24-01</u>	
DATE APPV'D <u>04-17-01</u>	
DATE EFF <u>01-01-01</u>	
HCFA 179 <u>01-01</u>	

STATE: NEW MEXICOPAGE 23e
NOV 18 2002

Citation

Groups Covered

PLANNING AND PROGRAM OPERATIONS BUREAU

B. Optional Coverage Other Than the Medically Needy (Continued)

1902 (a) (10) (A)
(ii) (XVIII) of the ActX [26]. Women who:

- a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;
- b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;
- c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and
- d. have not attained age 65.

1920B of the Act

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

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

11/19/02
did not send
original pages

TN No. 02-03 Approval Date: 10-29-02 Effective Date: 07-01-02

Supersedes

TN No. SUPERSEDES: NONE-NEW PAGE

STATE <u>New Mexico</u>	A
DATE REC'D <u>08-20-02</u>	
DATE APP'D <u>10-29-02</u>	
DATE EFF <u>07-01-02</u>	
HCFA 179 <u>NM 02-03</u>	

Revision: ~~HCFA PM-91-4~~
August 1991

(BPD)

~~ATTACHMENT 2.2 - A~~

Page 23f

OMB No.: ~~0938-~~

State: NEW MEXICO

Agency*	Citation(s)	Groups Covered
Social Services and IV A		B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(XVII) of the ACT		
	[X]	28. Young adults who were in foster care under the responsibility of the state's Children Youth and Families Department on their 18th birthday and who are eligible for and receiving independent living funds are eligible for Medicaid until their 21st birthday.
		(1) Resources. Resources are not countable.
		(2) Income. Income is not countable.

SUPERSEDES: NONE - NEW PAGE

STATE <u>New Mexico</u>	A
DATE REC'D <u>8-21-06</u>	
DATE APP'D <u>10-26-06</u>	
DATE EFF <u>10-1-06</u>	
HCFA 179 <u>06-08</u>	

TN No. 06-08

Supersedes

Approval Date 10-26-06

Effective Date 10-1-06

TN No. ~~SUPERSEDES~~ NONE - NEW PAGE

HCFA ID: 7983E

Revision:

~~CMS-PM-~~

~~ATTACHMENT 2.2 A~~

~~Page 23G~~

~~OMB No.:~~

State/Territory New Mexico

Citation

Groups Covered

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

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

~~1902(ii)~~

- ~~[29] X Individuals who are not pregnant and whose income does not exceed the State established income standard of 185 % of the Federal Poverty Level. This amount does not exceed the highest income limit for pregnant women in this State Plan, which is 185 % of the Federal Poverty Level.~~

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

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

~~1920C~~

~~Presumptive Eligibility for Family Planning:~~

A	
STATE	New Mexico
DATE REC'D	12-21-10
DATE APP'D	2-24-11
DATE EFF	2-1-11
HCFA 178	10-12

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

TN No. 10-12

Approval Date 2-24-11

Effective Date 2-1-11

Supersedes TN No. SUPERSEDES: NONE NEW PAGE

This page is superseded by SPA
TN 13-22 submitted via MMDL.

Revision:

~~CMS-PM~~

~~ATTACHMENT 2.2-A~~

~~Page 23 H~~

~~OMB NO.:~~

State ~~New Mexico~~

~~Citation~~

~~Groups Covered~~

~~In addition to family planning services, the State covers family planning related services to such individuals during the period of presumptive eligibility.~~

STATE ~~New Mexico~~
DATE REC'D ~~12-21-10~~
DATE APP'D ~~2-24-11~~
DATE EFF ~~2-1-11~~
HCFA 179 ~~10-12~~

~~A~~

TN No. ~~16-12~~

Approval Date ~~2-24-11~~

Effective Date ~~2-1-11~~

Supersedes TN No. ~~SUPERSEDES, NONE - NEW PAGE~~

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991
State: NEW MEXICO

ATTACHMENT 2.2-A
Page 24
OMB NO.: 0938-

Agency* Citation(s) Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR 435.301

This plan includes the medically needy.

☒ No.

☐ Yes. This plan covers:

1902(e) of the Act

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.
2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.
3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

1902(a)(10)
(C)(ii)(I)
of the Act

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Supersedes
TN No. 8907
8707 Page 10 Item C1
8707 Page 18 Items 2+3

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Agency* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

1902(e)(4) of
the Act

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

42 CFR 435.308

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

☐ b. Reasonable classifications of financially
eligible individuals under the ages of 21, 20,
19, or 18 as specified below:

____ (1) Individuals for whom public agencies are
assuming full or partial financial
responsibility and who are:

____ (a) In foster homes (and are under the age
of ____).

____ (b) In private institutions (and are under
the age of ____).

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page 18 items 4+5

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Agency* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

- (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ____).
- (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ____).
- (3) Individuals in NFs (who are under the age of ____). NF services are provided under this plan.
- (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ____).
- (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.
- (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

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State: NEW MEXICO

Agency* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

42 CFR 435.310 ☒ 6. Caretaker relatives.

42 CFR 435.320 ☒ 7. Aged individuals.
and 435.330

42 CFR 435.322 ☒ 8. Blind individuals.
and 435.330

42 CFR 435.324 ☒ 9. Disabled individuals.
and 435.330

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

435.340

11. Blind and disabled individuals who:

- a. Meet all current requirements for Medicaid
eligibility except the blindness or disability
criteria;
- b. Were eligible as medically needy in December
1973 as blind or disabled; and
- c. For each consecutive month after December 1973
continue to meet the December 1973 eligibility
criteria.

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90-20 page 19 Items 10 & 11

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Citation(s)

Groups Covered

C. Optional Coverage of Medically Needy
(Continued)

1906 of the
Act

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

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New Page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

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

Agency	Citation (s)	Groups Covered
1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	<p>The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.</p> <ol style="list-style-type: none">1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.	

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~~June, 1993~~

~~Supplement 1 Attachment 2.2 A Page 1~~

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

State: ~~New Mexico~~

~~REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER
THE AGE OF 21, 20, 19, AND 18~~

~~The New Mexico Medicaid program covers children for whom the State of New Mexico through the Children, Youth and Families Department (CYFD) has financial responsibility and who are in substitute care living arrangements but not under the care and control of a public institution. According to the terms of a Memorandum of Understanding between the secretaries of HSD and CYFD, CYFD is responsible for determining Medicaid eligibility and issuing identification cards to these children.~~

~~For purposes of this provision, "substitute care living arrangements" include placement in residential and non-residential treatment facilities in instances where medical treatment is required, placement in foster care, or adoption placement.~~

~~42 CFR 435.222 X Uninsured children under age 19 who meet the definition of
"optional targeted low income child" at 42 CFR 435.4~~

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~~Supersedes~~

~~TN No. 09-04~~

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

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SUPPLEMENT 12 ADDENDUM

Eligibility Under Section 1931 of The Act

SUPPLEMENT 13

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(MB)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	b. For the medically needy, meets the nonfinancial eligibility conditions of 42 CFR Part 435.
1905(p) of the	c. For financially eligible qualified Medicare Act beneficiaries covered under section 1902(a)(10)(E)(i) of The Act, meets the non-financial criteria of section 1905(p) Of the Act.
1905(s) of the	d. For financially eligible qualified disabled and Act working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).

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~~STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT~~
~~State NEW MEXICO~~

~~ELIGIBILITY CONDITIONS AND REQUIREMENTS~~

<u>Citation(s)</u>	<u>Condition or Requirement</u>
42 CFR 435.406 3.	Is residing in the United States (U.S.), and-
a.	Is a citizen or national of the United States;
b.	Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA's eligibility is required by section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended;
c.	Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;
d.	Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;
e.	Is a QA whose eligibility is authorized under section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended. <u>X</u> State covers all authorized QAs. State does not cover authorized QAs.
f.	State elects CHIPRA option to provide full Medicaid coverage to otherwise eligible pregnant women or children as specified below who are aliens lawfully residing in the United States; including the following:

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- (1) ~~A "Qualified alien" otherwise subject to the 5 year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;~~
- (2) ~~A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;~~
- (3) ~~An individual described in 8 CFR section 103.12(a)(4) who does not have a permanent residence in the country of their nationality and is in a status that permits the individual to remain in the U.S. for an indefinite period of time, pending adjustment of status. These individuals include:~~
- ~~(a) An individual currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);~~
 - ~~(b) An individual currently under Temporary Protected Status pursuant to section 244 of the INA;~~
 - ~~(c) A family Unity beneficiary pursuant to section 301 of Public Law 101-649 as amended by, as well as pursuant to, section 1504 of Public Law 106-554;~~
 - ~~(d) An individual currently under Deferred Enforced Departure pursuant to a decision made by the President; and~~
 - ~~(e) An individual who is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and~~
- (4) ~~An individual in non-immigrant classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including the following as specified in section 101(a)(15) of the INA:~~
- ~~• A parent or child of an individual with special immigrant status under section 101(a)(27) of the INA, as permitted under section 101(a)(15)(N) of the INA;~~
 - ~~• A Fiancé of a citizen, as permitted under section 101(a)(15)(K) of the INA;~~
 - ~~• A religious worker under section 101(a)(15)(R);~~
 - ~~• An individual assisting the Department of Justice in a criminal investigation, as permitted under section 101(a)(15)(S) of the INA;~~
 - ~~• A battered alien under section 101(a)(15)(U) (see also section 431 as amended by PRWORA); and~~
 - ~~• An individual with a petition pending for 3 years or more, as permitted under section 101(a)(15)(V) of the INA.~~

~~X~~

~~Elected for pregnant women.~~

~~X~~

~~Elected for children under age 21.~~

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- g. ~~X~~ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA section 214 option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

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42 CFR 435. 403
1902 (b) of the
Act

4.

Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.

☐ State has interstate residency agreement with the following States:

☐ State has open agreement (s).

☐ Not applicable: no residency requirement.

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State/Territory: NEW MEXICO

Citation	Condition or Requirement
42 CFR 435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. <input type="checkbox"/> Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 CFR 433.145 1912 of the Act	6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)

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Supersedes _____ Approval Date JAN 15 1992 Effective Date OCT 1 1991

TN No. 8917 page 3 Items 5 & 6

HCFA ID: 7985E

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HCFA 179	<u>91-79</u>

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 2.6-A
Page 3a.1
OMB No.: 0938-

State/Territory: NEW MEXICO

Citation

Condition or Requirement

An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(1)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

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

/X/ Assignment of rights is automatic because of State law.

42 CFR 435.910

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

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TN No. 89-17 *page 3 Item 7*

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Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 2.6-A
Page 3b
OMB No.: 0938-

State: NEW MEXICO

Citation	Condition or Requirement
1902(c)(2)	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

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STATE	<u>New Mexico</u>	A
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HCFA 179	<u>91-19</u>	

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 2.6-A
Page 3c
OMB No.: 0938-

State/Territory: NEW MEXICO

Citation

Condition or Requirement

1906 of the Act 10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

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HCFA ID: 7985E

STATE	<u>New Mexico</u>
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DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

State: New Mexico

Citation	Condition or Requirement
B. Posteligibility Treatment of Institutionalized Individuals' Incomes	
1. The following items are not considered in the posteligibility process:	
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to \$90 per month under 38 U.S.C. 5503.

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TN No. _____

Approval Date 12-14-00 Effective Date 07-01-00

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HCFA 179	<u>00-10</u>	

Revision: CMS-PM-01-1
June 2012

ATTACHMENT 2.6-A
Page 4a
OMB No.:0938-0673

State: New Mexico

Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	<p>2. The following monthly amounts for Personal needs are Deducted from total monthly income in the application of an institutionalized individual's couple's income to the cost of institutionalized care:</p> <p>Personal Needs Allowance (PNA) of not less than \$30 For Individualizes and \$60 For Couples For All Institutionalized Persons.</p> <p>a. Aged, blind, disabled Individuals <u>\$66</u> Couples <u>\$132</u></p> <p>For the following persons with greater need:</p> <p>Supplement 12 to <u>Attachment 2.6 A</u> described the greater need described the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p>b. AFDC related: Children <u>\$66</u> Adults <u>\$66</u></p> <p>For the following persons with greater need: Supplement 12 to <u>Attachment 2.6-4</u> described the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p>c. Individual under age 21 covered in the plan as specified in Item B.7 of <u>Attachment 2.2-A</u>. <u>\$ 66</u></p>

STATE <u>New Mexico</u>	A
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DATE EFF <u>7-1-12</u>	
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Revision: HCFA-PM-97-2
December 1997

ATTACHMENT 2.6-A
Page 4b
OMB No.:0938-0673

State: New Mexico

Citation

Condition or Requirement

For the following persons with greater need:

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

1924 of the Act

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

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

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

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

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

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

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Supersedes

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HCFA 179	<u>00-10</u>	

State: New Mexico

Citation

Condition or Requirement

In determining any excess shelter allowance, utility expenses are calculated using:

☒ the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or

the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

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

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

a greater amount calculated as follows:

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

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

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

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

STATE New Mexico
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DATE APP'D 12-14-00
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December 1997

ATTACHMENT 2.6-A
Page 5
OMB No.: 0938-0673

State: New Mexico

Citation

Condition or Requirement

435.725
435.733
435.832

4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:
- a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:

- ☒ AFDC level; or
☐ Medically needy level:

(Check one)

- ☒ AFDC levels in Supplement 1
- Medically needy level in Supplement 1
- Other: \$

- b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:

- (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.
- (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)

435.725
435.733
435.832

5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:

A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:

☒ No.

☐ Yes (the applicable amount is shown on page 5a.)

A				
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New Mexico	12-14-00	12-14-00	07-01-00	00-10

TN No. 00-10
Supersedes
TN No. 93-25

Approval Date 12-14-00

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State: New Mexico

Citation	Condition or Requirement
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- | | |
|-------|--|
| _____ | Amount for maintenance of home is:
\$ _____ |
| _____ | Amount for maintenance of home is the actual maintenance costs not to exceed \$ _____ |
| _____ | Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different. |
| _____ | Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act. |

STATE <u>New Mexico</u>	A
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91-19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	<p>C. <u>Financial Eligibility</u></p> <p>For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.</p> <p>For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.</p> <p>Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.</p>

STATE <u>New Mexico</u>	A
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TN No. 91-19

HCFA-PM-95-7 (MR)
10/95ATTACHMENT 2.6-A
Page 6aState: New Mexico

Citation	Condition or Requirement
—	Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
—	Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
—	Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
—	Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
X	Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
—	Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
—	Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(x)(1) of the Act.

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95-14
91-19
12/14/95
10/01/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	1. <u>Methods of Determining Income</u> a. <u>AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</u> <div style="border: 1px solid red; padding: 5px; margin: 5px 0;">Text stricken here is superseded by SPA TN 13-22 submitted via MMDL.</div> <div style="margin-left: 40px;">(1) In determining countable income for AFDC-related individuals, the following methods are used: <div style="margin-left: 40px;">(a) The methods under the State's approved AFDC plan only; or <u>X</u> (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</div></div> <div style="margin-left: 40px;">(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</div>
1902(e)(6) the Act	(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

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SUPERSEDES: TN- 92-04

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HCFA 179 <u>04-05</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. <u>Aged individuals</u> . In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: <u>X</u> The methods of the SSI program only. — The methods of the SSI program and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .

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HCFA 179		

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Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 2.6-A
Page 8
OMB No.: 0938-

State: NEW MEXICO

Citation

Condition or Requirement

- ☐ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
- ☐ For institutional couples, the methods specified under section 1611(e)(5) of the Act.
- ☐ For optional State supplement recipients under \$435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.
- ☐ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
 - ___ SSI methods only.
 - ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
 - ___ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

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HCFA 177	<u>91-19</u>

A

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ATTACHMENT 2.6-A
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State: NEW MEXICO

Citation	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	<p>c. <u>Blind individuals</u>. In determining countable income for blind individuals, the following methods are used:</p> <p><u>X</u> The methods of the SSI program only.</p> <p>— SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.</p> <p>— For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u>, and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.</p> <p>— For institutional couples, the methods specified under section 1611(e)(5) of the Act.</p> <p>— For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u>.</p> <p>— For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--</p> <p>— SSI methods only.</p> <p>— SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.</p> <p>— Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.</p>

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HCFA 179	91-19

STATE NEW MEXICO

CITATION

CONDITION OR REQUIREMENT

7. Maintenance standards for community spouses and other dependent family members used to calculate monthly income allowances under Section 1924 of the Act.

a. Community spouses

- ☒ 1. A standard based on the formula contained in Section 1924(d) is used.
- ☐ 2. The maximum standard contained in Section 1924(d)(3)(C).
- ☐ 3. A fixed standard which is greater than the minimum standard described in Section 1924(d) plus actual shelter costs not to exceed the maximum standard contained in Section 1924(d)(3)(C). The standard used is \$_____.

b. Other family members who are dependent

- ☒ 1. A standard based on the formula contained in Section 1924(d)(1)(C) is used.
- ☐ 2. A fixed standard greater than the amount which would be used if the formula described in Section 1924(d)(1)(C) were used. The standard used is \$_____.

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

STATE <u>New Mexico</u>	A
DATE REC'D <u>11-3-90</u>	
DATE APPV'D <u>3-8-91</u>	
DATE EFF <u>10-1-89</u>	
HCFA 179 <u>89-16</u>	

IN No. 89-16 Approval Date 3/8/91 Effective Date 10/1/89

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STATE New Mexico

CITATION

CONDITION OR REQUIREMENT

d. Definition of dependency

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

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

These other family members must reside with the community spouse.

The dependency requirements are met if either member of the couple could claim the individual as a dependent for tax purposes under the Internal Revenue Code.

STATE <u>New Mexico</u>	A
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HCFA ID. 4093E/0002P

State: NEW MEXICO

Citation	Condition or Requirement
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	<p>In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</p> <p>d. <u>Disabled individuals.</u> In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:</p> <p><u>X</u> The methods of the SSI program.</p> <p>— SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p>— For institutional couples: the methods specified under section 1611(e)(5) of the Act.</p> <p>— For optional State supplement recipients under \$435.230: income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A.</u></p> <p>— For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A;</u> and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p>

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STATE	<u>New Mexico</u>
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Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

State: NEW MEXICO

ATTACHMENT 2.6-A
Page 11
OMB No.: 0938-

Citation	Condition or Requirement
—	For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
—	SSI methods only.
—	SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
—	Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .

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

TN No. 91-19
Supersedes
TN No. 88-12

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ATTACHMENT 2.6-A
Page 11a

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

State: NEW MEXICO

~~ELIGIBILITY CONDITIONS AND REQUIREMENTS~~

Citation(s)	Condition or Requirement
1902(l)(3)(E) and 1902(r)(2) of the Act	e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act (1) The following methods are used in determining countable income: X The methods of the State's approved AFDC plan. — The methods of the approved title IV-E plan. — The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6 A. — The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6 A.

STATE <u>New Mexico</u>	A
DATE REC'D <u>APR 03 1992</u>	
DATE APPV'D <u>APR 29 1992</u>	
DATE EFF <u>JAN 01 1992</u>	
HCFA 179 <u>12-27</u>	

TN No. 92-04 Approval Date APR 29 1992 Effective Date JAN 01 1992
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TN No. 91-19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)

Condition or Requirement

Text stricken here is
superseded by SPA TN
13-22 submitted via MMDL.

1902(e)(6) of
the Act

(2) ~~In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.~~

(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

1905(p)(1),
1902(m)(4),
and 1902(r)(2) of
the Act

f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used:

— The methods of the SSI program only.

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

— For institutional couples, the methods specified under section 1611(e)(5) of the Act.

STATE	<u>New Mexico</u>	A
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DATE APPV'D	<u>01-11-95</u>	
DATE EFF	<u>07-01-95</u>	
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TN No. 94-14

Superseded

TN No. 92-04

Approval Date 01/11/95

Effective D

07/01/95

State: New Mexico

Citation

Condition or Requirement

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

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

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

1905(s) of the Act

g. (1) Qualified disabled and working individuals.

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

1905(p) of the Act

(2) Specified low-income Medicare beneficiaries.

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

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DATE REC'D <u>APR 01 1993</u>	
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DATE EFF <u>JAN 01 1993</u>	
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TN No. 92-04

State/Territory: NEW MEXICO

Citation

Condition or Requirement

1902(u)
of the Act

(h) COBRA Continuation Beneficiaries

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

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

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

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

- 1) The Trust is set up to receive only the assigned income. No resources are put into the ownership of the trust.
- 2) The trustee has the discretion to distribute to the beneficiary each month an amount, which in combination with all other income, will amount to less than the current Institutional Care Medicaid income standard. No other monies for any other purposes can be distributed from the trust.
- 3) Upon the death of the beneficiary, the trust funds will revert to the Medicaid program administered by the State of New Mexico, or any other state where the individual resides at the time of death, so long as the state has paid for Institutional Care Medicaid benefits.

STATE <u>New Mexico</u>	A
DATE REC'D <u>12-5-92</u>	
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DATE EFF <u>7-1-92</u>	
HCFA <u>92-15</u>	

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OMB No.:

State/Territory: NEW MEXICO

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XIII) of the Act	<p>(i) <u>Working Individuals with Disabilities - BBA</u></p> <p>In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied:</p> <p><input type="checkbox"/> The methodologies of the SSI program.</p> <p><input type="checkbox"/> The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A.</p> <p><input checked="" type="checkbox"/> The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.</p>

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HCFA 179 <u>01-01</u>	

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HCFA 179 <u>04-02</u>	

Revision:

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Page 12m
OMB No.:

State/Territory: NEW MEXICO

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII) (XV), (XVI), and 1916(g) of the Act	<p><u>Payment of Premiums or Other Cost Sharing Charges</u></p> <p>For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of Attachment 2.2-A:</p> <p><u>X</u> The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied are described below:</p> <p>Cost-sharing will be in the form of co-payments to be collected by providers at the time of service as follows:</p> <ul style="list-style-type: none"> \$ 7 per outpatient visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session or behavioral health session. \$ 7 per dental visit \$ 20 per emergency room visit \$ 30 per inpatient hospital admission \$ 5 per prescription, applies to prescription and nonprescription drug items <p>The state also has a maximum co-payment amount, after which the recipient will no longer have a co-payment requirement for the remainder of the calendar year. The co-payment maximum amounts are:</p> <p>\$600. for an individual with income under 100% of the Federal Poverty Income Guideline (FPL), and \$1500. for an individual with income between 100% and 250% of the FPL.</p>
TN No. <u>04-02</u>	Approval Date <u>6-22-04</u> Effective Date <u>6-1-04</u>
Supersedes TN No. <u>01-01</u>	CMS ID:

SUPERSEDES: TN- 01-01

Revision:

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OMB No.:

State/Territory: NEW MEXICO

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act (cont.)	<p>For individuals eligible under the Basic Coverage Group described in No. 24 on page 23d of Attachment 2.2-A, and the Medical Improvement Group described in No. 25 on page 23d of Attachment 2.2-A:</p> <p>NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds \$75,000 pay 100 percent of premiums.</p> <p>_____ The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income.</p> <p>The premiums or other cost-sharing charges, and how they are applied, are described on page 12o.</p>

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HCFA 179	<u>01-01</u>

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Citation	Condition or Requirement
Sections 1902(a)(10)(A) (ii)(XV), (XVI), and 1916(g) of the Act (cont.)	<u>Premiums and Other Cost-Sharing Charges</u>

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

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

\$ 5 per outpatient visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session or behavioral health session.

\$ 5 per dental visit

\$15 per emergency room visit

\$25 per inpatient hospital admission

\$ 2 per prescription, applies to prescription and nonprescription drug items

Native American are exempt from copayments.

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HCFA 179	<u>01-01</u>

State: NEW MEXICO

Citation	Condition or Requirement
1902(k) of the Act	<p>2. Medicaid Qualifying Trusts</p> <p>In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.</p> <p><input type="checkbox"/> The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. <u>Supplement 10 of ATTACHMENT 2.6-A</u> specifies what constitutes an undue hardship.</p>
1902(a)(10) of the Act	<p>3. Medically needy income levels (MNILs) are based on family size.</p> <p><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, <u>Supplement 1</u> so indicates.</p>

TN No. 91-19
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TN No. 87-15

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page 10 Items 2 & 3

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HCFA 179	<u>91-19</u>

State: NEW MEXICO

Citation	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only

a. Medically Needy

- (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either ____ or ____ month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.
- (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:
 - (a) Health insurance premiums, deductibles and coinsurance charges.
 - (b) Expenses for necessary medical and remedial care not included in the plan.
 - (c) Expenses for necessary medical and remedial care included in the plan.

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

1902(a)(17) of the Act

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

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Supersedes 87-15 page 10 Item 4 a)
87-17 page 11 Item 2
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October 1991

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Page 14a
OMB No.

State/Territory: NEW MEXICO

Citation	Condition or Requirement
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- 1903(f)(2) of the Act
- a. Medically Needy (Continued)
- (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

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AUGUST 1991

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OMB No.: 0938-

State: NEW MEXICO

Citation	Condition or Requirement
42 CFR 435.732	<p>b. <u>Categorically Needy - Section 1902 (f) States</u></p> <p>The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:</p> <ol style="list-style-type: none">(1) Any SSI benefit received.(2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.(3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.(4) Other deductions from income described in this plan at <u>Attachment 2.6-A, Supplement 4</u>.(5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

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TN No. 87-17 page 11 Item b(3)
87-18 page 12 Item b(4) + b(5)
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NEW MEXICO

Citation

Condition or Requirement

4.b. Categorically Needy - Section 1902(f) States
Continued

1903(f)(2) of
the Act

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

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

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HCFA 179	<u>91-19</u>

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State: NEW MEXICO

Citation

Condition or Requirement

5. Methods for Determining Resources

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

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

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

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

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

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AUGUST 1991

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Page 16a
OMB No.: 0938-

State: NEW MEXICO

Citation

Condition or Requirement

5. Methods for Determining Resources

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

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

X The methods of the SSI program.

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

— Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

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ATTACHMENT 2.6-A
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State: NEW MEXICO

Citation	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c. <u>Blind individuals.</u> For blind individuals the agency uses the following methods for treatment of resources: <u>X</u> The methods of the SSI program. — SSI methods and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u> — Methods that are more restrictive and/or more liberal than those of the SSI program. <u>Supplement 5 to ATTACHMENT 2.6-A</u> describe the more restrictive methods and <u>Supplement 8b to ATTACHMENT 2.6-A</u> specify the more liberal methods.

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

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Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	<p>d. <u>Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act.</u> The agency uses the following methods for the treatment of resources:</p> <p><u>X</u> The methods of the SSI program.</p> <p>— SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p>— Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in <u>Supplement 5 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902(l)(3) and 1902(r)(2) of the Act	<p>e. Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act.</p> <p>The agency uses the following methods in the treatment of resources.</p> <p>— The methods of the SSI program only.</p> <p>— The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</p>

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AUGUST 1991

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Citation	Condition or Requirement
	Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	X Not applicable. The agency does not consider resources in determining eligibility.
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(1)(3) and 1902(r)(2) of the Act	f. Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.
	The agency uses the following methods for the treatment of resources:
	The methods of the State's approved AFDC plan.
1902(1)(3)(C) of the Act	Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(r)(2) of the Act	Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	X Not applicable. The agency does not consider resources in determining eligibility.

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Page 4 Item f

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

State: NEW MEXICO

~~ELIGIBILITY CONDITIONS AND REQUIREMENTS~~

Citation(s)	Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g. 1. Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act. The agency uses the following methods for the treatment of resources: — The methods of the State's approved AFDC plan. — Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A. — Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A. x Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3)(C) of the Act	
1902(r)(2) of the Act	

This page is superseded by SPA
TN 13-22 submitted via MMDL.

STATE <u>New Mexico</u>	A
DATE REC'D <u>APR 03 1992</u>	
DATE APP'D <u>APR 29 1992</u>	
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HCFA 179 <u>92-04</u>	

TN No. 92-04 Superseded 91-19 Approval Date APR 29 1992 Effective Date JAN 01 1992

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

State: NEW MEXICO

~~ELIGIBILITY CONDITIONS AND REQUIREMENTS~~

Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act	g. 2. Poverty level children under section 1902(a)(10)(A)(i)(VII) The agency uses the following methods for the treatment of resources: X The methods of the State's approved AFDC plan. Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 5a of ATTACHMENT 2.6-A. Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8a to ATTACHMENT 2.6-A. Not applicable. The agency does not consider resources in determining eligibility. In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(1)(3)(C) the Act	
1902(r)(2) of the Act	

This page is superseded by SPA
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STATE <u>New Mexico</u>	A
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HCFA 179 <u>92-04</u>	

TN No. 92-04 Superseded 91-19 Approval Date APR 29 1992 Effective Date JAN 01 1992

State/Territory: NEW MEXICO

Citation	Condition or Requirement
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act	5. h. <u>For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources:</u> <input checked="" type="checkbox"/> The methods of the SSI program only. <input type="checkbox"/> The methods of the SSI program and/or more liberal methods as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u>
1905(s) of the Act	1. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: <input type="checkbox"/> The methods of the SSI program only. <input type="checkbox"/> More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

TN No. 91-19 Supersedes 89-02 Approval Date JAN 15 1992 Effective Date OCT 1 1991
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HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

State: New Mexico

Citation	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	<p>k. <u>Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act--</u></p> <p>The agency uses the same method as in 5.h. of <u>Attachment 2.6-A.</u></p> <p>6. Resource Standard - Categorically Needy</p> <p>a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:</p> <p>___ Same as SSI resource standards.</p> <p>___ More restrictive.</p> <p>The resource standards for other individuals are the same as those in the related cash assistance program.</p> <p>b. Non-1902(f) States (except as specified under items 6.c. and d. below)</p> <p>The resource standards are the same as those in the related cash assistance program.</p> <p>Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.</p>

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HCFA 179 <u>93-10</u>	

TN No. 93-10
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TN No. 91-19 Approval Date JUL 20 1993 Effective Date MAY 01 1993

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

State: NEW MEXICO

~~ELIGIBILITY CONDITIONS AND REQUIREMENTS~~

Citation(s)	Condition or Requirement
1902(1)(3)(A), (B) and (C) of the Act	<p>c. For pregnant women covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard.</p> <p>Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard under the SSI program.</p> <p>X No. The agency does not apply a resource standard to these individuals.</p> <p>For infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard.</p> <p>Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p>X No. The agency does not apply a resource standard to these individuals.</p>
1902(1)(3)(A) and (C) of the Act	<p>d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard.</p> <p>Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p>X No. The agency does not apply a resource standard to these individuals.</p>

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TN No. 92-04

Supersedes 91-19

TN No.

Approval Date

APR 29 1992

Effective Date

JAN 01 1992

STATE New Mexico

DATE REC'D APR 03 1992

DATE APPV'D APR 29 1992

DATE EFF JAN 01 1992

HCFA 179 92-04

A

State: NEW MEXICO

Citation	Condition or Requirement
1902(1)(3)(A) and (C) of the Act	<p>e. For children covered under the provisions of section 1902(a)(10)(A)(i)(VII) of the Act, the agency applies a resource standard.</p> <p><u>X</u> Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><u> </u> No. The agency does not apply a resource standard to these individuals.</p>
1902(m)(1)(C) and (m)(2)(B) of the Act	<p>f. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is:</p> <p><u>X</u> Same as SSI resource standards.</p> <p><u> </u> Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).</p> <p>Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.</p>

TN No. 92-04 Approval Date APR 29 1992 Effective Date JAN 01 1992
Supersedes 91-19
TN No. 91-19

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DATE EFF <u>JAN 01 1992</u>	
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State: New Mexico

Citation	Condition or Requirement
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7. Resource Standard - Medically Needy

1902(a)(10)(C)(i)
of the Act

- a. Resource standards are based on family size.
- b. A single standard is employed in determining resource resource eligibility for all groups.
- ☐ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for--

- ☐ Aged
- ☐ Blind
- ☐ Disabled

STATE <u>New Mexico</u>	A
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DATE AP'VD <u>8-30-10</u>	
DATE EFF <u>1-1-10</u>	
HCFA 179 <u>10-03</u>	

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

1902(a)(10)(E),
1905(p)(1)(D), 1905(p)(2)(B)
and 1860D-14(a)(3)(D)
of the Act

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

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

TN No: 10-03

Approval Date 8-30-10

Effective Date 1-1-10

SUPERSEDES: TN- 91-19

Revision: HCFA PM-91-8 (MB)
OCTOBER 1991

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Page 22a

State: New Mexico

Citation	Condition or Requirement
1902(a)(10)(E)(ii), 1905(s) of the Act	9. Resource Standard - Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is
1902(u) of the Act	10. For COBRA continuation beneficiaries, the resource standard is: ___ Twice the SSI resource standard for an individual. ___ More restrictive standard as applied under section 1902(f) of the Act as described in <u>Supplement 8 to Attachment 2.6-A.</u>

STATE <u>New Mexico</u>	A
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DATE APPV'D <u>8-30-10</u>	
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HCFA 179 <u>10-03</u>	

TN No: 10-03
Supersedes TN No. 91-19

Approval Date 8-30-10

Effective Date 1-1-10

SUPERSEDES: TN- 91-19

State: New Mexico

Citation Condition or Requirement

1902(u) of the Act

10. Excess Resources

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

Any excess resources make the individual ineligible.

- b. Categorically Needy Only

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

- c. Medically Needy

Any excess resources make the individual ineligible.

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DATE EFF <u>MAY 01 1993</u>	
HCFA 179 <u>93-10</u>	

TN No. 93-10
Supersedes 91-19 Approval Date JUL 20 1993 Effective Date MAY 01 1993
TN No. 91-19

State: NEW MEXICO

Citation	Condition or Requirement
42 CFR 435.914	11. Effective Date of Eligibility a. Groups Other Than Qualified Medicare Beneficiaries (1) For the prospective period. Coverage is available for the full month if the following individuals are eligible at any time during the month. <u>X</u> Aged, blind, disabled. <u>X</u> AFDC-related. Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements. <u> </u> Aged, blind, disabled. <u> </u> AFDC-related. (2) For the retroactive period. Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied: <u> </u> Aged, blind, disabled. <u> </u> AFDC-related. Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.. <u>X</u> Aged, blind, disabled. <u>X</u> AFDC-related.

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Supersedes
TN No. 89-02 page 21 Item 11(a) HCFA ID: 7985E
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DATE EFF <u>OCT 01 1991</u>	
HCFA 179 <u>91-19</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1920(b)(1) of the Act	<p><u>X</u> (3) For a presumptive eligibility period for pregnant women only.</p> <p>Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.</p>
1902(e)(8) and 1905(a) of the Act	<p><u>X</u> b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for--</p> <p><u>X</u> 12 months</p> <p>___ 6 months</p> <p>___ months (no less than 6 months and no more than 12 months)</p>

Text stricken here is superseded by SPA TN 13-22 submitted via MMDL.

STATE <u>New Mexico</u>	A
DATE REC'D <u>APR 03 1992</u>	
DATE APPV'D <u>APR 29 1992</u>	
DATE EFF <u>JAN 01 1992</u>	
HCFA 179 <u>92-04</u>	

TN No. 92-04
Superseded 91-19
Approval Date APR 29 1992
Effective Date JAN 01 1992

Citation	Condition or Requirement
1902(a)(18) and 1902(f) of the Act	<p>12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals</p> <p>The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.</p> <p>Disposal of resources at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9 to Attachment 2.6-A</u>.</p>
1917(c)	<p>13. Transfer of Assets - All eligibility groups</p> <p>The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.</p> <p>Disposal of assets at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9(a) to ATTACHMENT 2.6-A</u>, except in instances where the agency determines that the transfer rules would work an undue hardship.</p>
1917(d)	<p>14. Treatment of Trusts - All eligibility groups</p> <p>The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.</p> <p>_____ The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts;</p> <p><u>X</u> The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of <u>Miller</u> trusts.</p> <p>The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in <u>Supplement 12 to ATTACHMENT 2.6-A</u>.</p>

STATE	APR 03 1995	A
DATE REC'D	APR 18 1995	
DATE APPV'D	MAR 01 1995	
DATE EFF	95-06	
HCFA 179		

TN No. 95-06
Superseded 91-19
TN No. 91-19

Approval Date APR 18 1995 Effective Date MAR 01 1995

State: New MexicoCitationCondition or Requirement

1924 of the Act

15. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.

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

- ☐ the maximum standard permitted by law;
- ☐ the minimum standard permitted by law; or
- ☒ a standard that is an amount between the minimum and the maximum.

TN No. 00-10

Supersedes

Approval Date 12-14-00Effective Date 07-01-00TN No. SUPERSEDES: NONE - NEW PAGE

STATE	<u>New Mexico</u>	A
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DATE EFF	<u>07-01-00</u>	
HCFA 179	<u>00-10</u>	

REVISION: HCFA Region VI
September 1989

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STATE: NEW MEXICO

CITATION	CONDITION OR REQUIREMENT
Section 1924 (a) of the Act as amended by Sec. 303 of P.L. 100-360	13. Protection of Income and Resources of a Couple for Maintenance of Community spouse. The agency complies with the spousal impoverishment provisions as set forth in Section 1924 (a) of the Act. The agency applies the spousal impoverishment policies to persons receiving services under a Section 1915(c) home and community based waiver. Applies to all 1915(c) home and community based waivers. Applies only to the following 1915(c) waivers:

TN NO 91-19
Supersedes 89-13

STATE	New Mexico
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DATE ACT'D	JAN 18 1992
DATE OF	91-19
HCFA 179	

Revision: ~~New Mexico~~
~~July, 1995~~

~~SUPPLEMENT 1 TO ATTACHMENT 2.6A~~
~~Page 1~~

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

State: NEW MEXICO

~~INCOME ELIGIBILITY LEVELS~~

~~A. MANDATORY CATEGORICALLY NEEDY~~

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

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

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

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

~~/X/ 133 percent / / percent (no more than 185%)~~
~~(specify)~~

<i>New Mexico</i>	
STATE	
DATE REC'D	<i>07-18-95</i>
DATE APP'VD	<i>10-11-95</i>
DATE EFF	<i>07-01-95</i>
HCFA 179	<i>75-12</i>
A	

Revision: HCFA Region VI
April 1990

SUPPLEMENT 1 TO ATTACHMENT 7.6 A
PAGE 1a

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

State: New Mexico

~~A. INCOME ELIGIBILITY LEVELS - CATEGORICALLY NEEDY continued~~

~~Pregnant Women, Infants, and Children Under Age 6~~

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

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

# Of Persons in Assistance Unit	133% of FPL
1	\$ 755
2	1019
3	1283
4	1547
5	1810
6	2074
7	2338

~~Add \$ 264 for each additional household member.~~

STATE <u>New Mexico</u>	A
DATE REC'D <u>8-7-92</u>	
DATE APP'D <u>8-28-92</u>	
DATE EFF <u>7-1-92</u>	
HCFA 119 <u>72-13</u>	

Supersedes TN 91-12

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

SUPPLEMENT 1 TO ATTACHMENT 2.6-A
Page 2

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

State: NEW MEXICO

INCOME ELIGIBILITY LEVELS

A. ~~MANDATORY CATEGORICALLY NEEDY (Continued)~~

3. ~~For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.~~
4. ~~For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.~~

STATE	<i>New Mexico</i>	A
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DATE APP'VD	APR 29 1992	
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June, 1993

SUPPLEMENT 1 TO ATTACHMENT 2-E-A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
NEW MEXICO
State: _____

INCOME ELIGIBILITY LEVELS (Continued)

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

1. Pregnant Women and Infants

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

Based on 185 percent of the official federal income poverty level (no less than 133 percent and no more than 185 percent).

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STATE	<u>New Mexico</u>	A
DATE REC'D	<u>7-1-93</u>	
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DATE EFF	<u>8-1-93</u>	
HCFA 179	<u>93/15</u>	

Superseded: TN 92-13

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICOOPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO THE
SUPPLEMENTAL SECURITY INCOME (SSI) FEDERAL BENEFIT RATE

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

STATE <u>New Mexico</u>	A
DATE REC'D <u>6-9-99</u>	
DATE APP'D <u>8-17-99</u>	
DATE EFF <u>4-1-99</u>	
HCFA 179 <u>99-03</u>	

TN No. 9903 Approval Date 8-17-99 Effective Date 4-1-99
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TN No. 98-10

Revision: HCFA-PH-87-4 (BERC)
MARCH 1987

SUPPLEMENT 1 TO ATTACHMENT 2.6-A
Page 4
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

C. INCOME ELIGIBILITY LEVELS - OPTIONAL GROUP OF QUALIFIED MEDICARE
BENEFICIARIES WITH INCOMES UP TO FEDERAL POVERTY LINE

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

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

\$552 for an individual

\$740 for couple.

STATE <u>New Mexico</u>	A
DATE REC'D <u>7-2-91</u>	
DATE APPV'D <u>8-2-91</u>	
DATE EFF <u>7-1-91</u>	
HCFA <u>91-12</u>	

Supersedes: 91-04

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW MEXICO

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

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

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

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	\$ _____
<u>2</u>	\$ _____
<u>3</u>	\$ _____
<u>4</u>	\$ _____
<u>5</u>	\$ _____

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

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

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

STATE <u>New Mexico</u>	A
DATE REC'D <u>APR 03 1992</u>	
DATE APPV'D <u>APR 29 1992</u>	
DATE EFF <u>JAN 01 1992</u>	
HCFA 179 <u>92-04</u>	

TN No. 92-04
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HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

INCOME ELIGIBILITY LEVELS (Continued)

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

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

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

Eff. Jan. 1, 1989: ☒ 85 percent ☐ _____ percent (no more than 100

Eff. Jan. 1, 1990: ☒ 90 percent ☐ _____ percent (no more than 100

Eff. Jan. 1, 1991: 100 percent

Eff. Jan. 1, 1992: 100 percent

STATE	<i>New Mexico</i>	A
DATE REC'D	<i>7-1-93</i>	
DATE APP'D	<i>7-27-93</i>	
DATE EFF	<i>7-1-93</i>	
HCFA 177	<i>93-09</i>	

Supersedes TN 92-13

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

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

Income levels for QMB's & QD's will be revised each April 1 to reflect the updated FPL figures for that year; i.e., April 1, 1993; April 1, 1994 for 1994, etc.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW MEXICO

INCOME ELIGIBILITY LEVELS (Continued)

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

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

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

Eff. Jan. 1, 1989: ☒ 80 percent ☐ _____ percent (no more than 100)

Eff. Jan. 1, 1990: ☒ 85 percent ☐ _____ percent (no more than 100)

Eff. Jan. 1, 1991: ☒ 95 percent ☐ _____ percent (no more than 100)

Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size

Income Levels

1
2

\$ _____
\$ _____

TN No. 91-19 Approval Date JAN 15 1992 Effective Date OCT 1 1991
Supersedes _____
TN No. None Page HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 177	<u>91-19</u>

A

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 1 TO ATTACHMENT 2.6-A
Page 8
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

 Applicable to all groups.

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

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____ months	Amount by which Column (2) exceeds limits specified in 42 CFR	Net income level for persons living in rural areas for _____ months	Amount by which Column (4) exceeds limits specified in 42 CFR
<input type="checkbox"/> urban only		435.1007 ^{1/}		435.1007 ^{1/}
<input type="checkbox"/> urban & rural				
1	\$	\$	\$	\$
2	\$	\$	\$	\$
3	\$	\$	\$	\$
4	\$	\$	\$	\$

For each additional person, add:

\$ \$ \$ \$

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

TN No. 91-19

Supersedes

TN No. 87-18

Approval Date

JAN 15 1992

Effective Date

OCT 1 1991

HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE RECD	<u>DEC 17 1991</u>
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DATE EFF	<u>OCT 01 1991</u>
HCFA 177	<u>91-19</u>

A

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 1 TO ATTACHMENT 2.6-A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____ months	Amount by which Column (2) exceeds limits specified in 42 CFR	Net income level for persons living in rural areas for _____ months	Amount by which Column (4) exceeds limits specified in 42 CFR
<input type="checkbox"/> urban only		435.1007 ^{1/}		435.1007 ^{1/}
<input type="checkbox"/> urban & rural				
5	\$	\$	\$	\$
6	\$	\$	\$	\$
7	\$	\$	\$	\$
8	\$	\$	\$	\$
9	\$	\$	\$	\$
10	\$	\$	\$	\$
For each additional person, add:	\$	\$	\$	\$

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

TN No. 91-19
Supersedes _____ Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. New Rep
HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE AP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 2 TO ATTACHMENT 2.6-A
Page 1
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~~STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT~~

State: NEW MEXICO

~~RESOURCE LEVELS~~

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

~~1. Pregnant Women~~

~~a. Mandatory Groups~~

☒ ~~Same as SSI resources levels.~~

☒ ~~Less restrictive than SSI resource levels and is as follows:~~

Family Size	Resource Level
<u>1</u>	<u>no resource limit</u>
<u>2</u>	<u></u>

~~b. Optional Groups~~

☒ ~~Same as SSI resources levels.~~

☒ ~~Less restrictive than SSI resource levels and is as follows:~~

Family Size	Resource Level
<u>1</u>	<u>no resource limit</u>
<u>2</u>	<u></u>

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

HCFA ID: 7985E

STATE	<u>NEW Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APV'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

Revision: ~~HCFA-PM-91-4~~ (BPD)
AUGUST 1991

~~SUPPLEMENT 2 TO ATTACHMENT 2.6-A~~
Page 2
OMB No.: 0938-

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

State: NEW MEXICO

2. Infants

a. Mandatory Group of Infants

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

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	
<u>2</u>	
<u>3</u>	
<u>4</u>	no resource standards applied
<u>5</u>	
<u>6</u>	
<u>7</u>	
<u>8</u>	
<u>9</u>	
<u>10</u>	

TN No. 91-19 Approval Date JAN 15 1992 Effective Date OCT 1 1991
Supersedes 88-15
TN No. 88-15 HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE RECD	<u>DEC 17 1991</u>
DATE APVD	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 2 TO ATTACHMENT 2.6-A
Page 3
OMB No.: 0938-

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

State: NEW MEXICO

b. ~~Optional Group of Infants~~

☒ Same as resource levels in the State's approved AFDC plan.

☒ Less restrictive than the AFDC levels and are as follows:

Family Size

Resource Level

1
2
3
4
5
6
7
8
9
10

 no resource standards applied

TN No. 91-19
Supersedes Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. New Page
HCFA ID: 7985E

STATE	<u>NEW MEXICO</u>
DATE REC'D	<u>DEC 1 1991</u>
DATE AP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA	<u>91-19</u>

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

SUPPLEMENT 2 TO ATTACHMENT 2.6-A
Page 4

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

State: NEW MEXICO

3. Children

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

~~Same as resource levels in the State's approved AFDC plan.~~

X ~~Less restrictive than the AFDC levels and are as follows:~~

<u>Family Size</u>	<u>Resource Level</u>	<u>No Resource Test</u>
<u>1</u>	<u> </u>	
<u>2</u>	<u> </u>	
<u>3</u>	<u> </u>	
<u>4</u>	<u> </u>	
<u>5</u>	<u> </u>	
<u>6</u>	<u> </u>	
<u>7</u>	<u> </u>	
<u>8</u>	<u> </u>	
<u>9</u>	<u> </u>	
<u>10</u>	<u> </u>	

STATE <u>New Mexico</u>	A
DATE REC'D <u>APR 03 1992</u>	
DATE APPV'D <u>APR 20 1992</u>	
DATE EFF <u>JAN 01 1992</u>	
HCFA 179 <u>92-04</u>	

TN No. 92-04
Supersedes 91-77 Approval Date APR 29 1992 Effective Date JAN 01 1992
TN No. 91-77

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

~~b. Mandatory~~ Group of Children Under Section 1902(a)(10)(A)(i)(D) of the Act.
~~(Children who were born after 9-30-83 and have attained age 6 but have not attained age 19)~~

~~LX~~ Same as resource levels in the State's approved AFDC plan.

~~L~~ Less restrictive than the AFDC levels and are as follows:

Family Size

Resource Level

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

This page is superseded by SPA
TN 13-22 submitted via MMDL.

TN No. 92-04
Supersedes 91-19 Approval Date APR 29 1992 Effective Date JAN 01 1992
TN No. 91-19

STATE <u>New Mexico</u>	A
DATE REC'D <u>APR 03 1992</u>	
DATE APP'D <u>APR 29 1992</u>	
DATE EFF <u>JAN 01 1992</u>	
HCFA 179 <u>92-04</u>	

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 2 TO ATTACHMENT 2.6-A
Page 6
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

4. Aged and Disabled Individuals

☒ Same as SSI resource levels.

☐ More restrictive than SSI levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u> </u>
<u>2</u>	<u> </u>
<u>3</u>	<u> </u>
<u>4</u>	<u> </u>
<u>5</u>	<u> </u>

☐ Same as medically needy resource levels (applicable only if State has a medically needy program)

TN No. 91-19
Supersedes 88-15 page 2 item 3
Approval Date JAN 15 1992
Effective Date OCT 1 1991
HCFA ID: 7985E

STATE	<u>NEW MEXICO</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE AP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 177	<u>91-19</u>

A

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 2 TO ATTACHMENT 2.6-A
Page 7
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

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

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	_____
<u>2</u>	_____
<u>3</u>	_____
<u>4</u>	_____
<u>5</u>	_____
<u>6</u>	_____
<u>7</u>	_____
<u>8</u>	_____
<u>9</u>	_____
<u>10</u>	_____

For each additional person _____

TN No. 91-19
Supersedes _____ Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. New Page
HCFA ID: 7985E

STATE	<u>NEW MEXICO</u>
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DATE APP'D	<u>JAN 15 1992</u>
DATE L.F.	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

A

- ADDENDUM TO SECTION 4.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM
STATE PLAN TEMPLATE

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

4.1.3. X Income: Disregards

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

STATE <u>Nebraska</u>	A
DATE REC'D <u>03-20-00</u>	
DATE APPVD <u>06-08-00</u>	
DATE EFF <u>01-01-00</u>	
HCFA 179 <u>00-05</u>	

SUPERSEDES: ~~SECTION 4-4.1.3~~

Section 4-4.1.3-Page 9

Revision: New Mexico
June, 1993

SUPPLEMENT 3 TO ATTACHED 1-A
Page 1 2.6-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

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

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

If the institutionalized individual has medical or health insurance and is responsible for paying the premium(s), the full amount of the premium payment(s) are an allowable deduction from the individual's income when calculating the medical care credit.

STATE	<i>New Mexico</i>	A
DATE REC'D	<i>7-1-93</i>	
DATE APP'VD	<i>7-20-93</i>	
DATE EFF	<i>6-1-93</i>	
HCFA 179	<i>93-12</i>	

TR No. *93-12* Approval Date *7/20/93* Effective Date *6/1/93*
Supersedes *89-16*
TR No. *89-16* HCFA ID: 4093E/C002P

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 4 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

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

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

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

HCFA ID: 7985E

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>DEC 17 1991</u>	
DATE APVD	<u>JAN 15 1992</u>	
DATE EFF	<u>OCT 01 1991</u>	
HCFA 179	<u>91-19</u>	

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 5 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

TN No. 91-19 Approval Date JAN 15 1992 Effective Date OCT 1 1991
Supersedes
TN No. New Page
HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE AP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

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Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 5a TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

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

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

TN No. 91-19
Supersedes _____ Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. New Mex
HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APP'D	<u>JAN 15 1992</u>
DATE IN	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

Revision: HCFA-AT-85-

Amendment 85-7
T. L. 85-7
October 15, 1985SUPPLEMENT 6 TO
Attachment 2.6-AState New Mexico

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by		Income Level				Income Disregards Employed
			Gross		Net		
	Federal	State	1 per- son	Couple	1 per- son	Couple	
(1)	(2)		(3)		(4)		(5)
Individuals receiving SSI benefits and re- quiring care in an adult Residential Care Home. Supplement = \$75		X	Same as SSI	Same as SSI	Same as SSI	Same as SSI	Same as SSI
<div>APPROVED BY DHH DATE: JAN 30 TRANSMITTAL NO:</div>							

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

TN # 85-7
Supersedes
TN # NEW

Approval Date JAN 30 1986Effective Date 10-1-85

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 7 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
NEW MEXICO
State: _____

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

TN No. 91-19 Approval Date JAN 15 1992 Effective Date OCT 1 1991
Supersedes _____
TN No. 85-7 HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE AP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 17V	<u>91-19</u>

A

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 8 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

TN No. 91-19 Approval Date JAN 15 1992 Effective Date OCT 1 1991
Supersedes
TN No. 85-7 HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE AP'D	<u>JAN 15 1992</u>
DATE BY	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

Revision: HCFA-PM-00-1
February 2000

Supplement 8A to Attachment 2.6-A
ADDENDUM

State Plan Under Title XIX of the Social Security Act

State: New Mexico

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

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

* Less restrictive methods may not result in exceeding gross income limitations under section 1903(f).

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>03-30-00</u>	
DATE APPV'D	<u>06-08-00</u>	
DATE EFF	<u>01-01-00</u>	
HCFA 179	<u>00-04</u>	

SUPERSEDES: NONE - NEW PAGE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

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

☐ Section 1902(f) State

☒ Non-Section 1902(f) State

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

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

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

~~None whose income exceeds the FFP limits of 300% of the current FSI FBR will be made eligible by use of this more liberal income eligibility methodology. For married institutionalized individuals with more income in their own name than the spouse at home, this test will be done using the community property share (1/2) of the total community income.~~

Selected for reconsideration 8/24/94
Office Memorandum

*More liberal methods may not result in exceeding gross income limitations under section 1903(f).

TN No. 91-19
Supersedes None Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. See Page 1

HCFA ID: 7985E

*Supplement 11 to
Attachment 2.6-A
Page 1 (TN 90-13)*

STATE <u>New Mexico</u>	A
DATE REC'D <u>DEC 17 1991</u>	
DATE APPV'D <u>JAN 15 1992</u>	
DATE EFF <u>OCT 01 1991</u>	
HCFA 179 <u>91-19</u>	

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

SUPPLEMENT 8a to ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

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

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

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

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

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

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

*More liberal methods may not result in exceeding gross income limitations under section 1903(f).

TN No. 91-19 Approval Date JAN 15 1992 Effective Date OCT 1 1991
Supersedes _____
TN No. None HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APVD	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

Revision: New Mexico
July, 1995

SUPPLEMENT 8a to ATTACHMENT 2.6-A
Page 2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

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

☐ Section 1902(f) State

☒ Non-Section 1902(f) State

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

* More liberal methods may not result in exceeding gross income limitations under Section 1903(f).

TN No. 94-14
Supersedes None New Page Approval Date 1/11/95 Effective Date 07/01/95
TN No.

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>12-26-94</u>	
DATE APP'V'D	<u>01-11-95</u>	
DATE EFF	<u>02-01-95</u>	
HCFA 179	<u>94-14</u>	

Revision: ~~HCFA-PM-91 (BDP)~~
~~AUGUST 1991~~

~~SUPPLEMENT 8a TO ATTACHMENT 2.6-A~~
~~Page 3~~
~~OMB NO.: 0938-~~

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

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

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

- ~~1. For children identified under provisions of 1902 (a)(10)(A)(i)(VI), 1902 (1)(1)(C) of the Act, disregard from the countable income of the assistance unit the difference between 185% of the federal poverty guidelines, as revised annually in the Federal Register, and 133% of the federal poverty level guidelines for the size of the assistance unit involved.~~
- ~~2. For children born after September 30, 1983, as described in 1902 (a)(10)(A)(i)(VII), 1902 (1)(1)(D) disregard from the countable income of the assistance unit the difference between 185% of the federal poverty guidelines, as revised annually in the Federal Register, and 100% of the federal poverty guidelines for the size of the assistance unit involved.~~
- ~~3. For dependent children under age 1 under 1902(a)(10)(A)(i)(IV) or 1902(a)(10)(A)(ii)(XIV), children aged 1-5 under 1902(a)(10)(A)(i)(VI) or 1902(a)(10)(A)(ii)(XIV), and children aged 6-18 under 1902(a)(10)(A)(i)(VII) or 42 CFR 435.222 the state will disregard all earned income from the countable income calculations.~~

~~*More liberal methods may not result in exceeding gross income limitations under section 1903(f).~~

~~TN No. 13-10~~

~~Supersedes~~ ~~Approval Date 10/25/13~~ ~~Effective Date 7/1/13~~

~~TN No. 04-05~~

~~HCFA ID: 7985E~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State NEW MEXICO

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

☐ Section 1902 (f) state

☒ Non-section 1902 (f) state

4. The following applies to children under age 1 under 1902(a)(10)(A)(i)(IV) or 1902(a)(10)(A)(ii)(XIV) and children aged 1-5 under 1902(a)(10)(A)(i)(VI) or 1902(a)(10)(A)(ii)(XIV) of the statute:

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

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

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

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

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

~~8. The following applies to Family Planning covered under provisions of section 1902(a)(10)(A)(ii)(XXI) of the Act: An amount of income equal to the difference between 185% and 235% FPL for the appropriate household size will be disregarded from income calculations.~~

~~9. For eligible groups; 1902 (a)(10)(A)(i)(IV), 1902 (a)(10)(A)(i)(VI) and 1902 (a)(10)(A)(i)(VII): All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.~~

TN No. 13-10
Supersedes
TN No. 13-04

Approval Date 10/25/13 Effective Date 7/1/13

Text stricken here is
superseded by SPA TN
13-22 submitted via MMDL.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT* Section 1902(f) State X Non-Section 1902(f) State

Federal and State tax refunds and refundable tax credits are excluded as income for the following eligibility groups:

- ~~X Qualified children and pregnant women under 1902(a)(10)(A)(i)(III).~~
- ~~X Poverty level pregnant women and infants under 1902(a)(10)(A)(i)(IV).~~
- ~~X Poverty level children aged 1 up to age 6 under 1902(a)(10)(A)(i)(VI).~~
- ~~X Poverty level children aged 6 up to age 19 under 1902(a)(10)(A)(i)(VII).~~
- ~~X Optional categorically needy groups under 1902(a)(10)(A)(ii) as listed below.~~

Working Disabled Individuals under 1902(a)(10)(A)(ii)(XIII)

~~Pregnant women and infants under 1902(a)(10)(A)(ii)(IX)~~

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

 Medically Needy under 1902(a)(10)(C)(i)(III). All aged, blind or disabled groups in 209(b) states under 1902(f). X QMBs, SLMBs and QIs under 1905(p),SUPERSEDES: TN- 91-19

STATE <u>New Mexico</u>	A
DATE REC'D <u>3-29-10</u>	
DATE APPV'D <u>6-23-10</u>	
DATE EFF <u>1-1-10</u>	
HCFA 179 <u>10-05</u>	

TN No. 10-05

Supersedes

TN No. 91-19Approval Date 6-23-10Effective Date 1-1-10

Revision: HCFA-PM-91-1 (ADD)

SUPPLEMENT 8b to ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

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

☐ Section 1902(f) State

☒ Non-Section 1902(f) State

New Mexico will disregard all resources ~~for qualified children~~
as described in Attachment 2.2-A, pages 4 and 4a.

New Mexico will disregard resources as follows for the Working Disabled Who Buy In
to Medicaid group:

All funds held in retirement funds and accounts, including private retirement accounts
such as IRAs and other individual accounts, and employer-sponsored retirement accounts
such as 401(k) plans, Keogh plans, and employer pension plans.

The first \$8,000 in countable resources other than retirement funds and accounts for a
single individual, and the first \$13,000 in countable resources other than retirement funds
and accounts for a married individual.

SUPERSEDES: TN - 95-03

STATE <u>New Mexico</u>	A
DATE REC'D <u>01-24-01</u>	
DATE APP'D <u>04-17-01</u>	
DATE EFF <u>01-01-01</u>	
HCFA 179 <u>01-01</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT* Section 1902(f) State X Non-Section 1902(f) State

Federal and State tax refunds and refundable tax credits are excluded as resources for the following eligibility groups:

- X ~~Qualified children and pregnant women under 1902(a)(10)(A)(i)(III).~~
- ~~Poverty level pregnant women and infants under 1902(a)(10)(A)(i)(IV).~~
- ~~Poverty level children aged 1 up to age 6 under 1902(a)(10)(A)(i)(VI).~~
- ~~Poverty level children aged 6 up to age 19 under 1902(a)(10)(A)(i)(VII).~~
- X Optional categorically needy groups under 1902(a)(10)(A)(ii) as listed below.
- Working Disabled Individuals under 1902(a)(10)(A)(ii)(XIII)
- Medically Needy under 1902(a)(10)(C)(i)(III).
- All aged, blind or disabled groups in 209(b) states under 1902(f).
- X QMBs, SLMBs and QIs under 1905(p).

SUPERSEDES: NONE - NEW PAGE

STATE <u>New Mexico</u>	A
DATE REC'D. <u>3-29-10</u>	
DATE APPV'D <u>6-23-10</u>	
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HQFA 179 <u>10-05</u>	

TN No. 10-05Supersedes Approval Date 6-23-10 Effective Date 1-1-10

TN No. SUPERSEDES: NONE - NEW PAGE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

State: New Mexico

Date Received: 7 July, 2015

Date Approved: 29 September, 2015

Effective Date: 1 July, 2015

Transmittal Number: 15-09

SUPPLEMENT 8c TO ATTACHMENT 2. 6-A

Page 1

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2) 1917(b)(1)(C)	<p>The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:</p> <p style="text-align: center;">1902(a)(10)(A)(ii)(V) Institutional Care 1902(a)(10)(A)(ii)(XXII) Home and Community-Based Services</p> <p>An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a "qualified State long-term care insurance partnership" policy (partnership policy) as set forth below is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term "long-term care insurance policy" includes a certificate issued under a group insurance contract.</p> <p><u> X </u> The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State's Insurance Department.</p> <ul style="list-style-type: none"> • The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986. • The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

SUPPLEMENT 8c TO ATTACHMENT 2. 6-A

Page 2

	<ul style="list-style-type: none"> • The policy was issued no earlier than the effective date of this State plan amendment. • The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective. • The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act. • The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships. • The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies. • The State Insurance Department assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care. • The Agency provides information and technical assistance to the Insurance Department regarding the training described above.
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State: New Mexico
Date Received: 7 July, 2015
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TN NO: 15-09

Supersedes: NEW PAGE

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New Mexico Revision
December, 1993

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

TRANSFER OF RESOURCES

1917 of the
Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

Section 303(b)
of P.L. 100-360

A. The criteria for determining the period of ineligibility are:

1. Effective July 1, 1988 (except for interspousal transfers), no period of ineligibility will be imposed on an individual for uncompensated transfers unless the individual is an inpatient of a medical institution or nursing facility who transferred resources without compensation 30 months prior to institutionalization, if a Medicaid recipient at the beginning of institutionalization, or 30 months prior to application, if not Medicaid eligible at the beginning of institutionalization.

a. The agency uses a procedure which provides for a period of ineligibility that will be the lesser of:

i. 30 months, or

ii. A number of months equal to the uncompensated value of the transferred resources divided by the average cost to a private patient of nursing facility services in the state. Any remainder from the division will be disregarded.

TN No.

93-23

Approval Date

1/25/94

Effective Date

10/1/93

Supersedes

TN No.

87-13

STATE <u>New Mexico</u>	
DATE REC'D	<u>1-25-94</u>
DATE APPV'D	<u>1-25-94</u>
DATE EFF	<u>10-1-93</u>
HCFA 179	<u>93-23</u>
A	

SUPPLEMENT 9 TO ATTACHMENT 2.6A
PAGE 2

New Mexico Revision
December, 1993

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

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

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

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

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

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

TN No. 93-23 Approval Date 1/25/94 Effective Date 10/1/93
Superseded
TN No. 85-07

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>1-8-94</u>	
DATE APP'VD	<u>1-25-94</u>	
DATE EFF	<u>10-1-93</u>	
HCFA 179	<u>93-23</u>	

New Mexico Revision
December, 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

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

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

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

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

(c) It is verified that the applicant is unable to obtain care in any long-term care facility in the state without Medicaid coverage including state-run facilities.

TN No. 93-23 Approval Date 1/25/94 Effective Date 10/1/93

Superseded
TN No. 85-07

STATE <u>New Mexico</u>	
DATE REC'D	<u>1-23-94</u>
DATE APP'V'D	<u>1-25-94</u>
DATE EFF	<u>10-1-93</u>
HCFA 179	<u>93-23</u>
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SUPPLEMENT 9 TO ATTACHMENT 2.6A
PAGE 4

New Mexico Revision
December, 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

Section 13611

P.L. 101-66

dated August 10, 1993

2. Effective October 1, 1993, the transfer of asset provisions are in accordance with OBRA 93 as follows:
- a. The lookback period will be 36 months (or 60 months in the case of transfers to trusts);
 - b. There will be no cap on the period of ineligibility;
 - c. There will be no overlapping of periods of ineligibility;
 - d. The total value of all assets transferred will be divided by the average cost to a private patient of nursing facility services in the state to determine the number of months of ineligibility.
 - e. The exceptions to the period of ineligibility will be applied in accordance with Section 13611 of Public Law 101-66 dated August 10, 1993.

TN No.

93-23

Approval Date

1/25/94

Effective Date

10/1/93

Supersedes

TN No.

85-07

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>1-3-94</u>	
DATE APPV'D	<u>1-25-94</u>	
DATE EFF	<u>10-1-93</u>	
HCFA 179	<u>93-23</u>	

Revision: HCFA-AT-85-3 (BERG)
FEBRUARY 1985

SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 5

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

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

- i. A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;
- ii. Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;
- iii. A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or
- iv. The agency determines that denial of eligibility would work an undue hardship.

APPROVED BY DHHS/HCFA/DPO

DATE: JAN 30 1986

TRANSMITTAL NO: 85-7

TN No. 85-7
Supersedes
TN No. NEW

Approval Date JAN 30 1986

Effective Date OCT 1 1985

HCFA ID: 4093E/0002P

Revision: HCFA-AT-85-3 (BERC)
FEBRUARY 1985

SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 6

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

3. 1902(f) States

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

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

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

Specified elsewhere

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

Specified elsewhere

APPROVED BY DHHS/HCFA/DPO

DATE: JAN 30 1986

TRANSMITTAL NO: 85-7

TN No. 85-7
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Approval Date JAN 30 1986

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HCFA ID: 4093E/0002P

Revision: HCFA-AT-85-3 (BERC)
FEBRUARY 1985

SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 7

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

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

4. Other procedures:

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

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

TN No. 85-7
Supersedes
TN No. New

Approval Date JAN 30 1986

Effective Date OCT 1 1985

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April 2006

SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 8

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

TRANSFER OF RESOURCES

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

TN # 06-06 Approval Date 9-8-06 Effective Date 9-1-06
Supersedes
TN # SUPERSEDES: NONE - NEW PAGE

STATE <u>New Mexico</u>	A
DATE REC'D <u>5-2-06</u>	
DATE APP'D <u>9-8-06</u>	
DATE EFF <u>1-1-06</u>	
HCFA 179 <u>06-06</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

TRANSFER OF ASSETS

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

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

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

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

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

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

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

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

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

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

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

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

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>APR 03 1995</u>	
DATE APPV'D	<u>APR 18 1995</u>	
DATE EFF	<u>MAR 01 1995</u>	
HCFA 179	<u>95-06</u>	

TN No. 95-06
Supersedes
TN No. SUPERSEDES: NONE - NEW PAGE

Approval Date APR 18 1995

Effective Date MAR 01 1995

State: New Mexico

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:
- X the first day of the month in which the asset was transferred;
- the first day of the month following the month of transfer.
4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:
- X the average monthly cost to a private patient of nursing facility services in the state;
- the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.
5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;
- imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

STATE	<i>New Mexico</i>	A
DATE REC'D	APR 03 1995	
DATE APPV'D	APR 18 1995	
DATE EFF	MAR 01 1995	
HCFA 179	95-06	

TN No. 95-06
Supersedes
TN No. SUPERSEDES; NONE - NEW PAGE

Approval Date APR 18 1995 Effective Date MAR 01 1995

State: New Mexico

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

X does not impose a penalty;

 imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

X does not impose a penalty;

 imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap--
The agency:

X totals the value of all assets transferred to produce a single penalty period;

 calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap--
The agency:

X assigns each transfer its own penalty period;

 uses the method outlined below:

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>APR 08 1995</u>	
DATE APP'VD	<u>APR 18 1995</u>	
DATE EFF	<u>MAR 01 1995</u>	
HCFA 179	<u>95-06</u>	

State: New Mexico

TRANSFER OF ASSETS

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

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

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

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

10. Treatment of income as an asset--

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

— The agency will impose partial month penalty periods.

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

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

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

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

STATE	<i>New Mexico</i>	A
DATE REC'D	APR 03 1995	
DATE APPV'D	APR 18 1995	
DATE EFF	MAR 01 1995	
HCFA 179	95-06	

TN No. *95-06*

Supersedes

TN No.

Approval Date

APR 18 1995

Effective Date

MAR 01 1995

SUPERSEDES: NONE - NEW PAGE

State: New Mexico

TRANSFER OF ASSETS

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

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

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

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

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

- (1) The assets were transferred to someone other than a family member.
- (2) The applicant can present convincing evidence that every effort was made to recover the transferred resource, and
- (3) The applicant is unable to obtain care in any long-term care facility in the state without Medicaid coverage.

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>APR 0 3 1995</u>	
DATE APPV'D	<u>APR 18 1995</u>	
DATE EFF	<u>MAR 01 1995</u>	
HCFA 179	<u>95-06</u>	

TN No. 95-06
Supersedes APR 18 1995 Approval Date
TN No. SUPERSEDES: NONE - NEW PAGE Effective Date MAR 01 1995

Revision:
April 2006

SUPPLEMENT 9(a) TO ATTACHMENT 2.6-A
Page 6

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

TRANSFER OF ASSETS

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

STATE <u>New Mexico</u>	A
DATE REC'D <u>5-2-06</u>	
DATE APP'D <u>9-8-06</u>	
DATE EFF <u>7-1-06</u>	
HCFA 179 <u>06-06</u>	

TN # 06-06 Approval Date 9-8-06 Effective Date 7-1-06

Supersedes

TN # SUPERSEDES: NONE - NEW PAGE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

TRANSFER OF ASSETS

1917(c) **FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE**
DRA 2005 **ON OR AFTER FEBRUARY 8, 2006, the agency provides for the**
denial of certain Medicaid services.

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

The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

Nursing facility services;

Nursing facility level of care provided in a medical institution;

Home and community-based services under a 1915(c) or (d) waiver.

STATE <u>New Mexico</u>	A
DATE REC'D <u>11-7-06</u>	
DATE APP'VD <u>12-7-06</u>	
DATE EFF <u>10-1-06</u>	
HCFA 179 <u>06-09</u>	

2. Non-institutionalized individuals:

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

SUPERSEDES: TN- 95-06 (pg.1)

TN No. 06-09
Supersedes
TN No. 95-06 (pg.1)

Approval Date 12-7-06 Effective Date 10-1-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

TRANSFER OF ASSETS

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

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

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

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

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

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DATE EFF <u>10-1-06</u>	
HCFA 179 <u>06-09</u>	

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

X The State uses the first day of the month in which the assets were transferred

____ The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for

TN No. 06-09

Supersedes

TN No. 95-06 (pgs 1+2)

Approval Date 12-7-06 Effective Date 10-1-06

SUPERSEDES: TN- 95-06 (pgs 1+2)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

TRANSFER OF ASSETS

the imposition of the penalty period,
would be covered by Medicaid;

AND

which does not occur during any other
period of ineligibility for services by
reason of a transfer of assets penalty.

4. Penalty Period - Institutionalized Individuals--

In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of
nursing facility services in the State at the
time of application;

the average monthly cost to a private patient of
nursing facility services in the community in
which the individual is institutionalized at the
time of application.

5. Penalty Period - Non-institutionalized Individuals--

The agency imposes a penalty period determined by using
the same method as is used for an institutionalized
individual, including the use of the average monthly cost
of nursing facility services;

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

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DATE EFF. <u>10-1-06</u>	
HCFA 179 <u>06-09</u>	

TN No. 06-09

Supersedes

Approval Date 12-7-06 Effective Date 10-1-06

TN No. 95-06 (pg. 2)

SUPERSEDES: TN 95-06 (pg. 2)

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

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--

Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

X The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

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

- (a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.
- (b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

SUPERSEDES: TN- 95-06 (pg.3)

STATE <u>New Mexico</u>	A
DATE REC'D <u>11-7-06</u>	
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DATE EFF <u>10-1-06</u>	
HCFA 179 <u>06-09</u>	

TN No. 06-09
Supersedes Approval Date 12-7-06 Effective Date 10-1-06
TN No. 95-06 (pg.3)

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

TRANSFER OF ASSETS

8. Treatment of a transfer of income--

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

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

For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

SUPERSEDES: TN- 95-06 (pg. 3)

STATE <u>New Mexico</u>	A
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Supersedes

TN No. 95-06 (pg. 3)

Approval Date

Effective Date 10-1-06

12-7-06

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State: NEW MEXICO

TRANSFER OF ASSETS

9. Imposition of a penalty would work an undue hardship--

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

- (a) Of medical care such that the individual's health or life would be endangered; or
- (b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

- (a) Notice to a recipient subject to a penalty that an undue hardship exception exists;
- (b) A timely process for determining whether an undue hardship waiver will be granted; and
- (c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

SUPERSEDES: TN 95-06 (pgs 4+5)

STATE <u>New Mexico</u>	A
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DATE APP'D <u>12-7-06</u>	
DATE EFF <u>10-1-06</u>	
HCFA 179 <u>06-09</u>	

TN No. 06-09

Supersedes

TN No. 95-06 (pg. 4+5)

Approval Date 12-7-06

Effective Date 10-1-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

TRANSFER OF ASSETS

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

- X Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed 30 days (may not be greater than 30).

SUPERSEDES: NONE - NEW PAGE

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DATE EFF <u>10-1-06</u>	
HCFA 179 <u>06-09</u>	

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TN No.

Approval Date 12-7-06 Effective Date 10-1-06

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Revision: HCFA-PM-95-1 (MB)
March 1995

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

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

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

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

The maximum value of the exemption for an irrevocable burial trust is \$ N/A.

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>APR 0 8 1995</u>	
DATE APPV'D	<u>APR 1 8 1995</u>	
DATE EFF	<u>MAR 0 1 1995</u>	
HCFA 179	<u>95-06</u>	

TN No. 95-06
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Approval Date APR 1 8 1995 Effective Date MAR 0 1 1995

Revision: HCFA-PM-91-8 (MB)
October 1991

SUPPLEMENT 11 TO ATTACHMENT 2.6-A
Page 1
OMB No.:

State/Territory: NEW MEXICO

Citation

Condition or Requirement

**COST EFFECTIVENESS METHODOLOGY FOR
COBRA CONTINUATION BENEFICIARIES**

1902(u) of the
Act

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

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

TN No. 91-19
Supersedes
TN No. 91-05

Approval Date JAN 15 1992

Effective Date OCT 1 1991

HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
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DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

Revision: HCFA-PM-00-1 Supplement 12 to Attachment 2.6-A
February 2000 ADDENDUM

State Plan Under Title XIX of the Social Security Act

State: New Mexico

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

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

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

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

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

STATE	<i>New Mexico</i>	A
DATE REC'D	<i>03-30-00</i>	
DATE APP'D	<i>06-06-00</i>	
DATE EFF	<i>01-01-00</i>	
HCFA 179	<i>00-03</i>	

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Revision: CMS-PM-

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~~Page 1~~

~~OMB No.:~~

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

~~State/Territory: NEW MEXICO~~

~~ELIGIBILITY UNDER SECTION 1931 OF THE ACT~~

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

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

~~X Pregnant women in the 3rd trimester of their pregnancy with no other eligible children.~~

~~X Children age 18 who are full-time students in a secondary school or the equivalent level of vocational or technical training.~~

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

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

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

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

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

TN No.

Supersedes

TN No. 04-05

Approval Date 2-1-13

Effective Date 4-1-12

SUPERSEDES: TN 04-05

STATE <u>New Mexico</u>	
DATE REG'D <u>6-11-12</u>	
DATE APP'VD <u>2-1-13</u>	<u>A</u>
DATE EFF <u>4-1-12</u>	
WCEA 179 <u>12-03</u>	

Revision: HCFA-PM-97-2
December 1997

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OMB No.:0938-0673

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

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

In addition to the basic personal needs allowance, up to the first \$100 of income received by an institutionalized recipient in an ICF-NR from employment in a sheltered workshop or other work activity program may be allowed for personal needs.

TN No. 12-07

Supersedes

TN No. 09-01

Approval Date 9-20-12 Effective Date 7-1-12

SUPERSEDES: TN- 09-01

STATE <u>New Mexico</u>	A
DATE REC'D <u>6-26-12</u>	
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DATE EFF <u>7-1-12</u>	
HCFA 179 <u>12-07</u>	

Revision: CMS-PM-

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

~~State/Territory: NEW MEXICO~~

~~ELIGIBILITY UNDER SECTION 1931 OF THE ACT (Continued)~~

- ~~X~~ The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:
- ~~a~~ The agency uses TANF income methodologies and disregards the difference between the AFDC income standards as of July 16, 1996 and the current TANF income standards to determine eligibility under Section 1931 of the Act. New Mexico adopted the TANF methodology.
 - ~~a~~ The state disregards wages from the Census Bureau for temporary employment related to Census activities.
 - ~~a~~ Resource determination methodology allows for exclusion of all resources.

~~SUPERSEDES: TN- 08-01~~

STATE <u>New Mexico</u>	
DATE REQ'D <u>6-4-12</u>	
DATE APPVD <u>2-1-13</u>	A
DATE EFF <u>4-1-12</u>	
NCEA 179 <u>12-03</u>	

~~TN No.~~

~~Supersedes~~

~~TN No. 08-01~~

~~Approval Date 2-1-13 Effective Date 4-1-12~~

Revision:
~~CMS-PM~~

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~~OMB No.:~~

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

~~State/Territory: NEW MEXICO~~

~~ELIGIBILITY UNDER SECTION 1931 OF THE ACT (Continued)~~

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

- ~~• Earned Income disregards are the first \$90 and an additional \$30 and 1/3 of the remainder, if certain criteria are met, for a time-limited period of time.~~
- ~~• Excludable resources include the first \$1,500 liquid resources, \$2000 in non-liquid resources, and total value of at least one vehicle, and in some parts of the state additional vehicles.~~

~~SUPERSEDES: TN- 10-05~~

STATE <u>New Mexico</u>	A
DATE REG'D <u>6-11-12</u>	
DATE APPVD <u>2-1-13</u>	
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~~OMB No.:~~

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

~~State/Territory: NEW MEXICO~~

~~ELIGIBILITY UNDER SECTION 1931 OF THE ACT (Continued)~~

- ~~X~~ The agency terminates medical assistance (except for pregnant women and children described in section 1902(f) of the Act) for individuals who fail to meet Temporary Assistance for Needy Families (TANF) work requirements.

Unemployed Parent

For the purpose of determining whether a child is deprived on the basis of the unemployment of a parent, the agency:

____ Uses the standard of measuring unemployment which was in the AFDC State plan in effect on July 16, 1996.

____ Uses the following more liberal standard to measure unemployment:

- ~~X~~ The agency continues to apply the following waivers of provisions of part A of title IV of the Act in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997:

- ~~X~~ Waiver under sections 402(a)(41) and 407 of the Act allows the State to provide benefits to families in which the principal earner works 100 or more hours per month.

~~Waiver of 402 (a) (41) is as follows:~~

- ~~• The 100 hour rule for unemployed parents is waived. Thus, eligibility for 1931 Medicaid may exist regardless of the absence or presence of 'deprivation' criteria.~~

____ Other:

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TN No. 04-05

Approval Date 2-1-13

Effective Date 4-1-12

~~SUPERSEDES: TN. 04-05~~

STATE <u>New Mexico</u>	A
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DATE APPV'D <u>2-1-13</u>	
DATE EFF <u>4-1-12</u>	
HCFA 179 <u>12-03</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: NEW MEXICO

SECTION 1924 PROVISIONS

- A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.
- B. In the determination of resource eligibility the State resource standard is \$ 2,000.
- C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:
- 1). The excess resource must be a non-liquid asset with a fair market value of \$30,000 or less, and
 - 2). The client or representative must demonstrate that a bona fide effort to sell or liquidate the resource has been unsuccessful, and
 - 3). The applicant or representative must continue to make a bona fide effort to sell the property for as long as eligibility continues, or the property is sold, and
 - 4). It is verified that the applicant is unable to obtain care in any long-term care facility in the state without Medicaid coverage. The client is required to verify only that he/she cannot obtain admission to the state-run facilities.

STATE <u>New Mexico</u>	A
DATE REC'D <u>1-3-90</u>	
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DATE EFF <u>10-1-89</u>	
HCFA 179 <u>89-16</u>	

TN NO.

89-16

Approval Date

3/8/91

Effective Date

10/1/89

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STATE <u>New Mexico</u>	A
DATE REC'D <u>31 Mar, 09</u>	
DATE APPV'D <u>8 Mar 10</u>	
DATE EFF <u>1 Jul, 09</u>	
HCFA 179 <u>09-02</u>	

Revision:

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Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

ASSET VERIFICATION SYSTEM

1940(a)
of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.
 - A. The request and response system must be electronic:
 - (1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
 - (2) The system cannot be based on mailing paper-based requests.
 - (3) The system must have the capability to accept responses electronically.
 - B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).
 - C. The system must establish and maintain a database of FIs that participate in the agency's AVS.
 - D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.
 - E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

TN No. 09-02
Supersedes TN No. _____

Approval Date 3-8-2010
SUPERSEDES: NONE - NEW PAGE

Effective Date 7-1-09

STATE <u>New Mexico</u>	A
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HCFA 179 <u>09-02</u>	

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Page 2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

ASSET VERIFICATION SYSTEM

2. System Development

☐ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

☒ B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

☐ C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

☐ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

☐ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

TN No. <u>09 02</u>	Approval Date <u>3-8-10</u>	Effective Date <u>2-1-09</u>
Supersedes TN No. <u>SUPERSEDES: NONE - NEW PAGE</u>		

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

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TN No. 09-02

Approval Date 3-8-10

Effective Date 7-1-09

Supersedes TN No. 09-02 SUPERSEDES: NONE - NEW PAGE

State: NEW MEXICO
DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH
SUBSTANTIAL HOME EQUITY

State: New Mexico
Date Received: 02-28-18
Date Approved: 05-11-18
Date Effective: 03-01-18
Transmital Number: 18-0001

State Plan Under Title XIX of the Social Security Act

State: New Mexico

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 01/28/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	Relevant Population Group Income Standard	Resource Proxy	Enrollment Cap	Special Circumstances	Other Adjustments
	<p>For each population group, indicate the lower of:</p> <ul style="list-style-type: none"> The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or 133% FPL. <p>If a population group was not covered as of 12/1/09, enter "Not covered".</p>	<p>Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.</p>			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1, Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2, Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, institutionalized	Attachment A, Column C, Line 3, Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Children Age 19 or 20	Not Covered	N/A	N/A	N/A	N/A
Childless Adults	Not Covered	N/A	N/A	N/A	N/A

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

☒ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

The state:

☐ Applies existing state data from periods before January 1, 2014.

☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

☒ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).
3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:
☐ Yes. The combined enrollment cap adjustment is described in Attachment C
☐ No.
4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:
☐ Applies a special circumstances adjustment(s).
☒ Does not apply a special circumstances adjustment.
2. The state:
☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).
☒ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).
3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

- ☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.
- ☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

- ☒ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)
- ☐ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated _____.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

- ☒ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).
- ☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

- A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.
- B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ☒ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☒ Attachment E – Transition Methodologies

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Attachment A
Most Recent Updated Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan*
NEW MEXICO

11/25/2013

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibility standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	Parents/Caretaker Relatives					
	Dollar standards by family size					
	1	\$266	\$451	yes	Part 1 of approved state MAGI conversion plan	state data
	2	\$357	\$608			
	3	\$447	\$765			
	4	\$539	\$923			
	5	\$630	\$1,080			
	6	\$721	\$1,238			
	7	\$812	\$1,395			
	8	\$922	\$1,553			
	add-on	\$91	\$158			
2	Noninstitutionalized Disabled Persons					
	SSI FBR%	100%	103%	n/a	new SIPP conversion	SIPP
3	Institutionalized Disabled Persons					
	SSI FBR%	300%	300%	n/a	gross standard	n/a
4	Children Age 19-20	n/a	n/a	n/a	n/a	n/a
5	Childless Adults					
	FPL %	n/a	n/a	n/a	n/a	n/a

n/a: Not applicable.

*The contents of this table will be updated automatically in the case of modifications in the CMS approved MAGI Conversion Plan

TN Number: 13-15 Approval Date: 5/22/14 Date Effective: 1/1/14 Supersedes None: New Page

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METHODS OF PROVIDING TRANSPORTATION

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COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

State/Territory: NEW MEXICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: ☐ No limitations ☒ With limitations*

- 2.a. Outpatient hospital services.

Provided: ☐ No limitations ☒ With limitations*

- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic and covered under the Plan.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

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Supersedes 91-11 Approval Date JAN 15 1992
TN No. 91-11 *pages 1-3*

Effective Date OCT 1 1991

HCFA ID: 7986E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE AGENCY: NEW MEXICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

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

Provided: X No limitations With limitations*

- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. *

- 1905(a)(4)(C) 4.c.(i) Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Att. 2.2-A, B, if this eligibility option is selected by the State.

Provided: No limitations X With limitations*

- 4.c.(ii) Family planning-related services provided under the above State Eligibility Option

*Description provided on attachment.

STATE <u>New Mexico</u>	A
DATE REC'D <u>9-26-11</u>	
DATE APP'VD <u>12-21-11</u>	
DATE EFF <u>10-1-11</u>	
HCFA 179 <u>11-08</u>	

SUPPLIES ON 10-12

TN No. 11-08

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE AGENCY: NEW MEXICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

4.d. Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: ☒ No limitations ☐ With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:

NOT APPLICABLE

Face-to-Face Tobacco Cessation Counseling Services provided (by):

☒ (i) By or under supervision of a physician;

☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

☐ (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

*describe if there are any limits on who can provide these counseling services

There are no limitations on tobacco cessation services under the Early & Periodic Screening & Diagnostic Treatment (EPSDT) program.

STATE <u>New Mexico</u>	A
DATE REC'D <u>9-26-11</u>	
DATE APPV'D <u>12-21-11</u>	
DATE EFF <u>10-1-11</u>	
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE AGENCY: NEW MEXICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: No limitations X With limitations*

- 5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

- a. Podiatrists' services.

Provided: No limitations X With limitations*

*Description provided on attachment.

STATE <u>New Mexico</u>	A
DATE REC'D <u>9-26-11</u>	
DATE APPV'D <u>12-21-11</u>	
DATE EFF <u>10-1-11</u>	
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State/Territory: NEW MEXICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Chiropractors' services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

d. Other practitioners' services.

☒ Provided: Identified on attached sheet with description of
limitations, if any.
☐ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health
agency or by a registered nurse when no home health agency exists in the
area.

Provided: ☐ No limitations ☒ With limitations*

b. Home health aide services provided by a home health agency.

Provided: ☐ No limitations ☒ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the
home.

Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

TN No. 91-10 Approval Date JAN 15 1992 Effective Date OCT 1 1991
Supersedes
TN No. 89-10 page 2 items 6 b & c
85-8 page 3 items 6 d & 7 c HCFA ID: 7986E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 172	<u>91-19</u>

A

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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Page 3a
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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

8. Private duty nursing services.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

*Description provided on attachment.

TN No. 91-19
Supersedes 85-8 Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. page 3 items 70-8 HCFA ID: 7986E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 1 1991</u>
HCFA 179	<u>91-19</u>

Revision: HCFA-PH-85-3 (BERC)
MAY 1985

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Page 4
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AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

10. Dental services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Occupational therapy.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Services for individuals with speech, hearing, and language disorders
(provided by or under the supervision of a speech pathologist or
audiologist).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

STATE	<i>New Mexico</i>	A
DATE REC'D	<i>AUG 31 1989</i>	
DATE APPV'D	<i>FEB 11 1991</i>	
DATE EFF	<i>JUL 1 1989</i>	
HCFA 179	<i>89-10</i>	

TN No. _____
Supersedes _____
TN No. _____

Approval Date _____

Effective Date _____

HCFA ID: 0069P/0002P

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

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OMB NO.: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

*Description provided on attachment.

APPROVED BY DHHS/HCFA/DPO

DATE: 1-30-86

TRANSMITTAL NO: 85-8

TN No. 85-8
Supersedes
TN No. 74-2

Approval Date 1-30-86

Effective Date 10-01-86

HCFA ID: 0069P/0002P

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

c. Preventive services.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

d. Rehabilitative services.

☐ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

b. Nursing facility services.

☒ Provided: ☒ No limitations ☐ With limitations*

☐ Not provided.

STATE	<i>New Jersey</i>	A
DATE REC'D	<i>6-9-93</i>	
DATE APPV'D	<i>10-22-93</i>	
DATE EFF	<i>4-1-93</i>	
HCFA 179	<i>93-08</i>	

*Description provided on attachment.

TW No. *93-08*
Supersedes
TW No. _____

Approval Date: *10/22/93* Effective Date *04/01/93*

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. -Services in an intermediate care facility for the mentally retarded, as defined in section 1905(d), (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care.
- ☒ Provided: ☒ No limitations ☐ With limitations*
- ☐ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.
- ☐ Provided: ☐ No limitations ☐ With limitations*
- ☒ Not provided.

17. Nurse-midwife services.
- ☒ Provided: ☐ No limitations ☒ With limitations*
- ☐ Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).
- ☒ Provided: ☐ No limitations ☒ With limitations*
- ☐ Not provided.

*Description provided on attachment.

TN No. 90-23 Approval Date APR 25 1991 Effective Date OCT - 1 1990
Supersedes
TN No. _____

STATE <u>New Mexico</u>	A
DATE REC'D <u>DEC 31 1990</u>	
DATE APP'D <u>APR 25 1991</u>	
DATE EFF <u>OCT - 1 1990</u>	
HCFA 179 <u>90-23</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations

 Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

 Provided: With limitations*

 Not provided.

20. Extended services for pregnant women

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

 Additional coverage ++

- b. Services for any other medical conditions that may complicate pregnancy.

X Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

STATE <u>New Mexico</u>	A
DATE REC'D <u>7-20-94</u>	
DATE APPV'D <u>8-11-94</u>	
DATE EFF <u>7-1-94</u>	
HCFA 179 <u>94-08</u>	

TN No. 94-08
Supersedes 91-19 Approval Date 8-11-94 Effective Date 7-1-94

State/Territory: NEW MEXICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
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21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a ~~qualified~~ **ELIGIBLE** provider (in accordance with section 1920 of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

23. Pediatric or family nurse practitioners' services.

CERTIFIED
Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

TN No. 92-02
Supersedes 91-19 Approval Date MAR 10 1992 Effective Date JAN 01 1992
TN No. 91-19

HCFA ID: 7986E

STATE <u>New Mexico</u>	A
DATE REC'D <u>FEB 18 1992</u>	
DATE APPV'D <u>MAR 10 1992</u>	
DATE EFF <u>JAN 01 1992</u>	
HCFA 179 <u>92-02</u>	

AUGUST 1991

State/Territory: NEW MEXICOAMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY24. Any other medical care and any other type of remedial care recognized
under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

c. Care and services provided in Christian Science sanatoria.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☒ No limitations ☐ With limitations*

☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

f. Personal care services in recipient's home, prescribed in accordance
with a plan of treatment and provided by a qualified person,

☒ Provided: ☐ No limitations ☐ With limitations*

☐ Not provided.

*Description provided on attachment.

TN No. 94-05

Supersedes

Approval Date

12-21-99

Effective Date

9-1-99TN No. 91-19

HCFA ID: 7986E

STATE	DATE REC'D	DATE APP'D	DATE EFF	HCFA 179
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

ATTACHMENT 3.1-A

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25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A

_____ provided X not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

_____ Provided:

_____ State Approved (Not Physician) Service Plan Allowed

_____ Services Outside the Home Also Allowed

_____ Limitations Described on Attachment

X Not Provided

State: New Mexico
Date Received: 6/30/2014
Date Approved: 9/19/2014
Effective Date: 4/1/2014
Transmittal Number: 14-12

TN No. 14-12

Supersedes TN. No. 12-04

Approval Date 9/19/14

Effective Date 4/1/14

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

ATTACHMENT 3.1-A

Page 10

PACE State Plan Amendment Pre-Print

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

 No election of PACE: By virtue of this submittal, the State elects to not add PACE as an option State Plan service.

STATE <u>New Mexico</u>	A
DATE REC'D <u>3-22-12</u>	
DATE APPV'D <u>11-21-12</u>	
DATE EFF <u>6-1-12</u>	
HCFA 179 <u>12-04</u>	

TN No. 12-04

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Approval Date 11-21-12

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SUPERSEDES: TN 00-08

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State NEW MEXICO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: X No limitations ___ With limitations ___ None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations ☒ With limitations (please describe below)

☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☒ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

(b) Licensed Midwives (lay midwives licensed by the state))

TN: 17-0002 Approval Date: 06-19-17

Supersedes TN: 11-0005 Effective Date: 02-25-17

State: New Mexico
Date Received: 03-30-2017
Date Approved: 06-19-2017
Date Effective 02-25-2017
Transmittal Number: NM 17-0002

Revision:

ATTACHMENT 3.1-A

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OMB NO.:

State/Territory New Mexico

Citation

Family Planning Benefits

1905(a)(4)(C)

4.c.(i) Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Att. 2.2-A, B, if this eligibility option is elected by the State.

Provided: ☐ No limitations ☒ With limitations

Please describe any limitations:

Family planning services are limited to contraceptive management and related services. Non-covered services include procreative management, hysterectomy, and pregnancy termination

4.c.(ii) Family planning-related services provided under the above State Eligibility Option

Services generally provided as part of, or as follow-up to, a family planning visit for contraceptive management, including but not limited to: screening and treatment of sexually transmitted disease; HPV vaccine; treatment of lower genital and urinary tract infections, treatment of complications of contraception; annual office visit for men (including physical, laboratory tests, and contraceptive counseling); services provided as part of, or as follow-up to, a sterilization procedure; mammogram (with prior authorization); ovarian cyst identification and treatment (with prior authorization).

TN No. 10-12

Approval Date 2-24-11

Effective Date 2-1-11

Supersedes TN No. _____

SUPERSEDES: NONE - NEW PAGE

STATE <u>New Mexico</u>	A
DATE REC'D <u>12-21-10</u>	
DATE APP'D <u>2-24-11</u>	
DATE EFF <u>2-1-11</u>	
HCFA 179 <u>10-12</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitation

Attachment 3.1.A 1
Page 1

Citation(s)	Provision(s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	<p>The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare prescription Drug Benefit –Part D.</p> <p><input checked="" type="checkbox"/> The following excluded drugs are covered:</p> <p>("All" drugs categories covered under the drug class) <input type="checkbox"/></p> <p>("Some" drugs categories covered under the drug class <input checked="" type="checkbox"/> -List the covered common drug categories not individual drug products directly under the appropriate drug class)</p> <p>("None" of the drugs under this drug class are covered) <input type="checkbox"/></p> <p><input checked="" type="checkbox"/> (a) agents when used for anorexia, weight loss, weight gain</p> <p><input type="checkbox"/> (b) agents when used to promote fertility</p> <p><input type="checkbox"/> (c) agents when used for cosmetic purposes or hair growth</p> <p><input checked="" type="checkbox"/> (d) agents when used for the symptomatic relief of cough and colds</p>

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STATE	NEW MEXICO
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Supersedes 05-04

Approval Date 4-26-13

Effective Date 1-1-13

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitation

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Citation(s)

Provision(s)

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- ☒ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride
- ☒ (f) nonprescription drugs
- ☒ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)
- ☒ (h) barbiturates (Except for dual eligible individuals effective January 1, 2013 when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications)
- ☒ (i) benzodiazepines (Except for dual eligible individuals effective January 1, 2013 as Part D will cover all indications)
- ☒ (j) smoking cessation drugs (Except for dual eligible individuals as Part D will cover these drugs)

TN No. 13-01

Supersedes 05-04

Approval Date 4-26-13

Effective Date 1-1-13

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR
THE CATEGORICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitation

Attachment 3.1.A 1
Page 3

(a) **Agents when used for anorexia, weight loss, weight gain:** Appetite stimulants, anorexic agents, and fat absorption-decreasing agents.

(d) **Agents when used for symptomatic relief of cough and colds:** Antihistamines, antitussives, decongestants and expectorants.

(e) **Prescription vitamin and mineral products:** Single and multiple vitamins and minerals and combinations.

(f) **Nonprescription drugs:** Coverage for the following categories when an item is a drug of choice for a common medical condition or is an appropriate economical and therapeutic alternative to a prescription drug item: analgesics; anti-emetics; anti-inflammatory agents; anti-parasites; dermatological agents; enzyme replacements; gastrointestinal agents, including H-2 antagonists, proton pump inhibitors, laxatives and antacids; insulin; ophthalmic agents; otic agents; and respiratory agents.

(g) **Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee:** All items

(h) **Barbiturates:** All items (Except for dual eligible individuals effective January 1, 2013 when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications)

(i) **Benzodiazepines:** All items (Except for dual eligible individuals effective January 1, 2013 as Part D will cover all indications)

(j) **Smoking cessation drugs:** All items. The Medicaid agency will provide coverage of prescription and over-the-counter (OTC) smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence - 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

A	
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____ No excluded drugs are covered

TN No. 13-01

Supersedes 11-08

Approval Date 4-26-13

Effective Date 1-1-13

STATE: NEW MEXICO

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

CASE MANAGEMENT SERVICES

I. Case Management For the Chronically Mentally Ill

- A. Target Group: Case Management services will be provided to Medicaid eligible chronically mentally ill individuals who are not residents of an institution for mental disease. A chronically mentally ill individual is defined by diagnosis, disability, and duration. The major diagnoses include schizophrenia, affective disorders, bipolar disorders, and serious personality disorders (e.g., borderline personality); duration exceeds one year; and disability reflects serious impairment of functions relative to primary aspects of daily living.

B. Areas of the State in which services will be provided:

X Entire State

Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

TN No. 90-19
Supercedes
TN No. _____

Approval Date 5/9/91

Effective Date 7/1/90

STATE	DATE REC'D	DATE APP'D	DATE EFF	HCFA 179
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STATE: NEW MEXICO

 X Services are not comparable in amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a) (10) (B) of the Act.

D. Definition of Services:

The purpose of case management services for the chronically mentally ill is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services. Case management services will provide necessary coordination with providers of medical and non-medical services when services provided by these entities are needed to enable the individual to benefit from programs for which he or she is eligible. No limitation is placed on the number of units of case management service a client may receive each month.

Services - Case Management services include the following activities:

1. Identifying programs appropriate for the individual's needs, and providing assistance to the individual in accessing those programs.
2. Assessing the service needs of the individual in order to coordinate the delivery of services when multiple providers or programs are involved in care provision.
3. Reassessment of the individual to ensure that the services obtained are necessary.

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HCFA 179	<i>90-19</i>	

TN No. 90-19
Supercedes
TN No. _____

Approval Date 8/9/91

Effective Date 7/1/90

STATE: NEW MEXICO

E. Qualification of Providers: Qualified case management agencies must have responsible personnel management including written policies and procedures that include, but are not limited to, recruitment selection, retention and termination of case managers; job descriptions for case managers; grievance procedures; hours of work, holidays, vacations, leaves of absence; wage scale and benefits; conduct and general rules. In accordance with provisions of the Omnibus budget Reconciliation Act (OBRA) of 1987, the State will restrict the type of agencies that can provide case management services to the following provider types:

1. Community mental health centers funded by the Single State Mental Health Agency (New Mexico Health and Environment Department).
2. Indian Tribal Governments and Indian Health Service Agencies or clinics.
3. Federally Qualified Health Centers (FQHC).
4. Other agencies which have at least one year direct experience in case management services. Such experience may be through the agency as an entity or through its employees. These agencies must have knowledge of available community services and methods for accessing them.

Case Managers employed by case management agencies must possess the education, skills, abilities, and experience to enable them to perform the activities that comprise a Medicaid case management service. At a minimum, case managers must have at least a bachelor's degree in social work, counseling, psychology, or a related field, from an accredited institution plus one year of experience in the mental health field; OR be a licensed registered nurse with one year of experience in the mental health field.

In the event that there are no suitable candidates with the above qualifications, an individual with, preferably, an Associates Degree and a minimum of three years experience in the mental health field, or with a high school diploma and a minimum of five years experience in

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the mental health field may be employed as a case manager. In some cases, it may be important that individuals have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area.

- F. The State assures that the provision of case management services will not restrict an individuals's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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HCFA 179	<i>90-19</i>	

TN No. 90-19
Supercedes
TN No. _____

Approval Date 5/9/91

Effective Date 7/1/90

STATE: NEW MEXICO

VI. Case Management For Pregnant Women and Infants

A. Target Group: Case Management services will be provided to Medicaid eligible pregnant women and to their infants up to 60 days after the month of their birth.

B. Areas of the State in which services will be provided.

 X Entire state

 Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is invoked to provide services less than statewide)

C. Comparability of Services:

 Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

 X Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a)(10)(B) of the Act.

STATE <u>New Mexico</u>		A
DATE REC'D	<u>01-03-96</u>	
DATE APPV'D	<u>01-31-96</u>	
DATE EFF	<u>01-01-96</u>	
HCFA 179	<u>95-11</u>	

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D. Definition of Services:

The purpose of case management services for pregnant women is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services. Case management services will provide necessary coordination with providers of medical and non-medical services such as nutrition programs like WIC or educational agencies, when services provided by these entities are needed to enable the individual to benefit from programs for which she is eligible.

Case Management will be limited to 5 hours of service per client per pregnancy. Any additional units require prior approval by the State.

Case management services include the following activities:

1. Identifying programs appropriate for the individual's needs, including those which teach basic maternal and child health skills and providing assistance to the individual in accessing those programs.
2. Assessing the service needs of the individual in order to coordinate the delivery of services when multiple providers or programs are involved in care provision.
3. Reassessment of the individual to ensure that the services obtained are necessary.

These activities are structured to be in conformance with Section 1902 (a) (23) and not to duplicate any other service reimbursed in the Medicaid program or any other program.

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DATE REC'D	APR - 2 1990	
DATE APPV'D	MAY - 9 1991	
DATE EFF	JAN - 1 1990	
HCFA 179	90-06	

TN No.

Supercedes

TN No.

Approval Date

MAY - 9 1991

Effective Date

JAN - 1 1990

STATE: NEW MEXICO

E. Qualification of Providers:

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act.

1. Agency Qualifications:

Qualified case management agencies must have responsible personnel management including written policies and procedures that include, but are not limited to, recruitment selection, retention and termination of case managers; job descriptions for case managers; grievance procedures; hours of work, holidays, vacations, leaves of absence; wage scale and benefits; conduct and general rules. Agencies which may be certified include:

- a. Public Health Division of New Mexico Department of Health;
- b. Indian Tribal Governments or Indian health services;
- c. Federally qualified health centers (FQHC); and
- d. Other agencies which have at least one year direct experience in case management services. Such experience may be through the agency as an entity or through its employees. These agencies must have knowledge of available community services and methods for accessing them.

2. Case Manager Qualifications:

Case managers employed by case management agencies must possess the education, skills, abilities, and experience to enable them to perform the activities that comprise a Medicaid Case Management Service. It is important that individuals have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area.

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- a. Case managers must be licensed as a registered nurse and have a bachelors degree in nursing or be licensed as a social worker. The nurse or social worker must have two years of experience in community health and at least one year of experience in maternal or child health;
- b. OR be a licensed registered nurse or have a bachelors degree in social work with a minimum of two years of experience in community health and at least two years experience in maternal health or child health nursing.
- c. In the event that there are no suitable candidates with the above qualifications, an individual with, an associates degree and four years of experience in social work, community health and/or maternal and child health may be employed as a case manager.
- d. If no individuals with a college degree and appropriate experience are available, an individual with a high school diploma and five years of experience in social services, community health or maternal and child health may be considered. Agencies that are considering hiring individuals in option c or d must complete a waiver process.

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F. Freedom of Choice

The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services given that the providers meet the qualifications in Section E.
2. Eligible recipients will have free choice in participating in case management.
3. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Reimbursement

Payment for case management services under the plan does not duplicate payments made to public agencies for private entities under other program authorities for this same purpose.

STATE: NEW MEXICO

VI. Case Management for Children up to age Three

A. Target Group: Case Management services will be provided to Medicaid eligible children up to age three (3) who are medically at risk due to family conditions, but are not developmentally delayed. These are children who are not accessing health and social systems adequately or appropriately, which would impair their ability to thrive.

B. Areas of the State in which services will be provided.

X Entire state

Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is invoked to provide services less than statewide)

C. Comparability of Services:

Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a)(10)(B) of the Act.

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DATE EFF	<i>01-01-96</i>	
HCFA 179	<i>95-17</i>	

STATE: NEW MEXICO

D. Definition of Services:

The purpose of case management services for children is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services. Case management services will provide necessary coordination with providers of medical and non-medical services such as nutrition programs like WIC or educational agencies, when services provided by these entities are needed to enable the individual to benefit from programs for which he/she is eligible.

Case Management Services will be limited to four(4) hours per year per child. Any additional units require prior approval by the State.

Case Management services include the following activities:

1. Identifying programs appropriate for the individual's needs, including those which teach basic infant/young child care skills and providing assistance to the individual in accessing those programs.
2. Assessing the service needs of the individual in order to coordinate the delivery of services when multiple providers or programs are involved in care provision.
3. Reassessment of the individual to ensure tht the services obtained are necessary.

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DATE EFF	<i>1-1-90</i>	
HCFA 179	<i>90-07</i>	

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Supercedes
TN No. _____

Approval Date 5/9/91

Effective Date 1/1/90

STATE: NEW MEXICO

These activities are structured to be in conformance with Section 1902 (a) (23) and not to duplicate any other service reimbursed in the Medicaid program or any other program.

E. Qualification of Providers:

Enrollment will be accomplished in accordance with Section 1902 (a) (23) of the Act.

1. Agency Qualifications:

Qualified case management agencies must have responsible personnel management including written policies and procedures that include, but are not limited to, recruitment selection, retention and termination of case managers; job descriptions for case managers; grievance procedures; hours of work, holidays, vacations, leaves of absence; wage scale and benefits; conduct and general rules. Agencies which may be certified include:

- a. Public Health Division of New Mexico Department of Health;
- b. Indian Tribal Governments or Indian health services;
- c. Federally qualified health centers (FQHC); and
- d. Other agencies which have at least one year direct experience in case management services. Such experience may be through the agency as an entity or through its employees. These agencies must have knowledge of available community services and methods for accessing them.

2. Case Manager Qualifications:

Case managers employed by case management agencies must possess the education, skills, abilities, and experience to enable them to perform the activities that comprise a Medicaid Case Management Service. It is important that individuals have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area.

- a. Case managers must be licensed as a registered nurse and have a bachelors degree in nursing or be licensed as a social worker. The nurse or social worker must have two years of experience in community health and at least one year of experience in maternal or child health;

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- b. OR be a licensed registered nurse or have a bachelors degree in social work with a minimum of two years of experience in community health and at least two years experience in maternal health or child health nursing.
- c. In the event that there are no suitable candidates with the above qualifications, an individual with, an associates degree and four years of experience in social work, community health and/or maternal and child health may be employed as a case manager.
- d. If no individuals with a college degree and appropriate experience are available, an individual with a high school diploma and five years of experience in social services, community health or maternal and child health may be considered. Agencies that are considering hiring individuals in option c or d must complete a waiver process.

F. Freedom of Choice

The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

- 1. Eligible recipients will have free choice of the providers of case management services given that the providers meet the qualifications in Section E.
- 2. Eligible recipients will have free choice in participating in case management.
- 3. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Reimbursement

Payment for case management services under the plan does not duplicate payments made to public agencies for private entities under other program authorities for this same purpose.

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DATE EFF	<i>01-01-96</i>	
HCFA 179	<i>95-17</i>	

SUPERSEDES: TN. *90-07*

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1. Eligible recipients will have free choice of the providers of case management services, provided the providers meet the qualifications as specified in Section E.
2. Eligible recipients will have free choice in participating in case management.
3. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Reimbursement

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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DATE APPV'D	<i>3-8-91</i>	
DATE EFF	<i>1-1-90</i>	
HCFA 179	<i>90-07</i>	

TN No. *90-07*
Supercedes
TN No. _____

Approval Date *5/9/91*

Effective Date *1/1/90*

STATE: NEW MEXICO

IV. Case Management for Adults with Developmental Disabilities

A. Target Group: Case Management services will be provided for Medicaid eligible individuals who are developmentally disabled and are 21 years of age or older. The Centralized Services Team (CST) of the Department of Health, as the point of entry into services, will determine the urgency of need. Eligible individuals for continuing case management are those who meet the urgency of need based on medical necessity. Eligible individuals will include those needing residential and non-residential services as set forth by the CST, those that do not reside in a Medicaid certified ICF/MR facility; and those that do not participate in the Home and Community Based Waiver program.

B. Areas of the State in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide):

Comparability of Services:

☐ Services are provided in accordance with Section 1902 (a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of Section 1915 (g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a)(10)(B) of the Act.

D. Definition of Services:

The purpose of case management services for the adult developmentally disabled is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services. Case management provides a link between the developmentally disabled and the providers

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Superseded: TN 91-07

of needed medical, social, educational, and other services. Access to services is enhanced.

Case management services will be provided for up to sixty (60) days after the individual has been moved from the waiting list into the requisite residential or non-residential services as set forth by the CST.

Case management activities include the following activities:

1. Identifying programs appropriate for the individual's needs, and providing assistance to the individual in accessing those programs.
2. Assessing the service needs of the individual in order to coordinate the delivery of services when multiple providers or programs are involved in care provision.
3. Reassessment of the individual to ensure that the services obtained are necessary.

These activities are structured to be in conformance with 1902 (a)(23) and not to duplicate any other service reimbursed in the Medicaid program.

E. Qualification of Providers:

1. Agency Qualifications:

Qualified case management agencies must have responsible personnel management including written policies and procedures that include, but are not limited to recruitment selection, retention and termination of case managers; job descriptions for case managers; grievance procedures; hours of work, holiday, vacations, leaves of absence; wage scale and benefits; conduct and general rules.

They must demonstrate knowledge of the community to be served, its populations and its resources, including methods for accessing those resources.

In accordance with provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1987, the State will restrict the type of agencies that can provide case management services to the following provider types:

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- a. State agencies in New Mexico providing case management services to persons with developmental disabilities.
- b. Indian Tribal Governments and Indian Health Service Clinics.
- c. Community-based agencies in New Mexico that do not provide adult day habilitation, work related services and/or adult residential services to persons with developmental disabilities anywhere in New Mexico, and which have demonstrated direct experience in case management services in serving the target population, are eligible providers. Current Medicaid providers of case management for adults with developmental disabilities who also provide any of the above services must phase out case management services and no longer provide that service after October 1, 1994.

Agencies must be certified by the New Mexico Department of Health which serves as the certifying agency for this department.

2. Case Manager Qualifications:

Case Managers employed by case management agencies must possess the education, skills, abilities, and experience to enable them to perform the activities that comprise a Medicaid Case Management Service.

- a. At a minimum, case managers must have at least one year of experience working with persons with developmental disabilities and a bachelor's degree from an accredited institution in a human services field or any related academic discipline associated with the study of human behavior or human skill development (e.g., psychology, sociology, speech, gerontology, education, counseling, social work, human development, or any other study of services related to basic human needs or the human condition);

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- b. OR be a licensed registered nurse or licensed practical nurse with one year experience working with the developmentally disabled;
- c. In the event that there are no suitable candidates with the above qualifications, an individual with, preferably, an Associates Degree and a minimum of three years experience working with the developmentally disabled, or with a high school diploma and a minimum of four years experience working with the developmentally disabled may be employed as a case manager. In this case, a training and supervision plan must be submitted and approved by the Department of Health.

F. Freedom of Choice

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

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HCEA 179	<i>93-16</i>	

Supersedes: TN 91-07

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Reimbursement

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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DATE EFF	<i>1-1-91</i>	
HCFA 179	<i>91-07</i>	

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V. Case Management for the Traumatcally Brain Injured

A. Target Group: Case Management services will be provided to Medicaid eligible adults with traumatic brain injuries who are not residents of an institution. Traumatic brain injury is defined as an insult to the brain, not of a degenerative or congenital nature, but caused by an external physical force that may produce a diminished or altered state of consciousness which results in impairment of cognitive abilities or physical functioning. The impairments may be either temporary or permanent and cause partial or total functional disability or psychological maladjustment.

B. Areas of the State in which services will be provided.

____ Entire state

x Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is invoked to provide services less than statewide):

Santa Fe County, Chaves County, Dona Ana County, McKinley County, San Juan County and San Miguel County.

C. Comparability of Services:

____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

x Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a)(10)(B) of the Act.

D. Definition of Services:

The purpose of case management services for the traumatically brain injured is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services. Case management services will provide necessary coordination with providers of medical and non-medical services when services provided by these entities are needed to enable the individual to

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HCFA 179	<i>95-10</i>	

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benefit from programs for which he or she is eligible. No limitation is placed on the number of units of case management services a client may receive each month, however all services provided must be based on medical necessity and be designed to stabilize or improve the client's physical and mental functioning.

Services - Case Management services include the following activities:

1. Identifying programs appropriate for the individual's needs, and providing assistance to the individual in accessing those programs.
2. Assessing the service needs of the individual in order to coordinate the delivery of services when multiple providers or programs are involved in care provision.
3. Reassessment of the individual to ensure that the services obtained are necessary.

E. Case management providers for the traumatically brain injured are restricted to agencies who meet the following qualifications:

1. Community-based agencies which have demonstrated direct experience in providing case management services for the target population. Such agencies must have knowledge of available community services and methods of accessing them. They must be able to provide services on an ongoing basis without interruption.
2. Qualified case management agencies must have responsible personnel management including written policies and procedures that include, but are not limited to; recruitment, selection, retention and termination of case managers; job descriptions for case managers; grievance procedures; hours of work, holidays, vacations, leaves of absence; wage scale and benefits; conduct and general rules.
3. Providers are limited to agencies that can assume twenty four (24) hour responsibility for case management services.

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Supersedes: None - New Page

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4. Agencies must be certified by the Department of Health as providers of case management services to adults with traumatic brain injuries.

Case managers employed by case management agencies must possess the education, skills, abilities, and experience to enable them to perform the activities that comprise a Medicaid case management service. At a minimum, case managers must have at least a bachelor's degree in social work, counseling, psychology, or a related field, from an accredited institution, plus one year experience in the traumatic brain injury field or be a licenced registered nurse with one year experience in the traumatic brain injury field.

In the event that there are no suitable candidates with the above qualifications, an individual with, preferably an Associates Degree and a minimum of three years experience in the mental health/traumatic brain injury field, or with a high school diploma and a minimum of five years experience in the mental health/traumatic brain injury field may be employed as a case manager. In some cases, it may be important that individuals have language skills, cultural sensitivity and acquired knowledge and expertise unique to the geographic area.

- F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

- G. Payment for case management services under the plan does not duplicate payments made to public agencies for private entities under other program authorities for this same purpose.

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DATE EFF	<i>8-1-93</i>	
HCF# 179	<i>93-18</i>	

Supersedes: None New Page

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VI. Case Management of Adult Protective Services

A. Target Group: Case Management services will be provided to Medicaid eligible adults in need of adult protective services who are not residents of an institution. Adult protective services are defined as assistance to any person 18 years or older whom reports received show allegations of abuse, neglect or exploitation and is in need of services furnished by a protective services agency.

B. Areas of the State in which services will be provided:

☒ Entire state

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) Of the Act is invoked to provide services less than statewide)

C. Comparability of Services:

☐ Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (B) of the Act.

D. Definition of Services:

The purposes of case management services for adult protective services is to assist those eligible for Medicaid in gaining access to needed medical, social, educational, and other services. Case management services will provide necessary coordination with providers of medical and non-medical services when services furnished by these entities are needed to enable the individual to benefit from programs for which he or she is eligible. No limitation is placed on the number of units of case management services a client may receive each month.

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DATE REC'D <u>July 3, 1995</u>	
DATE APPE'D <u>September 4, 1995</u>	
DATE EFF <u>August 1, 1995</u>	
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Case Management services include the following activities:

1. Identifying programs appropriate for the individual's needs, and providing assistance to the individual in accessing those programs.
2. Assessing the service needs of the individual in order to coordinate the delivery of services when multiple providers or programs are involved in care provision.
3. Developing, implementing, and reviewing individual plans of care.
4. Monitoring the delivery of services.
3. Reassessment of the individual to ensure that the services obtained are necessary.

E. Qualifications of Providers:

1. Case Management Agencies:

- a. Must be an agency employing staff with case manager qualifications; and
- b. Have established referral systems and demonstrated linkages and referral ability with community resources required by the target population; and
- c. Have a minimum of five years experience in providing all core elements of case management services to the targeted populations; and
- d. Ensure 24-hr. Availability of case management services and continuity of those services; and
- e. Have an administrative capacity to ensure quality of services in accordance with State and Federal requirements; and
- f. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and
- g. Have a capacity to document and maintain individual case records in accordance with State and Federal requirements; and

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- h. Have a demonstrated ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program, including the ability to meet Federal and State requirements for documentation, billing and audits.
- 2. Case Managers employed by the case management agency must meet the following requirements for education and experience as defined below:
 - a. At a minimum, must have a bachelor's degree in Social Work and be licensed by the New Mexico Board of Social Work; and
 - b. Must possess the knowledge, skills and abilities to perform all of the components of case management services for the target population as determined by the provider agency; and
 - c. When necessary, must possess language skills, cultural sensitivity and acquired knowledge unique to a geographic area.

F. Freedom of Choice

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act.

- 1. Eligible recipients will have free choice of the providers of case management services given that the providers meet the qualifications in Section E.
- 2. Eligible recipients will have free choice in participating in case management.
- 3. Eligible recipients will have free choice of the providers of other medical care under the plan.

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DATE BY	August 1, 1995	
HCFR 1/3	95-09	

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DATE REC'D <u>5-15-04</u>	
DATE APPV'D <u>5-24-04</u>	
DATE EFF <u>6-1-04</u>	
HCFA 179 <u>04-01</u>	

State of New Mexico
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.
Same

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are: **Individuals who meet nursing home financial and medical necessity criteria at a special income level to 300% of the SSI federal benefit. 42CFR 435.217.**

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. X SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

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SUPERSEDES: TN- 98-12

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Approval Date 5-24-04
 Effective Date 6-1-04

TN NO.: 04-01

Effective Date 6-1-09

Approval Date 5-27-04
Effective Date 6-1-04

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B.) Spouse only (check one):

1. ☐ The following standard under 42 CFR 435.121:

2. ☐ The Medically needy income standard

3. ☐ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
4. ☐ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
5. ☐ The amount is determined using the following formula:

6. ☐ Not applicable (N/A)

(C.) Family (check one):

1. ☐ AFDC need standard
2. ☐ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ☐ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
4. ☐ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
5. ☐ The amount is determined using the following formula:

6. ☐ Other

7. ☐ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

SUPERSEDES: NONE - NEW PAGE

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STATE	<u>New Mexico</u>
DATE REC'D	<u>5-15-04</u>
DATE APPVD	<u>5-24-04</u>
DATE EFF	<u>6-1-04</u>
HCFA 179	<u>04-01</u>

A

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Approval Date 5-24-04
Effective Date 6-1-04

- (a.) Allowances for the needs of the:

5. _____ Other (specify): _____

- Note: If this amount changes, this item will be revised.

- If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

SUPERSEDES: NONE - NEW PAGE

TN NO.: 07-01

STATE New Mexico
DATE REC'D 5-15-04
DATE APP'VD 5-24-04
DATE EFF 6-1-04
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STATE <u>NEW MEXICO</u>	A
DATE REC'D <u>2-14-06</u>	
DATE APPV'D <u>5-9-06</u>	
DATE EFF <u>1-1-06</u>	
HCFA 179 <u>06-02</u>	

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State Plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology.

1. X Rates are set at a percent of fee-for-service costs
2. _____ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. _____ Adjusted Community Rate (please describe)
4. _____ Other (Please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

The PACE UPL was developed in accordance with the Centers for Medicare and Medicaid checklist regarding PACE capitated programs. The PACE program covers individuals ages 55+ who have been identified as needing a nursing home level of care.

In summary, the State utilized multiple years of historical fee-for-service data representative of the population and State Plan services covered under the PACE program. The fee-for-service base data was adjusted according to the CMS PACE checklist for completion factors and pharmacy rebates. Completion factors were developed from the fee-for-service paid claims experience and were grouped by major historical rebates claimed by the State. New rates were developed effective January 1, 2006 to exclude prescription drugs costs for dual eligible PACE participants. Trend factors were developed using linear regression analysis of the historical fee-for-service data. The trend factors were applied to the adjusted base period to the midpoint of the contract period. Programmatic changes were applied to the trended data to develop the upper payment limit (UPL) for the contract period.

The UPL's were developed for the Statewide region. These three following groups were used to research and develop the two rates for Duals and Non-Duals regardless of age. The following Statewide rate category groups were used for the PACE UPL development:

- * Non-Dual Eligibles 55 – 64 Years Old,
- * Dual Eligibles 55 – 64 Years Old,
- * Dual and Non-Dual Eligibles 65+ Years

TN No. 06-02
Supersedes

TN NO. 04-01

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Effective Date 1-1-06

SUPERSEDES: TN- 04-01

The state will pay fee-for-service, i.e., co-pay and deductible, for QMB only. Therefore, QMB only is not included in the rate development.

The rates were prepared by :
Mercer Government Human Services Consulting
Phoenix, AZ, US

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

STATE <u>New Mexico</u>	A
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DATE APP'D <u>5-27-04</u>	
DATE EFF <u>6-1-04</u>	
HCFA 179 <u>04-01</u>	

~~SUPERSEDES: NONE - NEW PAGE~~

TN No.: _____
Supersedes

TN NO.: 04-01

Enclosure 7, Page 7

Approval Date 5-24-04
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State Supplement A to Attachment 3.1A

Item 1 Inpatient Hospital Services

- a. Abortion services are limited as described in Item 5. Sterilization Services and hysterectomies are limited as described in Item 4.c.
- b. Payment for a private room is limited to those instances in which the Medicaid patient requires isolation either to protect the health of the recipient or to protect the health of others.
- c. Grace Day - When it is determined that an individual no longer needs acute level care, the Department will allow one additional day of care upon approval.
- d. Awaiting Placement Days - When it is determined that an individual no longer needs acute level care, but a lower level of care placement cannot be located, those days during which a client is awaiting placement in a lower level of care and termed "awaiting placement days". For the "awaiting placement days", no ancillary services will be covered. Medically necessary physician visits are not included in this limitation.
- e. Certain hospital service procedures require prior approval. The procedures that require prior approval are primarily those for which the medical necessity may be uncertain, which may possibly be for cosmetic purposes, or which may be of questionable effectiveness or long term benefit.
- f. Certain procedures are to be performed in the office, clinic, or as an outpatient institutional service as an alternative to hospitalization. Copies of the list can be obtained from the Medical Assistance Division.
- g. Experimental procedures are limited as described in item 5.

STATE	<i>New Mexico</i>	A
DATE REC'D	AUG 31 1989	
DATE APPV'D	FEB 11 1991	
DATE EFF	JUL 1 1989	
HCFA 179	89-10	

AMENDMENT 89-10
T.L. 89-10
JULY 1, 1989

State Supplement A to Attachment 3.1A

Item 2a. Outpatient Hospital Services

- a. Abortion services are limited as described in Item 5. below. Sterilization services and hysterectomies are limited as described in Item 4.c below.
- b. Physical therapy, occupational therapy, speech therapy, and other rehabilitation medical services are covered on a prior approval basis.
- c. Services, supplies, or equipment which require prior approval when performed in an office setting require the same when performed in an outpatient hospital setting.
- d. Outpatient hospital psychiatric services are subject to the following limitations and conditions, effective October 1, 1987:
 1. Coverage Criteria - The services rendered must comply with current State Mental Health Code and Health and Environment Department standards and regulations, and must meet the following criteria:
 - (a) Individualized Treatment Plan - Services must be prescribed by a psychiatrist or certified Ph.D. psychologist and provided under an individualized written plan. A plan is not required if less than 6 services will be furnished in a period of less than six weeks and there is no plan to continue to see the recipient.
 - (b) Supervision and Evaluation - Services must be supervised and evaluated by a psychiatrist or certified Ph.D. psychologist.

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- (c) Reasonable Expectation of Improvement-
Services must be for the purpose of
diagnostic study or reasonably expected to
improve the patient's condition.
2. The following are not covered:
- (a) Meals and transportation, (transportation
services are covered subject to the
transportation program requirements and
regulations).
 - (b) Activity therapies or other services which
are primarily recreational or diversional in
nature.
 - (c) Programs which are generally community
support groups in non-medical settings for
chronically mentally ill persons for the
purpose of social interaction.
 - (d) Vocational training.
 - (e) Patient education programs.
 - (f) Services to treat social maladjustments
without manifest psychiatric disorders
including occupational maladjustment,
marital maladjustment, and sexual
dysfunction.
 - (g) Services or programs which the Medicare
intermediary determines to be non-covered
under their outpatient hospital psychiatric
services regulations for reasons of medical
necessity.
- e. Experimental procedures are limited as described in
Item 5.

STATE	<i>New Mexico</i>	A
DATE REC'D	AUG 31 1989	
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State Supplement A to Attachment 3.1A

Item 2b. Rural Health Clinic Services

- a. Abortion services are limited as described in Item 5. Sterilization services and hysterectomies are limited as described in Item 4.c. Footcare and other physician services are limited as described in Item 5.
- b. Some services require prior approval, among them are the following:
 1. Services which require prior approval under Physician Services of the Medical Assistance Program also require prior approval for rural health clinics.
 2. Prior approval requirements for dental and pharmacy services must be in accordance with the specific requirements for those programs.

Item 2c. Federally Qualified Health Center Services

The following services are limited in coverage when provided by a federally qualified health center as specified in the State Plan for other providers in State Supplement A to Attachment 3.1A.

- a. Dental Services
- b. Vision Appliances
- c. Hearing Appliances
- d. Routine Foot Care
- e. Prosthetics and Orthotics
- f. Medical Supplies Equipment

STATE <i>New Mexico</i>		A
DATE REC'D	JUL 5 1990	
DATE APPV'D	APR 25 1991	
DATE EFF	APR - 1 1990	
HCFA 179	90-09	

AMENDMENT 91-11
T.L. 91-11
MAY 1, 1991

State Supplement A to Attachment 3.1A

Item 3 Other Laboratory and X-ray Services

- a. A professional component associated with laboratory services is covered only when the work is actually performed by a pathologist who is not billing for the complete procedure and is covered only for anatomic and surgical pathology (includes cytopathology and histopathology).
- b. Specimen collection fees are covered when drawn by venipuncture or collected by catheterization unless the patient is in a nursing home. Specimen collection fees are not payable for nursing home recipients.
- c. Laboratory tests are not covered if the tests are conveyed from an ordering physician's office to a different physician's office, office laboratory, or non-certified laboratory. Physician and other private practitioners may not bill for laboratory tests which are sent to an outside laboratory or other facility.
- d. Laboratory specimen handling or mailing charges are not a benefit of the program.
- e. Individual lab procedures that are routinely considered to be included in a profile or panel must be billed as a panel.
- f. The following services require prior approval (or retrospective approval following an emergency or retrospective eligibility):
 1. Cytogenetic Studies.
 2. Outpatient Magnetic Resonance Imaging.

Item 4b EPSDT Services In Excess of Federal Requirements

Nutritional assessment and nutritional counseling.

5

STATE <i>New Mexico</i>	A
DATE REC'D <i>JUN 28 1991</i>	
DATE APPV'D <i>JUL 26 1991</i>	
DATE EFF <i>MAY - 1 1991</i>	
HCFA 17 <i>91-11</i>	

Supercedes:

State Supplement A to Attachment 3.1A

Item 4b EPSDT Services Not Otherwise In The State Plan

All services provided in Section 1905(a) of the Act which are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions identified during an EPSDT screen, periodic or interperiodic, whether or not such services are covered or exceed the benefit limits in the state plan, are provided.

Specifically, the following services, which are not otherwise covered under the state plan, are provided when medically necessary:

1. Case management for medically at risk children and adolescents.
2. In-Patient services provided by institutions accredited by JCAHO as well as licensed by the New Mexico Department of Health, including free standing psychiatric facilities and residential treatment centers. Services must be provided under the direction of a physician.

Residential treatment center services are primarily for children or adolescents who have been diagnosed as having a severe emotional disturbance, mental disorder, or chemical dependency (drugs or alcohol), and for whom less restrictive settings are not appropriate. Services must be designed to reduce or control the individual's symptoms or maintain the individual's level of functioning.

3. Outpatient services provided by institutions accredited by JCAHO as well as licensed by the New Mexico Department of Health, including free standing psychiatric facilities. Services must be prescribed by a physician or licensed Ph.D. psychologist.
4. Services provided by licensed masters level practitioners, or by masters level counselors who are graduates of an accredited program. Services must be supervised by a licensed Ph.D. psychologist or a psychiatrist.

5a

STATE	<i>New Mexico</i>	A
DATE REC'D	<i>JUL - 3 1990</i>	
DATE APPV'D	<i>JAN - 3 1992</i>	
DATE EFF	<i>APR - 1 1990</i>	
HQA 179	<i>90-15</i>	

Supersedes - None - New Page

State Supplement A to Attachment 3.1A

Services must be rendered through a community mental health center as designated by the New Mexico Department of Health, a Federally Qualified Health Center, or provider accredited by the Council on Accreditation of Services for Families and Children.

5. Services of licensed masters level independent social work practitioners.
6. Private duty nursing services. Services must be provided through a licensed nursing agency, home health agency, or by a Federally Qualified Health Center. Services must be provided by a registered nurse or a licensed practical nurse.
7. Services of Christian Science Nurses.
8. Personal care services. Services must be provided by an agency licensed by the state.
9. Chiropractic services. Services must be provided by chiropractors licensed by the state.
10. Orthodontic and other dental services not otherwise covered under the state plan. Services must be provided by a dentist licensed by the state.
11. Therapies (physical, speech-language-hearing, occupational, and other rehabilitative therapies) provided by licensed individual therapists and centers. Included are rehabilitative services and therapies which are considered "maintenance" rather than "restorative" in nature.
12. Supplies, prosthetics, orthotics, and durable medical equipment to meet special physical needs.
13. Psychosocial services which are rehabilitative in nature and furnished in accordance with a written treatment plan. Specifically excluded from coverage are room and board, educational programs, and vocational training.

5b

STATE <i>New Mexico</i>	A
DATE REC'D <i>06-30-92</i>	
DATE APP'VD <i>04-17-96</i>	
DATE EFF <i>05-01-92</i>	
HCFA 179 <i>92-11</i>	

SUPERSEDES: TN. *92-15*

AMENDMENT 92-11
MAY 1, 1992

State Supplement A to Attachment 3.1A

Services are as defined in Dallas Regional Medical Services Letter (DRMSL) No. 92-73. They may be provided in either residential or home and community settings. Residential settings include Residential Treatment Centers and Group Homes. Non-residential settings include the home (natural, adoptive, or specialized therapeutic foster care), the school, or any other natural setting within the community. Actual services/settings consist of Non-JCAHO accredited Residential Treatment Centers; Group Homes; Treatment Foster Care; Behavior Management; and Day Treatment.

Each individual has a level of dysfunction determined by an interdisciplinary panel. The level is based upon diagnoses, psychological evaluations, and psychosocial criteria including current situations and past history concerning family and placements.

Activities include individual and group counseling and therapy; activities of daily living which facilitate age-appropriate skills re-development in the areas of household management, nutrition, physical and emotional health, basic skills, time management, money management, independent living, relaxation and self care techniques; crisis intervention.

Providers must be trained and certified in the services being provided, in accordance with the applicable certification standards adopted by the Department. The Department has adopted those certification standards for EPSDT psychosocial rehabilitation services promulgated and administered by the Children, Youth and Families Department. Providers must meet the qualifications as listed for their particular service in these standards.

Services may require prior approval as outlined in the State regulations pertaining to that service to assure medical necessity. Services may require a Plan of Care as outlined in the State regulations pertaining to that service.

5c

STATE <i>New Mexico</i>		A
DATE REC'D	<i>06-20-92</i>	
DATE APP'VD	<i>04-17-92</i>	
DATE EFF	<i>02-01-92</i>	
HCFA 179	<i>92-11</i>	

SUPERSEDES: TN - 90-15

OCTOBER 1, 1993

State Supplement A to Attachment 3.1A

14. Specific school based services provided by school districts or local education agencies certified by the State Department of Education. Services include EPSDT screens (periodic, interperiodic and partial); skilled nursing services; mental health services; case management; occupational therapy; physical therapy; speech pathology; audiology services; and transportation to and from medically necessary services prescribed in an Individual Education Plan (IEP) or an Individualized Family Service Plan (IFSP).
15. Special rehabilitation services which are evaluative, diagnostic and treatment in nature and necessary to correct any defects or conditions or to teach compensatory skills for deficits that directly result from a medical condition. These services include obtaining, interpreting and integrating the above evaluative, diagnostic and treatment information appropriate to an individual's Individualized Family Service Plan.

Special rehabilitation services include the following:

- (a) Speech, Language and Hearing: These are services for individuals with speech, language and hearing disorders. The services are provided by or under the direction of a speech pathologist or audiologist, as the result of a referral by a physician as defined in 42 CFR 440.110(c). These services mean evaluations to determine an individual's need for these services and recommendations for a course of treatment; and treatments to an individual with a diagnosed speech, language or hearing disorder adversely affecting the functioning of the individual.
- (b) Occupational Therapy: These services are prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice and provided by or under the direction of a qualified occupational therapist as defined in 42 CFR 440.110(b). These services mean evaluations of problems interfering with an individual's functional performance and therapies which are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age appropriate functional performance.
- (c) Physical Therapy: These services are prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice and provided by or under the direction of a qualified physical

STATE <i>en Mexico</i>	
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DATE APP'D	9-8-98
DATE EFF	10-1-93
HCFA 179	93-27

AMENDMENT 93-27
OCTOBER 1, 1993

State Supplement A to Attachment 3.1A

therapist as defined in 42 CFR 440.110(a). These services mean evaluations to determine an individual's need for physical therapy and therapies which are rehabilitative, active or restorative, and designed to correct or compensate for a medical problem.

- (d) Psychological, Counseling and Social Work: These services mean diagnostic or active treatments with the intent to reasonably improve the individual's physical or mental condition as prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice. They are provided to individuals whose condition or functioning can be expected to improve with these interventions. These services are performed by a licensed or equivalent psychological, counseling and social work staff acting within their scope of practice. These services include but are not limited to testing and evaluation that appraise cognitive, emotional and social functioning and self concept; therapy and treatment that is planning, managing, and providing a program of psychological services to individuals with diagnosed psychological problems.
- (e) Developmental Evaluation and Rehabilitation: These services mean testing performed to determine if motor, speech, language and psychological problems exist or to detect the presence of any developmental lags. Services include diagnostic, evaluative and consultative services for the purposes of identifying or determining the nature and extent of, and rehabilitating an individual's medical or other health-related condition. These services are performed by or under the supervision of a licensed physician or other provider acting within their scope of practice.
- (f) Nursing: These services are performed by a Nurse Practitioner, Registered Nurse, or Licensed Practiced Nurse within the scope of his/her practice relevant to the medical and rehabilitative needs of the individual. They are prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice. Services include medication administration/monitoring, catheterization, tube feeding, suctioning, screening and referral for health needs and explanations of treatments, therapies, and physical or mental conditions with family or other professional staff.

Providers of special rehabilitation services must be certified by the Department of

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DATE REC'D	1-3-94
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DATE EFF	10-1-93
HCFA 179	93-27

SUPERSEDES: NONE (NEW PAGE)

State Supplement A to Attachment 3.1A

AMENDMENT 08-003

Health and approved for participation and enrolled in the New Mexico Medicaid program. Services are provided directly by the special rehabilitation service provider or through subcontractors; and providers shall:

- (a) provide special rehabilitation services under the direction of professionals acting within their scope of practice as defined by State law; and
- (b) provide special rehabilitation services in the most appropriate least restrictive environment; and
- (c) assure that claiming for special rehabilitation services does not duplicate claiming for EPSDT administrative outreach services.

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Item 4b EPSDT Services Included In the State Plan

Services already included in the state plan are described in Attachment 3.1A. Limitations to those services are described in the other sections of State Supplement A to Attachment 3.1A.

5f

SUPERSEDES: TN- 99-06

STATE <u>New Mexico</u>	A
DATE REC'D <u>9-19-08</u>	
DATE APP'D <u>2-17-09</u>	
DATE EFF <u>9-12-08</u>	
HCFA 179 <u>08-03</u>	

State Supplement A to Attachment 3.1A

Specific program coverage restrictions, limitations in duration or service, and limitations in frequency of service, as described elsewhere in State Supplement A to Attachment 3.1A.

- (a) Experimental procedures are limited as described in Item 5, State Supplement A to Attachment 3.1A.
- (b) Documentation requirements must be met for abortion services, sterilization services, and hysterectomies.
- (c) Limitations in duration and frequency of service otherwise described in the state plan are not applicable when documented as medically necessary for the recipient.

SUPERSEDES: TN- 99-06

STATE <u>New Mexico</u>	A
DATE REC'D <u>7-2-04</u>	
DATE APPV'D <u>9-23-04</u>	
DATE EFF <u>7-1-04</u>	
HCFA 179 <u>04-08</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: NEW MEXICO

Amount, Duration and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy

State Supplement A to Attachment 3.1A

Preventive Services, 1905(a)(13)(c)

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Autism Intervention (AI) Services

AI services are covered for individuals under the age of 21 years who have a diagnosis of Autism Spectrum Disorder (ASD), and for individuals who are at risk for the development of ASD as defined by the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). AI services are provided to a child as part of a three-stage comprehensive approach.

Stage 1 AI Services:

Following a referral made by a physician or another licensed practitioner to an Autism Evaluation Practitioner (AEP), the AEP makes the diagnosis of ASD or At-risk for developing ASD. Following the diagnosis, the AEP develops an Integrated Service Plan (ISP).

Stage 1 Service Description

An AEP completes a comprehensive diagnostic evaluation (CDE) to confirm the presence of ASD must be conducted in accordance with current practice guidelines as offered by professional organizations such as the American Academy of Child and Adolescent Psychiatry, American Psychological Association, American Academy of Pediatrics, and American Academy of Neurology. Although aspects of the evaluation will vary depending on the child's age, developmental level, diagnostic history, etc., it is expected that the evaluation be multi-informant, multi-modal, ASD-specific, and conducted by an AEP who meets state agency AEP requirements. If a CDE is not medically warranted, a Targeted Evaluation or a Targeted Risk Evaluation is conducted.

CDE requirements:

- a) **Multi-informant:** CDEs must include information from:
The child's, him or herself, via direct observation and interaction; and
The child's legal guardian or other primary caregiver; and
Whenever possible, one additional informant who has direct knowledge of the child's functioning as it pertains to skill deficits and behavioral excesses associated with ASD:
 1. Child's educational or early interventionist provider; or
 2. Child's PCP; or
 3. Child's physical, behavioral and long term care health provider (e.g., Speech-Language Pathologist, Social Worker, Occupational Therapist, Physical Therapist, Psychologist, Psychiatrist, Behavior Analyst, etc.).
- b) **Multi-Sources:** CDE must rely on various sources of information gathering, including but not limited to:
 1. Review of educational and/or early interventions, physical, behavioral and long term care health records; and
 2. A legal guardian or primary caregiver interview for historical information, as well as a determination of current symptom presentation; and
 3. Direct observation of and interaction with the child; and
 4. Clear consideration of direct and/or indirect assessment of multiple areas of functioning, including but not limited to:
 - i. Developmental, intellectual, or cognitive functioning; and
 - ii. Adaptive functioning; and
 - iii. Social functioning; and
 - iv. Speech, language, and communicative functioning; and
 - v. Medical and neurological functioning.
- c) **ASD-specific:** The CDE must be specific enough to adequately assess symptoms associated with ASD, yet broad enough to make a valid differential diagnosis and consider possible co-morbid conditions.

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Date Received: 5 May, 2015
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: NEW MEXICO

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ISP Requirements: The AEP must issue a separate, individualized ISP if such a plan is not issued as part of the CDE Report. When developing and issuing the ISP, the AEP must adhere to the following requirements:

- a) If the AEP determines that AI services are clinically indicated, the ISP must include a statement that the AEP expects that the requested AI services will result in measurable improvement in the child's ASD symptomatology, associated behavioral excesses and deficits, and/or overall functioning.
- b) The ISP must ensure that all areas of need are adequately addressed through AI services and other medically necessary services (e.g., speech-language therapy, occupational therapy, and specialized physical and behavioral services). The ISP must include all services the recipient is or will be utilizing, regardless of the payor.
- c) The AEP must ensure other services that are recommended are aligned with the AI services such that the anticipated benefits to the child can be realized.
- d) The ISP must be linked to findings from the CDE and reflect input from the child (as appropriate for age and developmental level), legal guardian, or other caretaker, as well as school staff and behavioral health professionals involved in the child's care.
- e) The ISP must include a listing of all services and service providers as well as characteristics of the child that may affect the intervention positively or negatively.
- f) The ISP must be based on the child's current clinical presentation, while being mindful of the long-term vision for his or her potential.
- g) The ISP must address needs associated with the child's ASD-related symptoms, as well as symptoms associated with co-morbid conditions.
- h) Given that the needs of a child with ASD are characteristically numerous, the ISP must establish treatment priorities appropriate for the child defined by the pivotal nature of the skill and/or by the risk that the skill's absence or behavioral excess poses to the child or others.
- i) The ISP must include a plan for ongoing monitoring across multiple areas of functioning such that the plan can evolve as the child's behavioral presentation changes in response to treatment.

Stage 1 AI Services Practitioner Requirements

In order for an AEP to have an approved Provider Participation Agreement (PPA), an AEP must meet the following requirements in order to be eligible for reimbursement for provision of a Stage 1 Comprehensive Diagnostic Evaluation (CDE) or Targeted Evaluation and/or evaluation for the purposes of developing an Intervention Services Plan (ISP), and then the completion of an ISP. (Must meet a through f.)

- a) Be a licensed, doctoral-level clinical psychologist or a physician who is board-certified or board-eligible in developmental behavioral pediatrics, pediatric neurology, or child psychiatry; and
- b) Have experience in or knowledge of the medically necessary use of AI services and other empirically supported intervention techniques; and
- c) Be qualified to conduct and document both a CDE or a Targeted Evaluation for the purposes of developing an ISP; and
- d) Have advanced training and clinical experience in the diagnosis and treatment of ASD and related neurodevelopment disorders, including knowledge about typical and atypical child development and experience with variability within the ASD population; and
- e) Have advanced training in differential diagnosis of ASD from other developmental, psychiatric, and medical disorders; and
- f) Sign an attestation form affirming that all provider criteria, as outlined above, have been and will continue to be met; and when requested, provide documentation substantiating training, experience, licensure and/or certification.

Stage 2 AI Services:

Following the completion of an ISP that includes a recommendation for AI Stage 2 services, a Behavior Analyst (BA) conducts a Behavior Analytic Assessment specific to Stage 2 to determine the need for skill

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

Amount, Duration and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy

State Supplement A to Attachment 3.1A

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acquisition and behavior reduction. From this determination, goals and intervention services are developed specific to ASD and detailed in the Autism Intervention Treatment Plan (AITP).

Stage 2 Service Description

A BA conducts a Behavior Analytic Assessment that incorporates assessment strategies and assessment measures that are developmentally appropriate for the child must identify strengths and weaknesses across domains. The information from such a process is the basis for developing the individualized AITP. A Behavior Analytic Assessment utilizes information from multiple methods and multiple informants, such as:

- a) Direct observation, measurement, and recording of behavior are defining characteristics of AI services. The information gathered serves as the primary basis for identifying pre-treatment levels, discharge goals, and evaluation of responses to an AITP. They also assist the BA in developing and adapting treatment protocols on an ongoing basis.
- b) The assessments reflect the goal of treatment and are responsive to ongoing information updates as they are collected and analyzed.
- c) Legal guardians, caregivers and other stakeholders are included when selecting treatment goals, protocols, and evaluating progress as appropriate. Legal guardian and caregiver interviews, rating scales, and validity measures are used to assess the legal guardian and caregiver's perceptions of the child's skill deficits and behavioral excesses, and the extent to which these deficits and excesses impede the functioning of the child and his or her family. The child also participates in these processes as appropriate.

Treatment may vary in terms of intensity and duration, the complexity and range of treatment goals, and the extent of direct treatment provided.

- a) Many variables, including the number of behavioral targets, specific aspects of those behaviors, and the child's response to treatment protocols help determine which treatments, interventions, and behavior modification services most appropriate for the child. Although existing on a continuum, a combination of treatments, interventions, and behavior modification services can be generally categorized as a Focused AI or Comprehensive AI approach to services. The differences between these two general approaches are in regard to the age, intensity, duration, and frequency of services most appropriate for the child.
- b) Once the Behavior Analytic Assessment has been executed and responses and information have been gathered, the BA must select goals for intervention and determine how these goals will be measured. The AITP must identify all target behaviors that are to be addressed by the Behavior Technician (BT) and/or the BA directly.
- c) The AITP includes, when appropriate, a goal of working with the family of the child in order to assist with the acquisition, maintenance, and generalization of functional skills.

Stage 2 AI Services Practitioner Requirements: In order for an AP to have an approved Provider Participation Agreement (PPA), an AP must meet the following requirements in order to be eligible for reimbursement for provision of a Stage 2 Behavior Analytic Assessment and then the completion of an AITP:

- a) A Board Certified Behavior Analyst® (BCBA®) or Board Certified Behavior Analyst-Doctoral® (BCBA-D®) by the Behavior Analyst Certification Board (BACB®). A BCBA or BCBA-D may supervise other Behavior Analysts (BAs) and Behavior Technicians (BTs).
- b) A licensed psychologist with documented education and experience in behavior analysis. A psychologist may supervise BAs and BTs. The documentation required is:
 1. A professional credential issued by the Board of Psychologist Examiners of the New Mexico Regulation and Licensing Department (RLD).

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2. Documentation of education and training in behavior analysis comparable to that required to be eligible to take an examination for BCBA® or BCBA-D® certification including the following educational, supervised experiential training, and continuing education requirements:

Completion of graduate level instruction in the following behavior analytic content areas:

Ethical and professional conduct (at least 45 classroom hours); concepts and principles of behavior analysis (at least 45 classroom hours); research methods in behavior analysis including measurement (at least 25 classroom hours), experimental design (at least 20 classroom hours); AI services including identification of the problem and assessment (at least 30 classroom hours); fundamental elements of behavior change and specific behavior change procedures (at least 45 classroom hours); intervention and behavior change consideration (at least 10 classroom hours); behavior change systems (at least 10 classroom hours); implementation, management and supervision (at least 10 classroom hours); and discretionary coursework (at least 30 classroom hours).

3. Completion of supervised experience in the design and delivery of AI services.

The practitioner must have a significant portion of his or her supervised experience (at least 1/3) accrued with an ASD or closely related (e.g., Fragile X, Intellectual Disability) population.

4. In addition, a psychologist rendering services as a BA must have completed supervised independent field work in AI services (non-university based) of at least 1500 hours, or practicum experience in AI services (university based) of at least 1000 hours, or intensive AI services practicum experience (university based) of at least 750 hours, and completion of at least 32 hours of continuing education in behavior analysis within a two year cycle period.

- c) An AI services Practitioner/Supervisor is a BA who is not a BCBA or psychologist:

Stage 2 and 3 AI services may be delivered and/or supervised by a practitioner who has the minimum qualifications listed below. The practitioner must provide documentation of the following:

1. A master's degree which the BACB® recognizes and would lead to certification as a BCBA;
2. New Mexico licensure, as appropriate for degree and discipline;
3. Clinical experience and supervised training in the evidence-based treatment of children with ASD, specifically AI services; and
4. Experience in supervising direct support personnel in the delivery and evaluation of AI services.

Stage 3 AI Services:

The BA and the BT deliver the treatments, interventions, and behavior modification services as Stage 3 AI services in home, clinic, and community-based settings.

Stage 3 AI Services Service Description:

The following treatment and intervention services are rendered in the Stage 3:

- a) Increasing appropriate behavior via reinforcement. Treatment, intervention and behavior modification services include Positive and Negative Behavior Reinforcement.

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- b) Promoting stimulus control via differential reinforcement. Treatment, intervention and behavior modification services include Differential Reinforce and Matching to Sample.
- c) Promoting appropriate behavior via stimulus change. Treatment, intervention and behavior modification services include Goal Setting; Modeling and Imitation Training; Instruction and Rules; Prompt and Prompt Fading; Prompting to Transfer; and Expand Stimulus Control.
- d) Procedures for maintaining behavior. Treatment, intervention and behavior modification services include Schedules of Reinforcement.
- e) Teaching new behaviors: Treatment, intervention and behavior modification services include Shaping; Chaining; Task Analysis; Discrete Trial Teaching; Verbal Behavior; Echoic Training; Mand Training; Tact Training; Intraverbal Training; Listener Training; Discrete Trial Teaching; and Verbal Behavior.
- f) Preventing and reducing maladaptive behavior: Treatment, intervention and behavior modification services include Antecedent Methods and Procedural Packages for Preventing or Reducing Maladaptive Behavior; Redirecting; Use Activity Schedule; Distracting with a Preferred Event; Behavioral Momentum/High-Probability Request Sequence; Providing Choice; Reducing Response Effort; Applying Non-Contingent Reinforcement; Modeling; Social Stories; and Social Skills Training.
- g) Consequential methods for reducing maladaptive behavior: Treatment, intervention and behavior modification services include Differential Reinforcement of Alternative Behaviors; Differential Reinforcement of Other Behavior or Omission Training; Differential Reinforcement of Low Rates; Differential Reinforcement of Diminishing Rates; Response Cost; Time Out; Overcorrection; Negative Practice; Punishment; Manipulation of Antecedents; Stimulus Equivalence; Stimulus Generalization Training; Behavioral Contrast Effects; Matching Law and Factors Influencing Choice; High Probability Request Sequence/Behavior Momentum; Premack Principle; Errorless Learning; and Matching to Sample.
- h) Extinction. Treatment, intervention and behavior modification services include: Differential Reinforcement of Alternative Behaviors.
- i) Behavior-change systems. Treatment, intervention and behavior modification services include: Self-management Strategies; Token Systems and Other Conditioned Reinforcement Systems; Direct Instruction; Precision Teaching; Personalized Systems of Instruction; Incidental Teaching; Functional Communication Training; Natural Environment Teaching; Lovaas Model of AIS; Augmentative Communication; PECS (Picture Exchange Communication Systems)

Stage 3 AI Services Practitioner Requirements:

The practitioners who render Stage 3 services are BAs who have the qualifications described above, and a BT. A BT must receive at least one hour of case supervision from the BA for every 10 hours of intervention the BT renders per child. There are two avenues through which a practitioner may qualify as a BT.

- a) A Registered Behavioral Technician® (RBT®) by the BACB®
- b) Documented training in Behavior Analysis without (RBT®) credentials and meet the following requirements:
 - 1. Be at least 18 years of age;
 - 2. Possess a minimum of a high school diploma or equivalent;
 - 3. Complete a minimum of four hours of training in ASD including training on prevalence, etiology, core symptoms, characteristics, and learning differences;
 - 4. Complete at least 40 hours of training in AI toward the requirements for RBT® credentialing by BACB®.

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- A. (Registered Behavioral Technician® (RBT®) by providing a written attestation by the BACB®, and when appropriate, provide formal records documenting that the BT meets the following requirements:
- be at least 18 years of age;
 - possess a minimum of a high school diploma or equivalent;
 - successfully complete a criminal background registry check;
 - complete a minimum of four hours of training in ASD (prior to the BT billing for ABA services) including, but not limited to, training about prevalence, etiology, core symptoms, characteristics, and learning differences;
 - complete 40 hours of training in ABA that meets the requirements for Registered Behavioral Technician® (RBT®) by the BACB®; At least 20 hours of RBT training (in addition) to the four hours of ASD training) must occur prior to the AP billing for BT services. The other 20 hours of RBT training must be accrued, and RBT® certification from the BACB must be secured, no more than 90 calendar days following the first submission of billing for BT services.
- B. A Behavioral Technician (BT) without RBT® credentialing with documented training in behavior analysis, may render services for up to six months while working toward his or her certification as a RBT® with an attestation from the provider that the BT meets the following requirements:
- be at least 18 years of age;
 - possess a minimum of a high school diploma or equivalent;
 - successfully complete a criminal background registry check;
 - complete a minimum of four hours of training in ASD including, but not limited to, training about prevalence, etiology, core symptoms, characteristics, and learning differences prior to the AP billing for BT services;
 - complete 40 hours of training (provided by a BA as defined above) with at least 20 hours of training occurring prior to the AP billing for the BT's services, and the other 20 hours accrued no more than 90 calendar days following first submission of billing for the BT's services.

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Item 4c. Family planning services and supplies for individuals of child bearing age.

- a. The New Mexico Medical Assistance program covers sterilizations including non-emergency and elective sterilizations only when all the requirements of 42 CFR 441 Subpart F are met.
- b. A hysterectomy requires an acknowledgement of the sterilization results of the hysterectomy to be signed by the recipient or her representative prior to the operation.

Item 5 Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

- a. Coverage does not include the services of assistant surgeons furnished in a teaching hospital where there is a resident available to perform the services unless exceptional medical circumstances exist.
- b. Osteo-manipulative therapy is limited to 3 manipulations per month regardless of the area or areas manipulated, unless authorized as medically necessary.

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- c. Coverage of experimental procedures is restricted to heart, liver, and heart-lung transplants. Experimental procedures and services related to experimental procedures, including but not limited to hospitalization, anesthesiology, laboratory tests and x-ray, are covered on a limited basis with prior approval when anticipated to positively affect the recipient's outcome.
- d. Cosmetic surgery performed for aesthetic purposes only are not covered.

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- e. Reimbursement for induced abortions is provided only when the physician certifies that the pregnancy was a result of rape or incest or the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition cause or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

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Item 6a Podiatrists' Services

- a. Medicaid coverage is limited to the podiatrists' scope of practice as defined by state law.
- b. Foot care services ordinarily considered to be routine are covered only if medically necessary due to the medical condition of the recipient.
- c. Certain procedures are to be performed in the office, clinic or as an outpatient institutional services as an alternative to hospitalization.
- d. Services directed toward the care or correction of a flat foot condition are not covered.
- e. Orthopedic shoes and other supportive devices for the feet are not covered. The exclusion of orthopedic shoes does not apply to such a shoe, however, if it is an integral part of a leg brace.
- f. Surgical or non-surgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered unless documented to be medically necessary. Surgical correction of a subluxated foot structure that is an integral part of the treatment for foot pathology is covered if medically necessary based on the medical condition of the recipient.

Item 6b Optometrists' Services

Orthoptic assessment and treatment are not covered by the New Mexico Medical Assistance Program.

Routine vision exams are allowed only once in a 36-month period except as provided as an EPSDT service or the medical condition of the client requires more frequent examination, treatment or follow up.

Item 6d Other Practitioner' Services

I. Behavioral Health Practitioners:

- Licensed behavioral health practitioners include: Psychologists, Licensed Professional Clinical Counselors, Licensed Marriage & Family Therapists, School Certified Psychologists, Psychiatric Clinical Nurse Specialists, and Licensed Independent Social Workers.
- Licensed non-independent behavioral health practitioners include: Licensed Master's Level Social Workers, Master's Level Licensed Counselors and other behavioral health practitioners licensed under state law at a licensed community mental health center (CMHC), a certified core service agency (CSA), a federally qualified health center (FQHC) or a tribal 638 compact facility.

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a. The following services are not benefits of the program:

1. Hypnotherapy
2. Biofeedback
3. Conditions where a reasonable prognosis does not exist.
4. Social maladjustments without manifesting psychiatric disorders, including occupational maladjustment, marital maladjustment, sexual dysfunction, and personality disorders.

b. Coverage of psychiatric or psychological services are allowed only for services in which an eligible provider to patient relationship exists.

II. Licensed Midwife Services

Services are limited to those within their scope of practice as authorized by state law.

III. Certified Nurse Anesthetist's and Anesthesiology Assistant's Services

Anesthesia services, physician directed and non-physician directed, provided during a surgical procedure covered under the state plan are a benefit of the Medicaid program.

IV. Other Certified Nurse Practitioners

Other Certified Nurse Practitioner services are covered regardless of the practitioner's specialty. Surgical procedures are not a benefit of the program when they are not within the practitioner's scope under state law.

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V. Services of Licensed Independent Social Workers (LISWs) and Clinical Nurse Specialists (CNSs)

Services of Licensed Independent Social Workers (LISWs) are covered consistent with their licensure and includes Licensed professional mental Health Clinical Counselors (LPCCs), Licensed Marriage and Family Therapists (LMFTs), and Clinical Nurse Specialists (CNSs) certified in psychiatric nursing.

VI. Licensed Alcohol and Drug Abuse Counselor

The services of a Licensed Alcohol and Drug Abuse Counselor (LADAC) are covered when provided within a federally qualified health center, an Indian Health Service facility, a PL 93-638 tribally-operated hospital or clinic, or a community mental health center or core service agency licensed by the appropriate state or federal agency or department. All services must be rendered within the scope of practice and licensure for each provider and must be in compliance with the statutes, rules, and regulations of the applicable state practice acts. All requirements for supervision in state law must be met.

10a

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Item 7a Intermittent or part time nursing services provided by a home health agency, etc.

All home health agency services beyond the initial visit for evaluation purposes require prior approval. The medical necessity criteria that a recipient must meet to receive home health services includes the determination that the individual is physically unable or has great difficulty leaving the home to obtain necessary medical care and treatment (i.e., is essentially homebound) or that the medical need for care at home is more appropriate and cost-effective and will prevent or delay institutionalization.

Item 7b Home health aide services provided by a home health agency

Home health aide services must be provided under the supervision of a registered nurse or other appropriate professional staff member. The registered nurse or other professional staff member must make a supervisory visit to the recipient's residence at least every two weeks to observe and determine whether goals are being met.

Item 7c Medical supplies, equipment, and appliances suitable for use in the home

Medical supplies must be necessary and reasonable to the treatment plan

Durable medical equipment (DME) is considered for coverage only if it is reasonable and necessary for treatment of an illness or injury, or to improve the functioning of a body part. A list is available from the Medical Assistance Division identifying items that require prior approval.

Coverage is limited to services and items that are medically necessary for treatment of a medical condition and do not include the following unless specific medical justification can be made:

1. Items that do not primarily and customarily serve a therapeutic purpose and/or are generally used only for comfort or convenience purposes;
2. Environment control equipment not primarily medical in nature;

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AMENDMENT 04-008
JULY 1, 2004

3. Institutional equipment inappropriate for home use;
4. Items not generally accepted by the medical professional as being therapeutically effective or are determined by Medicare regulations not to be effective or necessary;
5. Items primarily hygienic in nature rather than medical;
6. Hospital or physician diagnostic items not appropriate for home use;
7. Instruments or devices manufactured for use by a physician or other practitioner not appropriate for home use;
8. Items for administration of heat that are primarily for convenience and not essential to administration of heat therapy
9. Exercise equipment not primarily medical in nature;
10. Items which produce no demonstrable or proven therapeutic effect;
11. Support exercise equipment primarily for institutional use where, in the home setting other devices more appropriately satisfy the recipient's need;
12. Devices for monitoring the pulse of a homebound recipient with or without a cardiac pacemaker not otherwise medically necessary;
13. Items used to improve appearance or are primarily for comfort purposes rather than therapeutic purposes;
14. Items to have available as a precaution not otherwise medically necessary;
15. Emergency communications systems not serving a therapeutic purpose;
16. Oral dietary formula and food products to meet dietary needs in the absence of an inborn metabolic disorder and unless documented as medically necessary and serving a distinct therapeutic need.
17. Pressure support stockings other than those prescribed and custom fitted to meet the needs of the recipient.

11a

SUPERSEDES: NONE - NEW PAGE

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Multiple redundant services are not covered. Equipment and supplies are limited in frequency consistent with reasonable use for the medical condition unless justified by a change in the recipient's condition.

Interest and/or carrying charges are not covered.

The delivery of DME is covered only when the equipment is initially purchased or rented; when the supplier customarily makes a separate charge for delivery; and only for delivery charges of over 75 miles (round trip).

Item 7d Physician therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation center.

Therapy must be provided by a qualified physiotherapist, occupational therapist or assistant, speech pathologist, or audiologist as per 42 CFR 440.100, and in conformance with state law and in accordance with an approved plan of treatment.

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Item 9 Clinical Services

- a. Limitations for physicians, item 5, also apply to clinics.
- b. Ambulatory surgical center facility services are covered when all the following conditions are met:
 - 1. The surgical procedure and use of the facility is medically necessary and is a benefit of the program.
 - 2. All program requirements for the surgery are met by the physician such as valid consent forms, prior approval requirements, etc.
- c. Dialysis Services
 - 1. The New Mexico Medicaid Program will reimburse providers for renal dialysis services for the first three months of dialysis if not covered by Medicare pending the establishment of Medicare eligibility.
 - 2. The New Mexico Medicaid Program will cover fifteen sessions of dialysis training sessions without special medical justification. Additional sessions require medical justification be attached to the claim.

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Item 10 Dental Services

New Mexico Medicaid Program does not cover dental services performed for aesthetic or cosmetic purposes only.

Services for which medical necessity may be questionable are covered only with prior approval (or on retrospective approval in emergency situations or following retroactive eligibility). A complete list of those services may be obtained from New Mexico Medical Assistance Division.

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Item 11(a)(b)(c) Physical Therapy, Occupational Therapy, and Services for Individual with Speech, Hearing and Language Disorders

Therapy and related services provided on an outpatient basis require prior approval.

The following services are not a benefit of the New Mexico Medicaid Program:

1. Services classified as educational.
2. Services provided by home health agencies, independent physical therapists, or out-patient rehabilitation centers to patients in a skilled nursing facility or an inpatient hospital.
3. Speech therapy provided by speech therapists unless certified as a rehabilitation center.

Item 12(a) Prescribed drugs

Limitations are as follows:

- a. Drugs rated as ineffective by the FDA are not a benefit of the program.
- b. The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3) or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. The State will cover new drugs of participating manufacturers (except excluded/restricted drugs) for six months after Food and Drug Administration approval and upon notification by the manufacturer of a new drug. Any prior authorization program instituted after July 1, 1991 will provide for a 24 hour turnaround from receipt by mail of the request for prior authorization. The prior authorization program also provides for at least a 72 hour supply of drugs in emergency situations.

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- c. Items must be prescribed by a practitioner licensed to prescribe drugs in accordance with state law.
- d. Drug items for which the use or approve indications may be of questionable medical necessity, highly abusable or recreational in nature are subject to a review or prior authorization to assure the use is medically necessary.
- e. Review or prior authorization may be required for items for which a lesser expensive or therapeutically preferred alternative should be used first. Establishing these therapeutic "step" requirements will be based on published clinical practice guidelines and professional standards of health care in addition to cost.
- f. Drug restrictions include dosage, day supply, and refill frequency limits necessary to ensure appropriate utilization or to prevent fraud and abuse. In establishing such limits, professional standards of health care are considered. Exceptions to these limits are allowed where medically justified.
- g. Orphan drugs (drugs used in the treatment of rare diseases), drugs used for unlabeled purposes, and very expensive drugs not routinely stocked in pharmacies may also require review or prior authorization.

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- h. Drug items are not covered under the program when they are included in another provider's reimbursement (example: floor stock medication in a nursing facility already included in the facilities reimbursement.)
- i. Flu and pneumococcal vaccines are covered when prescribed in accordance with the seasonal recommendations of the Public Health Services.

SUPERSEDES TN- 04-09

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Item 12(b) Dentures

Partial dentures, full upper, and/or full lower dentures require prior approval.

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Item 12(c) Prosthetic Devices

- a. All prosthetic devices require prior approval except for prosthetic limbs attached immediately following surgery for traumatic injuries while the recipient is a hospital inpatient.
- b. The following prosthetics and orthotics are not benefits of the program:
 1. Orthopedic shoes unless they are an integral part of a leg brace(s).
 2. Orthotic supports for the arch or other supportive devices for the foot unless they are integral parts of a leg brace.
 3. Prosthetic devices or implants that are primarily for cosmetic purposes are not a benefit of the program unless otherwise determined to be medically necessary for the recipient.

Replacements are limited in frequency unless there has been a change in the recipient's medical condition or the item has exceeded its expected duration of use.

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d. Hearing Aids

1. The following services are covered by the Medical Assistance Programs but require approval from the Medical Assistance Program prior to providing the service:
 - (a) Hearing aid dispensing, purchase, rentals, and replacements.
 - (b) Hearing aid repairs exceeding \$100.

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Item 11(d) Eyeglasses

- a. Coverage of eyeglasses (frames and lenses) are subject to the following criteria.
1. Diopter correction must meet or exceed one of the following:
 - (a) -1.00 Myopia (nearsightedness)
 - (b) +1.00 Hyperopia (farsightedness)
 - (c) 0.75 Astigmatism (distorted vision, the combined refractive error of sphere and cylinder to equal 0.75 will be accepted)
 - (d) ± 1.00 Presbyopia (farsightedness of aging)
 2. If updating an existing prescription, there must be a minimum 0.75 diopter change in the prescription. Exceptions will be made for recipient with cataracts or when an ophthalmologist or optometrist recommends a change due to a medical condition.
 3. For bifocal lenses, a correction of 0.25 or more for distance vision and 1 diopter or more for added power (bifocal lens correction).
 4. For Prism, when indicated to prevent diplopia (double vision).
 5. For tinted, filtered, or photochromic lenses, the examiner must document the condition which makes the lenses medically necessary and the dioptric criteria listed above must be met.
- b. The following services are not covered by the New Mexico Medical Assistance Program:
1. Orthoptic assessment and treatment.
 2. Oversize frames and oversize lenses.
 3. Low vision aids.

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4. Contact Lenses, except when prior authorized.
5. Glass cases, anti-scratch lenses, anti-reflective coatings, progressive lenses, trifocals and other items not related to medical necessity.
6. Routine vision exams and glasses are allowed only once in a 24-month period except as provided as an EPSDT service or the medical condition of the client requires more frequent examination, treatment or follow up.

Item 13d Rehabilitative Services

The rehabilitative services listed below must be recommended by a physician or OLP.

Services are limited to mental health rehabilitation services for eligible recipients for whom the medical necessity of such services has been determined and who are not residents of an institution for mental illness.

The services are limited to goal oriented mental health rehabilitative services individually designed to accommodate the level of the recipient's functioning and which reduce the disability and to restore the recipient to his/her best possible level of functioning.

Services are limited to assessment, treatment planning, and specific services which reduce symptomatology and restore basic skills necessary to function independently in the community including:

1. Therapeutic Interventions: Provides face to face therapeutic services which include assessments, treatment planning, ongoing treatment, and transition planning.
2. Medication Services: Provides for the assessment of the efficacy of medication and evaluation of side effects, and administration of medication by qualified personnel when it cannot be self administered. Also provides educationally structured face to face activities delivered to patients, their families and others who provide care to patients regarding medication management.
3. Community Based Crisis Interventions: Provides coordinated services utilizing a crisis team. The service includes immediate access, evaluation, crisis intervention and respite care to patients.
4. Professional Consultation: Provides consultation services by mental health professionals as part of treatment team, to patients for the purpose of clinical case review, treatment plan development and ongoing treatment.

5. Group Psychosocial Interventions: Provides rehabilitation services directed towards the remediation of functional limitations, deficits, and behavioral excesses exhibited in patients. Services focus on improving daily living skills, impaired social skills, and problem solving.
6. Assertive Community Treatment (ACT): Provides intensive, integrated rehabilitative, crisis, treatment and community support services by an interdisciplinary staff team available 24-hours seven days a week. Services are rendered in a community setting or the home. ACT is an intensive, highly individualized service for individuals discharged from hospitals after multiple or extended stays, or who are difficult to engage in treatment, and have continuous high service needs that are not being met in more traditional service settings. All services must be medically necessary and are limited to Medicaid eligible recipients.

Services are rendered through an assembled and fully trained team constituted according to certification requirements of the Behavioral Health Services Division of the New Mexico Department of Health that include standards for education, skills, abilities, and experience necessary to perform the activities that comprise assertive community treatment services. Each assertive community treatment team includes at least one psychiatrist (licensed and board eligible or certified); two registered nurses (licensed); two mental health professionals (licensed psychiatric nurse practitioner or licensed master's level behavioral health professional); one substance abuse professional (licensed alcohol and drug abuse counselor "LADAC" or licensed master's level behavioral health professional with experience in substance abuse treatment) and at least one trained peer professional. The qualifications of the peer professional include having been in a similar medical situation as the recipient but successfully having come out of that situation, previous experience in serving as a peer professional, passing a written and/or oral examination, receiving 10 to 12 hours per year in specific program training, and working under the direction and supervision of a licensed behavioral health professional in order to help direct the client toward the appropriate goals of the program, help model the client's relationship with the therapists, and help monitor the compliance of the client with regards to substance abuse abstinence.

Assertive Community Treatment services include the following activities:

- a. Assessing the service needs of the individual to assure the services obtained are medically necessary; and identifying services appropriate for the individual's needs.
- b. Establishing a care plan to assure medically necessary services are provided and reassessing the individual's needs to ensure that the services obtained continue to be necessary and effective.
- c. Crisis intervention for individuals needing emergent psychiatric care, available 24 hours 7 days a week.
- d. Medication assessment and management for individuals who need ongoing pharmacological management including prescribing and administering psychiatric medications.
- e. Medically necessary psychiatric, psychological, and behavioral health and substance abuse treatment.

Services must be provided by qualified providers of rehabilitative services for the mentally ill, whose staff members are certified by the single state mental health agency or through the Indian Health Services as being trained according to standards for ACT; and who have also signed an ACT agreement with the Human Service Department.

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7. Comprehensive Community Support Services (CCSS). Comprehensive Community Support Services are goal-directed mental health rehabilitation services and supports for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. The service assists in the development and coordination of the recipient's service plan and includes therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community. It includes one-on-one interventions with the recipient to develop interpersonal and community coping skills; adaptation to home, school and work environments; assessment support and intervention in crisis situations; and symptom monitoring and self-management of symptoms.

Comprehensive Community Support Services must be medically necessary, promote recovery and rehabilitation, and be provided as part of a comprehensive service plan that includes a recovery or resiliency management plan, a crisis management plan, and when requested, advanced directives related to the recipient's behavioral health care. The crisis management plan recognizes the early signs of crisis or relapse, the use of natural supports, and the use of alternatives to emergency departments and inpatient services.

Services are rendered through a federally qualified health center (FQHC), an Indian Health Service (IHS) facility, a PL 93-638 tribally-operated facility, an agency licensed by the New Mexico Department of Health as a Community Mental Health Center, or a Children's Core Service Agency licensed by the Children, Youth, and Families' Department as a Children's Core Service Agency. Private agencies and schools may also be certified by the New Mexico Department of Health or the Children, Youth, and Families' Department for Comprehensive Community Support Services.

Clinical supervisors within the facility, agency, or center must have one (1) year of documented supervisory experience; be licensed by the appropriate licensing board as a psychiatrist, psychologist, Licensed Independent Social Worker (LISW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Art Therapist (LPAT), or Certified Nurse Specialist (CNS); and practicing within the scope of his or her licensure.

Services must be provided by a community support worker. A community support worker must possess the education, skills, abilities, and experience to perform the activities that comprise community support services including holding a bachelor's degree in a human service field with a minimum of one years' relevant experience with the target population, or an associate's degree with a minimum of two years' relevant experience with the target population, or a high school diploma or GED with a minimum of three years' relevant experience with the target population, or be certified as a peer or family specialist by the New Mexico Department of Health.

21b

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8. Multi-Systemic Therapy (MST). MST provides an intensive family preservation model of treatment for youth and their families who are at risk of out-of-home placement. MST is for the benefit of the child. The MST model is based on evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services include an initial assessment to identify the focus of the MST intervention and face-to-face therapeutic interventions with the youth and family in the following functional domains: adaptive, communication, psychosocial, problem solving, and behavior management. Specialized therapeutic and rehabilitative interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence.

Any agency that seeks and is certified by MST, Inc. can provide MST services. Services are available in-home, at school and in other community settings including a federally qualified health center (FQHC), an Indian Health Service (IHS) facility, a PL 93-638 tribally-operated facility, an agency licensed by the Children, Youth, and Families' Department as a Children's Core Service Agency, and private agencies and schools certified by the New Mexico Department of Health or the Children, Youth, and Families' Department.

All agencies must be able to provide twenty-four (24) hour coverage, seven (7) days per week, by licensed Masters and/or Bachelors level staff. Bachelor's level staff must have a degree in social work, counseling, psychology or a related human services field and must have at least three (3) years of experience working with the target population that is, children/adolescents and their families. Staffing for MST services shall be comprised of no more than one-third Bachelors level staff and, at minimum, two-thirds licensed Masters level staff.

9. Substance Use Disorder Continuum of Services

The comprehensive continuum of services for the screening, assessment, and treatment of substance use disorders includes several new services based upon the American Society of Addiction Medicine's levels of care (ASAM LOC) including placement criteria, staffing, and standards. These services are designed for an individual's restoration to a functional level within his or her life and community.

1. Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- A. Definition: SBIRT is a community-based practice designed to identify, reduce and prevent problematic substance use or misuse and co-occurring mental health disorders as an early intervention. SBIRT is a universal screening specific to age, face-to-face brief intervention for positive screening results, and a referral to behavioral health services if indicated.

- B. Practitioners delivering the service must be trained in a state-approved educational curriculum and include:

1. Registered nurses;
2. Certified nurse practitioners;
3. Clinical nurse specialists;
4. Behavioral health practitioners at all educational levels;
5. Behavioral health interns under the supervision of an independently licensed behavioral health practitioner;
6. Certified peer support workers;
7. Certified family peer support workers;
8. Licensed physician assistants;

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9. Physicians;
10. Medical assistants; and
11. Community health workers.

2. Peer Support Services

- A. Definition: Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. Recovery is a rehabilitative process characterized by continual growth and improvement in one's health and wellness, social and spiritual connection, and renewed purpose.

Family Peer Support Services (FPSS) enable parents and other primary caregivers to gain the knowledge, skills and confidence to effectively manage their own needs and the needs of the family member with the condition, ultimately moving to more family independence.

B. Practitioners:

1. Certified Peer Support Workers

- a. Must complete the educational program offered at the Behavioral Health Services Division of the Human Services Department or the Family Peer Support training by the Children, Youth and Families Department
- b. Must complete the test and be certified by the Counseling and Therapy Practice Board
- c. Must be supervised by an independent practitioner or someone trained and certified to supervise peers.

2. Certified Family Peer Support Workers

- a. Must complete the educational program offered at the Children, Youth and Families Department
- b. Must complete the test and be certified by the Counseling and Therapy Practice Board
- c. Must be supervised by an independent practitioner or someone trained and certified to supervise peers.

3. Dyadic and triadic therapy for a baby or child diagnosed with a behavioral health condition or at risk because of the caregiver's behavioral health condition includes the mother, father, or primary caregiver together with the child. Dyadic and triadic therapies are types of family therapies for the direct benefit of the child. Independently licensed practitioners represent the dyadic and triadic providers.

4. Outpatient withdrawal management (WM):

- A. Definition: Withdrawal signs and symptoms are sufficiently resolved so that the patient can be safely managed outside of the clinic; at night has supportive living situation.

1. Ambulatory WM without extended on-site management

Services: a comprehensive medical history and physical examination; medication or non-medication methods of WM; patient education; non-pharmacological clinical support; involvement of family members or significant others in the WM process; and discharge or transfer planning including referral for counseling and involvement in community recovery support groups.

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- b. Staff:
 - i. on call physician, nurse, psychologist
 - ii. on-site nurse, counselors, social workers, peer support workers

2. Ambulatory WM with extended on-site monitoring

- a. services include the above services plus an addiction-focused history; sufficient biopsychosocial screening to determine the level of care; an individualized treatment plan; and monitoring and assessment of progress throughout the day
- b. Staff:
 - i. on call physician, nurse, psychologist
 - ii. on-site nurse, counselors, social workers, peer support workers

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5. Crisis Stabilization

- A. Definition: Crisis Stabilization is an outpatient service providing up to 24-hour stabilization of crisis conditions. Crisis Stabilization includes services that are designed to ameliorate or minimize an acute crisis episode or to prevent incarceration, emergency department, inpatient psychiatric hospitalization, or medical detoxification. Services are provided to eligible recipients who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors, or moods which could threaten the safety of self or others. Ambulatory withdrawal management may be included. Some Centers may also offer navigational services for individuals transitioning to the community from correctional facilities upon official release from custody/detention.
- B. Staffing: Crisis stabilization community centers must be minimally staffed during all hours of operation with:
 - 1. one registered nurse with experience or training in crisis triage and managing intoxication and withdrawal management if offered;
 - 2. one licensed master's level mental health practitioner;
 - 3. one certified peer support worker; and
 - 4. either on-site or on call one board certified physician or licensed clinical nurse specialist, or licensed certified nurse practitioner.

6. Intensive Outpatient for SUD:

- A. Definition: Time limited IOP services utilizing a multi-faceted approach to treatment for an eligible recipient who requires structure and support to achieve and sustain recovery. IOP must utilize a research and evidence-based model approved by the IOP Interagency Council and target specific behaviors with individualized behavioral interventions. IOP core services include: individual substance use disorder related therapy; group therapy and psycho-education.
- B. Staff: IOP services are provided through an integrated interdisciplinary approach including staff expertise in both addiction and mental health treatment
 - 1. Each IOP program must have an independently licensed clinical supervisor
 - 2. The team may have services rendered by non-independent practitioners under the direction of the IOP supervisor including LMSW, LMHC, LADAC, CADAC, LSAA, and master's level psych associates.

7. Intensive Outpatient for Mental Health Conditions: All conditions as IOP for SUD apply.
8. Partial hospitalization: 20 or more hours of service/week for multi-dimensional instability, not requiring 24-hour care.
 - A. Partial hospitalization updated coverage criteria:
 1. Extend coverage to youth as part of EPSDT in a psychiatric hospital;
 2. Include SUD in addition to mental health;
 3. Qualified agency types include acute care hospitals with psychiatric services and psychiatric hospitals as specialty hospitals.
9. Accredited Residential Treatment Centers (ARTC) for adults with SUD with three sub-levels:
 - A. Definition: Accredited Residential Treatment Centers for Adults with Substance Use Disorder are facilities for adult recipients, who have been diagnosed as having a substance use disorder (SUD).
 - B. Sub-levels of care
 1. Level 3.1: Clinically managed low-intensity residential service: 24-hour structure with trained personnel; at least 5 hours of clinical service/week. This level is often a step down from a higher level of care and prepares the recipient for outpatient treatment and community life.
 2. Level 3.3, 3.5, and 3.2 withdrawal management are clustered together in a second level of service with specific programming for each sub type:
 - a. Level 3.3, clinically managed population specific high intensity residential services: 24-hour structure with trained counselors to stabilize multi-dimensional imminent danger; less intense programming and group treatment for those with cognitive or other impairments unable to use full therapeutic community; and preparation for outpatient treatment.
 - b. Level 3.5, clinically managed high intensity residential services: 24-hour care with trained counselors to stabilize multi-dimensional imminent danger; and preparation for outpatient treatment.
 - c. Level 3.2 withdrawal management, clinically managed residential withdrawal management: Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.

The recipient remains in a Level 3.2 withdrawal management program until:

- i. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
- ii. the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management services is indicated.

3. Level 3.7 and 3.7 withdrawal management are clustered together in a third level of service with specific programming for each sub type.

Services are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, peer support workers or other health and technical personnel under the direction of a licensed physician.

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- a. Level 3.7: medically monitored intensive inpatient services: 24-hour nursing care with physician availability for significant problems; 16 hour/day counselor availability.
- b. Level 3.7 withdrawal management: medically monitored inpatient withdrawal management: Severe withdrawal, 24-hour nursing care and physician visits; unlikely to complete withdrawal management without medical monitoring.

The recipient remains in a level 3.7 withdrawal management program until:

- i. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
- ii. the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management services is indicated.

10. Crisis Triage Centers (CTCs)

- A. Definition: Crisis Triage Centers are community-based alternatives to hospitalization or incarceration authorized by 2014 NM HB212 Crisis Triage Center legislation. The facilities are either outpatient only (providing crisis stabilization as indicated above), or outpatient and residential, with no more than 16 beds. They serve youth and adults to provide voluntary stabilization of behavioral health crises including emergency mental health evaluation, withdrawal management, and care.

Services include physical and mental health assessment, de-escalation and stabilization; brief intervention and psychological counseling; clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems; psychological and psychiatric consultation; other services determined through the assessment process; and may include ambulatory withdrawal management; and, if residential, all level 3 withdrawal management services.

- B. The following individuals and practitioners must be contracted or employed by the provider agency as part of its crisis triage center service delivery:
 - 1. an administrator which can be the same person as the clinical director;
 - 2. a full-time clinical director;
 - 3. a charge nurse on duty 24 hours/day, seven days/week;
 - 4. an on-call physician 24 hours/day, seven days/week;
 - 5. a master's level licensed mental health practitioner;
 - 6. two certified peer support workers;
 - 7. a part time psychiatric consultant, hours dependent on the size of the facility; and
 - 8. at least one staff trained in basic cardiac life support (BCLS), the use of the automated external defibrillator (AED) equipment, and first aid.

The ratio of direct care staff to individuals shall increase on the basis of the clinical care needs of the individuals in residence as well as the number of operational beds.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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8. Medication Assisted Treatment (MAT): MAT services provided through an Opioid Treatment Center include the provision, administration, and / or dispensing of methadone or other narcotic replacement or narcotic agonist drug items as part of a detoxification treatment or maintenance treatments as defined in 42 CFR part 8, *Certification of Opioid Treatment Programs*. The Opioid Treatment Center must comply with the requirements and meet all accreditation and certification standards as specified in 42 CFR part 8, subparts A and B *Accreditation and Certification and Treatment Centers*.

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Item 17 Nurse Midwife Services

Nurse midwives participating in the Medicaid Program must be licensed by the Board of Nurses as registered nurses and be registered with the Health Services Division of the Department of Health as certified nurse midwives. Services are limited to those within the scope of practice authorized by state law.

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T.L. 91-10
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State Supplement A to Attachment 3.1A

Item 18 Hospice Care

The hospice care benefit will follow the amount, duration and scope of services as outlined in the State Medicaid Manual, Hospice Services, Section 4305. Persons eligible for the hospice benefit will be limited to those recipients who are categorically needy, certified as terminally ill and electing to receive hospice services. The recipient may reside in a long term care facility or be admitted into long term care if he or she does not have a family member or friend to assist with home care. Election of the hospice benefit results in a waiver of the recipient's rights to Medicaid payment for only those services which are related to treatment of the terminal illness or related conditions and common to both Title XVIII and Title XIX. The recipient does not waive rights to payment for services related to the terminal illness and unique to Title XIX. The duration of the hospice benefit continues for an unspecified time period as long as the individual remains in hospice care and does not revoke the election.

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Superior

AMENDMENT 91-19
T.L. 91-19
October 1, 1991

State Supplement A to Attachment 3.1-A

Item 20a, b, and c Pregnancy Related Services

The New Mexico Medicaid program will pay for pregnancy related and post-partum services through the two months following the month in which the child is born or the pregnancy terminates. Any services not related to the pregnancy would not be considered covered services for this population through the two months following the month in which the child is born or the pregnancy terminates.

Services or supplies not related to the pregnancy but which are necessary as a result of a condition which may complicate the pregnancy prior to delivery would be covered, as follows.

All services are subject to the same limitations as specified for the service elsewhere in the state plan:

- Hospital services
- Physician services
- Laboratory and Radiology services
- Clinic services
- Rural Health Clinics services
- Federally Qualified Health Clinic services
- Drug services
- Durable medical equipment and medical supplies
- Family planning services
- Transportation services
- Midwife services
- Prenatal case management
- Certified Nurse Practitioner services
- Vision services
- Psychological services
- Ambulatory Surgical Center services

Increases in covered services for pregnant women:

Nutritional assessment.

OCT 1 1991

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SUPERSEDES

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State Supplement A to Attachment 3.1-A

Item 23 Certified Nurse Practitioner Services

Surgical procedures are not a benefit of the program as they are not within the scope of state law. Psychiatric services rendered by Certified Nurse Practitioners are not a benefit of the program

Item 24a Transportation

Out-of-state transportation services (except nearby border cities) are allowable only when the services needed cannot be obtained in New Mexico or the physician provides adequate justification for the out of state travel. Emergency transportation will be reviewed retrospectively to determine if the transport was necessary.

Item 24e Emergency Hospital Services

Emergency hospital services may be provided by facilities not certified by Title XVIII. These services must meet the definition of emergency hospital services as defined in 42 CFR 440.170(e).

See limitations for Items 1 and 2a, inpatient and outpatient hospital services.

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State: _____

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided _____ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided: X State Approved (Not Physician) Service Plan Allowed
X Services Outside the Home Also Allowed
_____ Limitations Described on Attachment
_____ Not Provided.

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Item 26 Personal Care Services

Individuals eligible for Personal Care Option (PCO) services have the option of choosing the consumer-delegated (traditional PCA service delivery model) or the consumer-directed personal care model. Under the consumer-delegated model, the consumer chooses the PCO agency to perform all employer-related tasks and the agency is responsible for ensuring all service delivery to the consumer. The consumer-directed model allows the consumer to oversee his/her own service care delivery, and requires the consumer to work with a PCO agency that acts as a fiscal intermediary agency to process all financial paperwork.

Personal care services are provided in accordance with 42 CFR 440.167.

Description of PCO services:

1. Individualized bowel and bladder services;
2. Meal preparation and assistance;
3. Feeding or assisting the consumer with eating;
4. Household support services;
5. Hygiene/grooming;
6. Supportive mobility assistance.

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A

PCO Agencies:

PCO agencies must be certified by the Human Services Department or its designee.

Personal Care Attendants:

Personal care attendants providing PCO Services to consumers electing either consumer-directed or consumer delegated :

- A. Be hired by the consumer (consumer-directed model) or the PCO agency (consumer-delegated model);
- B. Cannot be anyone who meets the definition of a legally responsible relative pursuant to 42 CFR Section 440.167 and CMS state medicaid manual section 4480-D;

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- C. Cannot be the recipient's legal representative unless approved by the Department due to the lack of availability of other options. If the legal representative is also a legally responsible relative, as described in B above, the legal representative cannot provide services;
- D. Cannot be the consumer's personal representative, unless he/she is also the legal representative;
- E. Be 18 years of age or older;
- F. Successfully pass a nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq., of the Caregivers Criminal History Screening Act, performed by an agency certified to conduct such checks; attendants are required to submit to a criminal history screening within the first 20-days of hire; an attendant may be conditionally hired by the agency contingent upon the receipt of written notice from the certified agency of the results of the nationwide criminal history screening; attendants who do not successfully pass a nationwide criminal history screening are not eligible for further PCO service employment;
- G. If the attendant is a member of the consumer's family, he/she may not be paid for services that would have otherwise been provided to the consumer; if the attendant is a member of the consumer's household, he/she may not be paid for household services, support services (shopping and errands), or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., cleaning consumer's room, linens, clothing, and special diets);
- H. For consumer-delegated models: complete 12-hours of training yearly and must maintain certification throughout the entire duration of providing PCO services.

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NOFA 179	12-04	

TN No. 12-04

Approval Date 11-21-12

Supersedes TN. No. SUPERSEDES: NONE - NEW PAGE

Effective Date 6-1-12

November 1990

State/Territory: NEW MEXICO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
 MEDICALLY NEEDY GROUP(S): NOT APPLICABLE

1. Inpatient hospital services other than those provided in an institution for mental diseases.
- ☐ Provided: ☐ No limitations ☐ With limitations*
- 2.a. Outpatient hospital services.
- ☐ Provided: ☐ No limitations ☐ With limitations*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
- ☐ Provided: ☐ No limitations ☐ With limitations*
- c. Federally qualified health center (FQHC) services and other ambulator services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
- ☐ Provided: ☐ No limitations ☐ With limitations*
3. Other laboratory and X-ray services.
- ☐ Provided: ☐ No limitations ☐ With limitations*
- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- ☐ Provided: ☐ No limitations ☐ With limitations*
- b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.
- ☐ Provided: ☐ Limited to Federal requirements ☐ In excess of Federal requirements
- c. Family planning services and supplies for individuals of childbearing age.
- ☐ Provided: ☐ No limitations ☐ With limitations*

*Description provided on attachment.

TN No. 9023

Supersedes

TN No. _____

Approval Date

APR 25 1991

Effective Date

OCT - 1 1990

A	
STATE	NEW MEXICO
DATE REC'D	DEC 31 1990
DATE APP'D	APR 25 1991
DATE EFF	OCT - 1 1990
HCFA 179	

State/Territory: NEW MEXICO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NOT APPLICABLE

- c. Prosthetic devices.
☐ Provided: ☐ No limitations ☐ With limitations*
- d. Eyeglasses.
☐ Provided: ☐ No limitations ☐ With limitations*
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.
- a. Diagnostic services.
☐ Provided: ☐ No limitations ☐ With limitations*
- b. Screening services.
☐ Provided: ☐ No limitations ☐ With limitations*
- c. Preventive services.
☐ Provided: ☐ No limitations ☐ With limitations*
- d. Rehabilitative services.
☐ Provided: ☐ No limitations ☐ With limitations*
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services.
☐ Provided: ☐ No limitations ☐ With limitations*
- b. Nursing facility services.
☐ Provided: ☐ No limitations ☐ With limitations*
- *Description provided on attachment.

TN No. 90-23
Supersedes
TN No.

Approval Date APR 25 1991

Effective OCT -1 1990

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 31 1990</u>
DATE APPV'D	<u>APR 25 1991</u>
DATE EFF	<u>OCT -1 1990</u>
HCFA 179	<u>90-23</u>
	A

State/Territory: NEW MEXICO

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NOT APPLICABLE

c. Intermediate care facility services.

☒ Provided: ☐ No limitations ☐ With limitations*

15. Intermediate care facility services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions, for persons determined, in accordance with Section 1902(a)(31)(A) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☐ With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☐ No limitations ☐ With limitations*

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☐ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☐ No limitations ☐ With limitations*

*Description provided on attachment.

STATE <u>New Mexico</u>	A
DATE REC'D <u>DEC 31 1990</u>	
DATE APP'D <u>APR 25 1991</u>	
DATE EFF <u>OCT - 1 1990</u>	
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TN No. _____

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State/Territory: NEW MEXICO

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): NOT APPLICABLE

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).
- ☒ Provided: ☐ No limitations ☐ With limitations*
☐ Not provided.
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.
- ☒ Provided: ☐ No limitations ☐ With limitations*
- b. Services of Christian Science nurses.
- ☒ Provided: ☐ No limitations ☐ With limitations*
- c. Care and services provided in Christian Science sanatoria.
- ☒ Provided: ☐ No limitations ☐ With limitations*
- d. Nursing facility services provided for patients under 21 years of age.
- ☒ Provided: ☐ No limitations ☐ With limitations*
- e. Emergency hospital services.
- ☒ Provided: ☐ No limitations ☐ With limitations*
- f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
- ☒ Provided: ☐ No limitations ☐ With limitations*

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DATE EFF <u>OCT - 1 1990</u>	
HCFA 179 <u>90-23</u>	

Attachment 3.1-B

State of New Mexico

PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

☐ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

☒ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

SUPERSEDES: TN- 98-12

STATE <u>New Mexico</u>	A
DATE REC'D <u>5-15-04</u>	
DATE APPV'D <u>5-24-04</u>	
DATE EFF <u>6-1-04</u>	
HCFA 179 <u>04-01</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitation

Attachment 3.1.B.1
Page 1

Citation(s)

Provision(s)

1935(d)(1)

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

1927(d)(2) and 1935(d)(2)

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit -Part D.

A				
STATE	New Mexico			
DATE REC'D	2-14-13			
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HCFA 179	13-01			

☐ The following excluded drugs are covered:

("All" drugs categories covered under the drug class) ☐

("Some" drugs categories covered under the drug class) ☐

-List the covered common drug categories not individual drug products directly under the drug class)

("None" of the drugs under this drug class are covered) ☐

- ☐ (a) agents when used for anorexia, weight loss, weight gain
- ☐ (b) agents when used to promote fertility
- ☐ (c) agents when used for cosmetic purposes or hair growth
- ☐ (d) agents when used for the symptomatic relief of cough and colds

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: NEW MEXICO

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR
THE MEDICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitation

Attachment 3.1.B.1
Page 2

Citation(s)

Provision(s)

- ☐ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride
- ☐ (f) nonprescription drugs
- ☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)
- ☐ (h) barbiturates (Except for dual eligible individuals effective January 1, 2013 when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications)
- ☐ (i) benzodiazepines (Except for dual eligible individuals effective January 1, 2013 as Part D will cover all indications)
- ☐ (j) smoking cessation drugs (Except for dual eligible individuals as Part D will cover these drugs)

NOT APPLICABLE

STATE <u>New Mexico</u>	A
DATE REC'D <u>2-14-13</u>	
DATE APPV'D <u>4-26-13</u>	
DATE EFF <u>1-1-13</u>	
HCFA 179 <u>13-01</u>	

TN No. 13-01
Supersedes 05-04

Approval Date 4-26-13
Effective Date 1-1-13

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX

Attachment 3.1-C

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

The Medical Assistance Bureau has in operation several separate, but inter-related methods of assuring high quality care. These methods include: review of acute care, long term care and ambulatory care by the New Mexico Professional Standards Review Organization (NMPSRO); drug program monitoring through the Department, operation of the Surveillance and Utilization Review subsystem and the Medical Management Program for recipients; Department monitoring of the NMPSRO review activities; and special provisions relating to quality of care in IHS hospitals.

PSRO operations are discussed in the following Part I; Department operations are discussed under Part II.

PART I - NMPSRO REVIEW FUNCTION

NMPSRO provides utilization review of services to acute care patients and long term care patients through contracts with the Department of Human Services. These activities are described below in Sections A and B. NMPSRO also provides utilization review of services to ambulatory patients through a direct contract with the Department. The specifics of each area of care are described below in Section C.

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DATE: 8/24/82

TRANSMITTAL NO: 82-7

A. REVIEW OF HOSPITAL ADMISSION

I. INTRODUCTION

The New Mexico Medical Assistance Program (MAP) has directed its review efforts to ensure compliance with the Medicaid program's objectives for cost containment and quality control. The NMMRA, acting under contract to the MAP, will perform medical review under the Medicaid system to ensure that:

1. Admissions to acute care hospitals and medically necessary.
2. All hospital services and surgical procedures provided were appropriate to the patient's condition and were reasonable and necessary to the care of the patient.
3. Patterns of inappropriate admissions and transfers are identified and are corrected. Reimbursement will not be allowed for inappropriate admissions or transfers.
4. The new method of payment and its application by hospitals have not jeopardized quality of patient care.
5. All cases which require a medical peer review decision regarding appropriate utilization of hospital resources, quality of care, or appropriateness of admission, transfer into a different hospital, and readmission, will be reviewed by a NMMRA Physician Consultant or will be reviewed by the NMMRA Medical Director.

II. CRITERIA FOR REVIEW

The NMMRA has developed and the MAP has approved the Acute Level of Care Criteria (ALOCC) and Specialty Criteria for the procedures under medical review in NMMRA's Preadmission Review Program. The criteria are utilization screening tools for use by NMMRA's professional nursing staff.

In the event that these criteria are modified the hospitals will be notified of such modifications including the effective date of implementation.

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III. PREADMISSION REVIEW

The NMMRA will perform preadmission review for 100% of those surgical procedures as described in 310.020302 which are proposed as inpatient hospital admissions and all proposed rehabilitation admissions. The preadmission review procedures require that the attending physician's office or the admitting hospital make a request by telephone to the NMMRA for elective surgical procedures prior to the admission. Any such request which is not received for a review determination by the NMMRA prior to the surgery will be subject to retrospective review, denial, and recoupment proceedings, should denial occur.

The NMMRA will utilize Health Service Reviewers and Physician Consultants by appropriate specialty for reviewing elective procedures proposed as inpatient admissions. Any proposed patient admission which fails the criteria will be referred to a Physician Consultant appointed by the NMMRA Medical Director for a determination of medical necessity.

In the event the admission and/or proposed procedures are pending denial, the attending physician and hospital will be contacted by telephone. Should a denial occur, both the physician and the hospital will be notified by NMMRA. It is the responsibility of the attending physician to notify the patient. Should a denial occur, the attending physician and/or patient will have the right to a reconsideration hearing.

IV. CONCURRENT ADMISSION AND CONTINUED STAY REVIEW

The NMMRA will perform concurrent admission and continued stay review for all admissions to specialty hospitals and specialty units within hospitals.

V. RETROSPECTIVE REVIEW

The NMMRA will perform retrospective review on certain types of inpatient cases. Cases will be reviewed on-site at the hospital or in-house for both PDO (reimbursed per discharge) and Non-PDO (reimbursed per TEFRA) hospitals (excluding specialty hospitals and specialty units) based on the volume of cases identified by the Fiscal Agent. On-site review can be expected when the number of cases exceed one hundred (100) per quarter; or, when the NMMRA is in the area for other review reasons. The NMMRA may also perform review at the NMMRA using copies of charts mailed to the NMMRA.

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DATE: JUL. 2 1986

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VI. REVIEW OF INTER-HOSPITAL TRANSFERS AND READMISSIONS

A. Review of Inter-Hospital Transfers

The NMMRA will perform prepayment review of all Medicaid discharges resulting in a transfer to another acute care hospital. The NMMRA will review the medical records, either on-site or in-house, and make a determination regarding the medical necessity and appropriateness of the transfer. If the NMMRA determines non-medical necessity, the NMMRA will institute the denial procedure. The hospital inappropriately transferring the patient will be the hospital subjected to the denial of payment. The receiving hospital will be held harmless.

B. Review of Readmissions Within Seven (7) Calendar Days of Discharge From An Acute Care Facility

The NMMRA will perform prepayment review on Fiscal Agent identified admissions which have occurred within seven (7) calendar days of discharge from an acute care facility. Neither the day of discharge, nor the day of admission is counted when determining whether a (re)admission has occurred.

1. When the admissions are for patently different diagnoses (unrelated reasons), the NMMRA follows the standard that no medical record review is required.

2. If the admissions appear to be related, NMMRA will perform medical review.

3. If the admissions are found to be medically necessary and appropriate, no further action will be taken.

4. If either or both admissions are found to be medically unnecessary, denial will follow.

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VII. REVIEW FOR DIAGNOSIS VERIFICATION AND MEDICAL NECESSITY OF THE ADMISSION

A. The MAP and NMMRA will define the sample size for PDO and Non-PDO hospitals and method of selection for those cases to be subjected to diagnosis verification and medical necessity review.

B. If medical necessity criteria for admission are not met, the HSR will refer the case to a Physician Consultant (PC) by appropriate specialty for a determination of approval or denial of the admission.

C. If the admission is approved, the HSR will perform diagnosis verification by review of the discharge summary and complete the appropriate portion of the worksheet.

D. If the admission is denied by the PC, the HSR will complete the appropriate portion of the review worksheet and initiate a medical necessity denial. No further review is required by NMMRA. The reconsideration process is then available.

VIII. EXAMPLES OF MEDICAID NON-COVERED SERVICES THAT CAN RESULT IN TECHNICAL DENIALS

A. Private duty nursing.

B. Custodial care.

C. Surgery for solely cosmetic reasons.

D. Any hospitalization solely for administration of a drug or biological which is not reasonable or necessary (not safe and effective by FDA), including investigational drugs.

E. Hospitalization for procedures excluded from Medicaid coverage.

F. If the patient reaches a Skilled Nursing or Intermediate Level of Care the hospital stay will no longer be covered by the Medicaid inpatient program.

G. Hospitalization for a person who is hospitalized as part of a workman's compensation claim or a person who is hospitalized as part of a liability claim.

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TRANSMITTAL NO: 86-5

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Attachment 3.1 - C
Page 1e

DATE: JUL. 2 1986

TRANSMITTAL NO: 86-5

Amendment 86-05

T. L. 86-05

April 1, 1986

IX. RECONSIDERATIONS

If a recipient or recipient's next of kin or personal representative or attending physician or hospital is dissatisfied with a NMMRA medical review determination, that party may request a reconsideration. If the patient has been discharged, this request must be made within sixty (60) days of receipt of the contested determination or if more than sixty days have elapsed the requesting party must submit documentation of extenuating circumstances for late filing. The request for reconsideration shall be made in writing to the NMMRA Medical Director and must identify for what part of the determination a reconsideration is being requested.

On receiving such a request, the NMMRA Medical Director shall notify all potential parties of the reconsideration and shall conduct reconsideration hearing(s) with a panel of Physician Consultants by appropriate specialty, at a time convenient for all parties within ten (10) working days of receiving the request. The panel shall consist of NMMRA Physician Consultants who have no previous association with the case and who are at least equal in expertise to that of the attending physician.

If the patient is still an inpatient when the reconsideration is requested, the hospital is required to contact the NMMRA for a review determination by telephone request. The NMMRA will make its reconsideration determination and provide verbal notice with follow-up written notice to the parties within one (1) working day after it receives the verbal request for reconsideration.

If the patient is no longer an inpatient when reconsideration is requested, the NMMRA will make its reconsideration determination and provide written notice to the parties within ten (10) working days after it receives the request for reconsideration and all necessary documents for review. In reconsidering the original determination, the NMMRA shall review the evidence and findings upon which such determination was based and any additional evidence submitted to or otherwise obtained by the Committee. A reconsideration hearing is not an adversary process.

The NMMRA Medical Director and panel of Physician Consultants shall use at least the following information for a reconsideration:

1. The records which were submitted to the panel initially when the attending physician or practitioner proposed to provide services.
2. The findings which led to the adverse initial determination.
3. The complete record of the hospital stay of the patient.
4. Any additional documentary information submitted by the party with its request for reconsideration.
5. Any oral presentation which the appealing party or its authorized representative may choose to present to the Committee.

The NMMRA shall make a reconsideration determination affirming, modifying, or reversing the initial adverse determination.

The reconsideration determination shall be final and binding upon all parties to the determination unless a request is made for a hearing to be conducted by the Human Services Department. In order to preserve a record for possible appeal to the Human Services Department, or possible judicial review, the NMMRA shall document and preserve a record of the reconsideration determination for a period of one year following the date of the reconsideration hearing. This record shall include all documentation of the adverse initial determination, the complete record of the hospital stay of the patient, any additional evidence presented by the appealing party, and a copy of the notice of reconsideration determination.

A party requesting a reconsideration may decide to withdraw the request by submitting a written withdrawal statement to the NMMRA Medical Director.

X. QUALITY ASSURANCE REVIEW

All cases reviewed for any reason by Physician Consultants and the Medical Director of NMMRA, will also be reviewed to assure that the patients received services and treatment appropriate to the condition being treated and were not discharged prematurely. A worksheet will be completed and maintained by the NMMRA for each case reviewed for quality of care.

Any case which fails quality screens or physician standards of care will be referred by NMMRA's Medical Director in writing to the Hospital Chief of Staff or Chairperson of Quality Assurance Review for follow through. In the event that an aberrant pattern is identified, the NMMRA will require that the hospital initiate appropriate action to correct the pattern.

NMMRA's Medical Director will monitor the hospital's progress for assuring quality of patient care in the event that such cases are identified as described above.

XI. DISCHARGE PLANNING

Discharges should be coordinated with utilization review efforts and should never be delayed because post-hospital planning has been neglected. Upon request, the County Income Support Division or Social Services Division case-worker handling the case will assist the hospital's social service department in arranging for the most appropriate post-hospital care for the recipient.

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DATE: JUL. 2 1986

TRANSMITTAL NO: 86-5

B. REVIEW OF CARE PROVIDED TO RECIPIENTS
ADMITTED TO LONG TERM CARE FACILITIES

I. INTRODUCTION

As a result of the loss of Federal funding for binding review of Long Term Care under Title XI on September 30, 1981, the responsibility for assuring that UR/UC review is carried out in Long Term Care facilities was shifted to the Human Services Department.

The Department has elected to contract with the NMPSRO to carry out the Long Term Care review function. The NMPSRO will carry out this function according to the New Mexico Plan for Long Term Care Review which is set forth in this document.

The Department has received a superior performance waiver for this review process because it deviates from the requirements of Section 1861 (k) of the Social Security Act, but has been determined to be a superior review procedure by the Health Care Financing Administration as allowed under Section 1903 (i) (4) of the Act.

II. GENERAL INFORMATION

The N.M. Plan for Long Term Care Review will consist of two basic elements.

1. Level of Care/Length of Stay Determinations
2. On-Site PMR/IPR Review

The level of care/length of stay determinations will be carried out using a combination of in-house abstract review and on-site review. All determinations will be made according to the criteria and guidelines set forth in this plan.

The on-site PMR/IPR review will be carried out using a modified method of the Title XIX regulations.

III. LOC/LOS REVIEW

The LOC/LOS review will be carried out by PSRO staff. This staff consists of Review Coordinators, who are RNs, and physician reviewers.

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DATE: 8/24/82
TRANSMITTAL NO: 82-7

Medical information supplied by the LTC facility, the attending physician, and/or information gathered on-site by the review coordinator will be utilized in rendering level of care/length of stay determinations.

A. Criteria

An established set of medical criteria will be used in rendering level of care determinations. The Level of Care Criteria has been adopted for screening review and was developed by New Mexico physicians for use in determining need for services which are usually delivered in either skilled or intermediate care facilities. These criteria have been approved and in use since February, 1979. These are screening criteria which are specifically utilized by the Review Coordinators for all LTC admission, re-admission, and continued stay assessment reviews.

If screens are met and the Review Coordinator is satisfied that the recipient's condition justifies the level of care requested, the admission, re-admission, or continued stay review is determined as medically necessary and a level of care and length of stay is assigned.

If the Review Coordinator has some doubt that the screens are met or that the level of care request is appropriate, i.e., the recipient appears to require a higher or lower level of care than that requested, the Review Coordinator will refer the case to a Physician Reviewer for a determination. The Physician Reviewer is not strictly bound by the Level of Care Criteria because his/her own expertise and medical judgement will be utilized and is encouraged as part of the peer review concept.

An exception to this will be made in the case of continued stay recertification review on a recipient who does not clearly meet the screens, but whose condition has remained the same since the last review. Rather than referring this case to a Physician Reviewer, the Review Coordinator may reassign the level of care determined by the Physician Reviewer at the time of the last review. This exception will only be utilized in those cases where the recipient's condition has clearly remained stable and no new medical need has developed.

LEVELS OF CARE

In order to justify stay at a SN level of care, a resident must require skilled nursing services (listed on the following pages)

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on a daily basis. The need for a single skilled service on an occasional basis would not justify, by itself, a skilled level of care. In determining the level of care, therefore, consideration must be given to:

1. The level of services required.
2. The frequency with which they are required.

Criteria are predetermined indicators against which aspects of actual care can be compared to judge their necessity for services. The following criteria lists types of care and services that are often appropriate in a skilled or non-skilled LTC facility. The criteria indicate the level of care recommended for residents who require any of the listed services routinely. If a service justifies the skilled level in certain circumstances and the non-skilled services are such that they can only be accomplished in a SNF, through skilled management or observation, assignment of a skilled level of care is appropriate. (See Criterion 9.)

SKILLED LEVEL OF CARE

An individual requires a skilled level of services if she/he needs: (1) on a daily basis, (2) skilled nursing care or other skilled rehabilitation services, and (3) such services can be provided only in a skilled nursing facility on an inpatient basis. The patient's medical record must clearly show that all three factors are met and continue to be met.

- A. Daily Skilled Services -- Skilled nursing services or skilled rehabilitation services must be required and provided on a "daily basis" -- i.e., on essentially a 7-day-a-week basis. A break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical would not violate the requirement.
- B. Skilled Services Defined -- A skilled service is one which must be furnished by or under the general supervision of skilled personnel to assure the safety of the patient and achieve the medically desired result.
- C. Skilled Nursing Services Defined -- A skilled nursing service is one which must be furnished by or under the general supervision of licensed nursing personnel and under the general direction of a physician to assure the safety of the patient and achieve the medically desired result.
- D. Need Satisfied Only by SNF Inpatient Care -- In determining whether the care needed can only be provided in a skilled nursing facility on an inpatient basis, consideration must be given to the patient's condition and to the availability

and feasibility of using more economical alternative facilities and services.

E. Specific Services which are Skilled Nursing -- Skilled nursing services include but are not limited to the following:

1. Intravenous or intramuscular injections and intravenous feeding. (Injections which can usually be self-administered -- e.g., the well-regulated diabetic who receives a daily insulin injection -- does not require skilled services.)
2. Levine tube and gastrostomy feedings.
3. Naso-Pharyngeal and tracheotomy aspiration.
4. Insertion or replacement of catheters and sterile irrigations of catheters.

INTERMEDIATE LEVEL OF CARE

Services Which Are Not Skilled Nursing (statements contained herein are not intended to negate the Nurse Practice Act but rather are used only in the context of differentiating between Skilled and Intermediate level of care.)

A. Importance of Service to the Patient -- The importance of a particular service to an individual patient does not necessarily make it a skilled service, e.g., a primary need for a nonambulatory patient may be frequent changes of position to avoid development of decubitus ulcers. Since changing of position can ordinarily be accomplished by unlicensed personnel, it would not be a skilled service.

B. Specific Services Which Are Supportive or Unskilled -- Supportive services include but are not limited to the following:

1. Administration of routine oral medications, eye drops, and ointments.
2. General maintenance care of colostomy or ileostomy.
3. Routine services in connection with indwelling bladder catheters. (This would include emptying containers and cleaning them, clamping tubing, and refilling irrigation containers with solution.)
4. Changes of dressings for noninfected postoperative or chronic conditions.
5. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of

minor skin problems.

6. General methods of treating incontinence, including use of diapers and rubber sheets.
7. General maintenance care in connection with a plaster cast.
8. Routine care in connection with braces and similar devices.
9. Use of heat for palliative and comfort purposes.
10. Administration of medical gases after initial phases of teaching the patient to institute therapy.
11. General supervision of exercises which have been taught to the patient.
12. Assistance in dressing, eating, and going to the toilet.

<u>ASSESSMENT FACTORS</u>	<u>SNF LEVEL</u>	<u>ICF LEVEL</u>	<u>CUSTODIAL/RESIDENTIAL</u>
1. TREATMENT FACTORS			
A. Medication	<p>Where, because of patient's condition or type of medication, immediate changes of dosage may be required due to sudden, undesirable effects, in accordance with a physician's orders.</p> <p>Administration of intravenous solutions. Administration of insulin, daily or oftener on a sliding scale, based on urine tests, according to physician's orders if patient is unable to self administer for uncontrolled diabetes.</p> <p>Administration of injectables more frequently than once in an 8 hour period (does not apply to prn orders).</p>	<p>Routine administration of prescribed medications.</p> <p>Medications requiring monitoring of vital signs, symptoms or adverse effects.</p> <p>Administration of insulin, daily or oftener on a sliding scale, based on urine tests, according to physician's orders if patient is unable to self administer for controlled diabetes. (IVs may be given in ICF under physician's orders by licensed nurses administering and monitoring.)</p>	<p>Verbal reminder to take prescribed medications.</p>
B. Oxygen	<p>Patient requires trained observation, close supervision, & monitoring by RN or LPN, for frequent administration of oxygen based on patient's condition. May be necessary to give oxygen by nasal cannula or catheter.</p>	<p>Patient requires supervision of frequently administered oxygen.</p>	<p>Self administered.</p>
C. Respiratory Therapy	<p>Patient's condition is such that rehabilitative respiratory therapy must be administered by professional staff.</p>	<p>Patient's condition is such that assistance is required from staff.</p>	<p>Self administered respiratory therapy.</p>
D. Ostomy Care	<p>Active teaching of new ostomy care &/or care of ostomy complications.</p>	<p>Resident requires assistance with ostomy care.</p>	<p>Self administered ostomy care.</p>
E. Skin Care	<p>According to physician's orders, patient requires treatment of existing decubitus lesions larger than one inch in diameter or smaller multiple decubiti; infected, necrotic, purulent &/or draining.</p>	<p>Based on needs & according to physician's orders requires ongoing skin care for the prevention of recurring decubiti.</p>	<p>Based on needs resident requires occasional assistance with routine care of skin including cleanliness.</p>

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F. Dressings	Dressings for deep lesions or wounds which, due to location, copious drainage, etc., require complex & sterile technique changes more frequently than once a day.	Dressings for areas requiring cleaning, irrigation, medication & sterile technique.	Application of band aides, elastic stockings or Ace bandage, when prescribed.
G. Restorative Care	Includes related teaching & adaptive aspects of skilled nursing, part of active treatment & requires presence of RN or LPN at performance.	Requires some assistance with range of motion exercise (active & passive) &/or proper positioning of patients.	Independent range of motion & exercises to maintain level of restoration.
H. Specialized Rehabilitative Procedures by Qualified Therapists	Initial or immediate post-hospitalization speech therapy &/or audiology, physical therapy, occupational therapy, etc. This criterion, per se, does not qualify for skilled nursing level.	Not applicable.	Not applicable.
I. Other special services required such as sterile set-ups for spinal puncture, paracentesis, thoracentesis, suture removal, tracheostomy care, electric suction (for mucus removal) for continuing care which can be provided only under direction of a licensed nurse.	The scope of these specialized services (comprehensive care) may require maximum nursing time of ancillary nursing personnel as well as direct observation, supervision & care by professional nurses. Detailed documentation must reflect the scope & response of the patient to the care. Patient's condition may be: <ul style="list-style-type: none"> a. An acute episode of an already existing illness. b. Nature of the illness may require the most comprehensive care for unlimited time to meet all of the needs of the totally dependent patient. c. Cerebral or spinal cord pathology where the patient is totally dependent. Comprehensive nursing care may be necessary to sustain life. 	Not applicable.	Not applicable.

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2. FEEDING	<p>a. Chokes easily &/or aspirates.</p> <p>b. Needs levine &/or gastrostomy tube feeding on a sustained basis.</p> <p>c. Tendency towards regurgitation &/or potential danger.</p>	<p>Hand feeding may be required due to physical or mental condition, however, not merely because of blindness, slowness or awkwardness.</p> <p>Patient should evidence (a) Weakness &/or fatigue (b) Major paralysis; major deformity of hands, (c) prolonged psychological reasons, (d) minor difficulty in swallowing.</p> <p>Patient may need self help device</p>	<p>Resident may need supervision to eat & some assistance in eating (some foods may need to be cut, bread buttered, milk carton opened, etc.).</p> <p>Assistance & encouragement eat may be necessary due to (a) Tremors; minor residual paralysis; some deformity of hands, (b) to eat.</p>
3. MOBILITY & TRANSFER	<p>Patient unable to ambulate or transfer without trained assistance.</p>	<p>Patient requires assistance from attendant to get from bed to chair, wheelchair, bathroom or dining room.</p>	<p>Fully ambulatory or semi-ambulatory (necessary assistance & guidance provided).</p>
4. NUTRITION (Regular and Therapeutic)	<p>Nutritional value requirements of diet may need to be calculated & adequate replacement made for food refused from planned meal patterns.</p> <p>This criterion does not, per se, warrant skilled nursing level.</p>	<p>Nutritional value requirements of diet may need to be calculated & adequate replacement made for food refused from planned meal patterns.</p> <p>This criterion does not, per se, warrant ICF nursing level.</p>	<p>May be unable to manage own food & requirements.</p> <p>May need texture modification of regular diet (example: meat ground or vegetables mashed).</p> <p>May need therapeutic diet for control of existing organic condition.</p>
5. FLUID INTAKE & OUTPUT	<p>Adjustment of medication may be required, due to fluid retention, according to physician's orders.</p>	<p>Measuring of urinary intake & output may be ordered by physician.</p> <p>Documentation of assessment to reflect signs of fluid retention such as pedal edema, etc., with notification to physician.</p>	<p>Resident may need encouragement or assistance to drink adequate water.</p>

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6. BOWEL AND BLADDER FUNCTION	<p>May require procedures due to complications which require professional involvement.</p> <p>Chronic incontinence with skin breakdown which requires frequent perineal care.</p>	<p>May require assistance with elimination of a regular & recurrent basis.</p> <p>Chronic incontinence; needs to be taken to bathroom routinely or needs use of bed pan, urinal, or commode.</p> <p>Some perineal care required.</p>	<p>Includes toilet routine to encourage continence. Needs reminding to prevent occasional incontinence.</p>
7. BLADDER & BOWEL RETAINING	<p>Specific bladder & bowel retraining may be required. Assessment & initiation of bladder &/or bowel retraining plan.</p>	<p>Facility is evaluating resident's potential for retraining program OR resident is in a specific program.</p>	<p>Not applicable.</p>
<p>A. Bowel &/or bladder continence based on:</p> <p>(1) Neurogenic Bladder</p> <p>(2) Bladder Tumor (new growth) or other organic conditions</p> <p>(3) Hypertrophied Prostate.</p> <p>(4) Post-Surgical</p>			
B. Cathether Care	<p>Cathether care with complications (bleeding, urinary tract infections, medicated irrigations, etc.).</p>	<p>Due to physical condition patient requires assistance with regular catheter care.</p>	<p>Routine cathether self care.</p>
8. BEHAVIOR & MENTAL STATUS	<p>Behavior may be labile requiring 24 hour a day availability of professional judgment. A physical condition may be present in a totally dependent individual who would be unable to communicate recurring problems & needs requiring professional evaluation. May require frequent IM or IV medications for additional control.</p> <p>Comatose & requiring nasogastric tube feedings or intravenous therapy for nutrition.</p>	<p>Automatic Physician Reviewer Referral.</p> <p>Not Applicable.</p>	<p>Presence of behavior problems which can be managed by using common sense, respect & guidance.</p> <p>Not Applicable.</p>

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9. Conditions involving multiple complications requiring <u>skilled</u> management of an aggregate of services.	Patient's condition requires daily, regular trained observation, close supervision, treatment plan management and monitoring by RN or LPN for multiple complications, the relationship and effect of which necessitate ensuring the patient's recovery and/or medical safety.	Not applicable.	Not applicable.
	Non-physician reviewer must apply this criterion only to those cases in which there is a high <u>probability</u> , as opposed to a <u>possibility</u> , that complications		
10. Mental Retardation (Limited to ICF (MR) Facilities only)	Except in unusual medical necessity cases, mental retardation would not qualify a patient for this level. Patient would normally meet other criteria.		
11. No medical criteria are met. However, Patient is in a Discharge Status as defined by NMPSRO. Review Coordinator <u>may</u> certify.	Not applicable.	NMPSRO requires documented charting of placement progress, availability of appropriate placement, etc., in order to recertify on this basis.	Not applicable.
12. Physician Reviewer approves.	Rationale must be given and documented on review worksheet.	Rationale must be given and documented on review worksheet.	Not applicable.
13. Physician Reviewer denies.	Rationale must be given and documented on review worksheet.	Rationale must be given and documented on review worksheet.	Not applicable.
14. Patient is administratively denied because level of care request is not a Medicare/Medicaid program benefit. Review Coordinator <u>may</u> deny request for review.			

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B. Admission Review

Before authorization for payment, a review of each applicant's or recipient's need for admission must be accomplished. This will be done through submission of a long term care abstract to the NMPSRO for review.

1. SNF Admission

The attending physician must make a medical evaluation of the recipient's need for SNF care, and certify such need on the abstract. This evaluation must include diagnosis, summary of present medical findings, mental and physical functional capacity, and prognosis. After the evaluation is made the attending physician must establish a written plan of care that includes:

- Diagnosis, symptoms and complaints
- Description of functional level
- Objectives
- Any orders for medications, treatments restorative or rehab services, diet, and special procedures
- Plans for continuing care
- Plans for discharge

The above required information will be condensed onto the abstract and forwarded to the NMPSRO for review. The NMPSRO will make a level of care determination and assign an initial continued stay review date will. The initial continued stay review date will in most instances be 30 days. The Review Coordinator may assign a length of stay shorter than 30 days based on the recipients needs and stability of conditions. Under no circumstances, will the initial period exceed 30 days.

2. ICF Admission

The attending physician must make an evaluation of the recipient's need for ICF care and certify such need on the abstract. This evaluation must include diagnosis, summary of present medical and social findings, mental and physical functioning, prognoses, and kind of services needed. After the evaluation is made the attending physician must establish a written plan of care that includes:

- diagnosis, symptoms, complaints
- functional level description
- objectives
- any orders for medications, treatments, restorative and rehab services, activities, therapies, social services, diet, special

procedures, plans for continuing care, and plans for discharge.

The above required information will be condensed onto the abstract and forwarded to the NMPSRO for review. The NMPSRO will make a level of care determination and assign an initial continued stay review date. The initial continued stay review date will in most instances be 90 days. The Review Coordinator may assign a length of stay shorter than 90 days based on the recipient's needs and stability of condition. Under no circumstances will the initial period exceed 90 days.

3. ICF/MR Admission

The same as set forth above for ICF admissions will apply with the following addition. An interdisciplinary team of health professionals must make a comprehensive medical, social, and psychological evaluation of the recipient's need for admission to the ICF/MR. This evaluation will include diagnoses, summary of present medical, social and developmental findings, medical and social family history, mental and physical functional capacity, prognoses, kinds of services needed, evaluation of resources available in the home, family and community, and a recommendation concerning the need for admission to the ICF/MR.

C. Continued Stay Review

Continued stay review will be accomplished through the submission of an abstract to the NMPSRO for review and/or through on-site review.

Using the level of care criteria described in this plan, the reviewer will review the abstract and make a determination as to the continued need for level of care and assign a recertification date for review.

1. SNF

In most instances the reviewer will assign a continued stay review date of 90 days. The reviewer has the option of assigning a period of less than 90 days, based on the recipient's medical needs and stability of condition. Under no circumstances will the continued stay review date exceed 90 days.

2. ICF

In most instances the reviewer will assign a continued

stay review date of 6 months. The reviewer has the option of assigning a period less than 6 months, based on the recipient's medical needs and stability of condition. Under no circumstances will the continued stay review date exceed 6 months.

3. ICF/MR

Same as above for ICF.

4. Change in Level of Care

When it has become apparent that a recipient's condition and needs have changed sufficiently to warrant a different level of care, it is the responsibility of the physician and the facility to submit an abstract reflecting these changes so that a new level of care determination can be made.

D. Abstract & Forms

Attached is a copy of the abstract and other forms to be used in carrying out long term care review. Instructions for completion of the abstract can be found in the accompanying manual.

E. Appeals

Should the NMPSRO, through carrying out this plan, render an adverse decision regarding admission, level of care, or length of stay, the following appeal procedure is available.

Any resident, admitting/attending physician or provider of services who is dissatisfied with an adverse review determination of the NMPSRO may request a reconsideration of such determination by the NMPSRO LTC Subcommittee. After the procedures for the reconsideration (contained in the manual) are carried out, should the appealing party still be dissatisfied with the NMPSRO reconsideration determination, the appealing party may then avail themselves of the State Fair Hearing Process.

IV. On-Site PMR/IPR Review

To accomplish the on-site PMR/IPR Review process, the Department contracts with the New Mexico Professional Standards Review Organization. Using Registered Nurses as on-site evaluators with NMPSRO physician participation when appropriate, NMPSRO staff reviews each facility on an annual basis observing 100% of the Title XIX population in the facility as described below. The method employed allows a concentration of effort on those recipients receiving and those facilities delivering what might be presumed to be a quality of care not in accordance with accepted medical standards.

A. Introduction

The on-site review will consist of two stages. Stage I will consist of a rapid review of 100% of the Medicaid population in a facility. This rapid review will be directed towards filtering out those recipient's where a possibility of a lesser degree of quality of care exists.

Stage II will consist of a comprehensive review on the quality of care being rendered to those recipients that have been focused on during Stage I. Theoretically, this will enable the on-site review team to direct their time and efforts towards those facilities where problems or potential problems exist, with the outcome being an improvement in quality of care rendered to all recipients.

B. Stage I

Stage I of the PMR/IPR is a very rapid review of all Medicaid recipients in the facility to determine the absence or presence of a Signal For Review (SFR). This review will be accomplished in two steps.

Before going on-site to a facility, the on-site reviewer will gather information from the abstracts that have been submitted on each resident. This will enable the reviewer to establish the core group sample which will be used for Stage II review. Once in the facility, the reviewer will further screen incident reports and use direct observation of the recipients to further add to or delete from the sample for Stage II review.

Using a combination of the abstracts, on-site review and observation to determine the sample will allow us to assess the accuracy of information being provided on the abstract for level of care and length of stay determinations. Should discrepancies in the accuracy of the abstract exist, corrective action will be taken with the facility.

1. Signal for Review (SFR)

An SFR is simply an event or outcome that leads the reviewer to ask "why did this occur?" The presence of an SFR does not necessarily mean that inadequate care is being rendered by the facility, rather it may be caused by circumstances beyond the facility's control. It is a means by which the reviewer can concentrate on those recipients where potential problems may exist.

a. SNF/ICF SFR Definitions

Accidents/Incidents

In the past 6 months: occurrence of a) two or more accidents or b) one accident/incident which led to serious injury.

Behavioral Problems

In the past three months: occurrence of behaviors which are uncontrolled, disruptive, and/or dangerous to self and others.

Decubitus Ulcer/Lesions

On the day of the review visit: one or more decubitus ulcers as evidenced by an area of soft tissue breakdown resulting from sustained pressure or other causes.

Contracture (To be used for SNF's only)

On the day of the review visit, one or more contractures. EXCEPTION: treatment is contraindicated.

Lack of Ambulation

In the past three months: decrease in the level of ambulation. EXCEPTION: a permanent or temporarily identified physical impediment which makes ambulation impossible.

Indwelling Urethral Catheter

On the day of the review visit. (ICF's only) Insertion of a catheter in the last three months (SNF only).

Poor Grooming

On the day of the review visit: evidence of poor personal care, failure of the facility to promote or assist in personal care, inappropriate or unclean clothing, unclean immediate environment (bed, chair, room)

Discharge/Transfer

In the past three months: discharge to a higher or lower level of care.

Poor Nutrition

In the past three months: occurrence of unplanned or fluctuating weight changes, emaciation, dehydration, edema, constipation and other nutritional problems.

Contagious Infections

In the past three months: presence of a contagious infection.

Incontinence

In the past three months: indication that recipient should be receiving bowel and bladder retraining. EXCEPTION: Physical or mental impairment that prohibits successful retraining.

Therapies

In the past three months: recipient has received physical, occupational or speech therapy.

b. ICF/MR SFR Definitions

Accident/Incidents

In the past three months: occurrence of a) two or more accidents/incidents; or b) one accident/incident which led to serious injury.

Behavioral Problems

In the past three months: occurrence of behaviors which are uncontrolled, disruptive, and/or dangerous to self, others, or the facility environment.

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Decubitus Ulcer/Lesions

On the day of the review visit: one or more decubitus ulcers as evidenced by an area of soft tissue breakdown resulting from sustained pressure or other causes.

Poor Eating Habits

On the day of the review visit: failure of the facility to promote or assist in teaching of self feeding, failure to provide adaptive eating equipment.

Poor Grooming

On the day of the review visit: evidence of poor personal care, failure of the facility to promote or assist in personal care; inappropriate, unclean or poorly maintained clothing.

Contagious Infections

In the past three months: presence of a contagious infection.

Annual Physical

Lack of an annual physical examination.

Interdisciplinary Program Plan (IPP)

Lack of an updated IPP.

2. Focusing methodology

All recipients who have an indication of one or more SFR's will go into the focused populace for which comprehensive review of quality of care will be performed.

C. Stage II

Stage II of the process is directed toward assessment of the resident's status, the clinical record of his/her treatment, services, and progress, and the facility's overall ability to delivery quality care. This is carried out during each facility assessment visit to insure that Title XIX LTC residents throughout New Mexico are receiving proper medical, nursing, personal, social and rehabilitative services at a level of care appropriate to their needs which met local standards for care.

These review program objectives will be met by on-site quality of care assessment by professionals with knowledge and expertise in the various fields of nursing but particularly in medical and geriatric areas. The NMPSRO on-site evaluators shall be Registered Nurses with NMPSRO physician participation, when appropriate.

A. Review of Title XIX Residents' Record to evaluate the following standards:

1. Physician Participation - Frequency of visits by attending physician, physical examinations, medical treatment, medical plans of care, medications ordered, response to request for medical attention, etc.
2. Nurses Participation - Nursing observations, notes, documentation of unusual events and illnesses, treatment, plans of care, response to medications, etc.
3. Treatments and Medications - Facility handling, distribution, and ordering of medication, etc.
4. Laboratory Work - Insure that studies ordered by the physician are carried out as ordered and that abnormal values are reported immediately to the attending physician and appropriately noted by the nurses.
5. Diets - Insure that there is a dietetic care plan written by a dietician and that the resident's reactions to therapeutic diets are recorded and that special diets are ordered when necessary and carried out properly by facility dietary personnel.
6. Health Care Plans - Insure that the plans are goal oriented, that the individual resident's problems and solutions to those problems are stated in multidisciplinary terms, and that the plans are revised as needed, including the discharge plan.

B. Conduct a personal interview and clinical nursing examination of the Title XIX resident population sample on each visit to determine the following:

1. That no life threatening/endangering situation exists.

2. Adequacy of nursing care through observed prevention of skin breakdown; care of decubiti, signs of malnutrition or dehydration, personal hygiene, use and positioning of restraints, etc.
 3. The type and quality of restorative care being administered.
 4. The mental and psycho-social functioning of each resident.
 5. The resident's response to the facility's program.
 6. The competency of health care personnel who are carrying out the prescribed plans of care.
 7. The abilities and disabilities of the resident.
- C. Assess the level of care needed by each resident as indicated by his/her physical and mental condition, as to the following levels:
1. Actue Care Level
 2. Skilled Care Level
 3. Intermediate Care Level
 4. Non-medical Setting (Residential Care/Boarding Home/Home)
- D. Review and evaluate the environment of the facility to insure that it does not adversely affect the facility's capability to render quality care. The following areas will be assessed:
1. General cleanliness and sanitation
 2. Utilization of dining area during meals
 3. Staffing ratio
 4. Physical Therapy Department/Services
 5. Bathrooms
 6. Living area for adequacy of space
 7. Activities area
 8. Laundry Area
 9. Medication and Treatment Rooms
- E. Reports

After Stage II of the process is completed all the findings shall be compiled preliminarily and reported verbally to the administration and staff of the facility in an exit interview. This is an ideal time for

both parties to clarify issues and to consider on-site findings, agree upon what areas should be targeted for improvement in services delivery, and how to best implement any needed changes, and a future date set for successfully implementing any changes.

The NMPSRO on-site evaluation process is an assessment "tool" and the evaluator(s) may provide advice and recommendations, including referral of non-XIX matters to appropriate agencies. Problems, actual or potential, and approaches to problem management will be discussed during the exit interview concerning any areas relating to the quality of care and welfare of the residents.

After returning to the NMPSRO office, the on-site evaluator(s) shall compile the information obtained from individual resident assessments during the on-site assessment and complete a facility report. A copy of this report shall be distributed to the State Licensing and Certification Agency, the Title XIX State Agency, and the LTC facility Administrator.

The Title XIX State Agency will review the reports and request a plan of correction with reasonable time frames to implement such correction.

V. Coordination with Licensing and Certification

Copies of all on-site review reports will be forwarded to Licensing and Certification. When possible on-site review will be scheduled to fall approximately 4 to 6 weeks prior to the annual Certification Survey. This will enable the Certification Survey team to focus in on those areas where known problems and possible non-compliance to Standards of Participation exist.

Should the on-site review indicate that substantial non-compliance to Federal Standards exists, an Exception Report will be prepared. The State Agency will act upon the exception report by requesting that Licensing and Certification perform an immediate re-survey of the facility.

VI. Monitoring of PSRO Performance

The State Agency will carry out formal monitoring of the PSRO performance under the contractual arrangement. A copy of the monitoring plan is attached.

C. REVIEW OF CARE PROVIDED TO RECIPIENTS
ON AN AMBULATORY BASIS

1. Retrospective Review

Operate a retrospective professional review system based on focused review of Medicaid ambulatory services. This ambulatory care review system will involve retrospective analysis of providers' practice patterns. Claims as determined necessary by MAB will be subjected to prepayment screening and review. Claims subjected to this method of review will represent a fraction of claims submitted thus allowing the majority of claims to flow rapidly through the claims processing system. In implementing the overall review approach, NMPSRO will have access to the Medicaid data base in order to obtain reports which contain information concerning medical procedures, providers and patients.

2. Prepayment Review

Place upon prepayment review the claims of any provider whose practice pattern, in the opinion of the MAB, shows an identified overutilization of Medicaid ambulatory services. Such review will be conducted by review physicians and will result, to the extent appropriate, in the denial or adjustment of claims payment. In the event that serious and/or chronic practice problems are identified (such as overutilization or underutilization of services, inappropriate medications, etc.), the Ambulatory Review Committee may contact the provider and undertake the proper educational activities. Any provider placed on prepayment review will be monitored by the MAB. Such action will cease when it is determined that his/her practice pattern falls within established quality and utilization parameters or for a specific time frame designated by the MAB. PSRO also performs prepayment review on claims failing Medicaid payment edits, such as those for emergency room services.

3. Prior Approvals

Administer system of prior approval by means of ongoing review for certain ambulatory services and supplies in the following areas:

- | | |
|----------------------------------|--|
| a. Vision | g. Orthotic |
| b. Psychiatric and Psychological | h. Medical Equipment and Supplies |
| c. Home Health Agency | i. Dental |
| d. Elective Outpatient | j. Selected Inpatient surgeries which |
| e. Rehabilitative | can be provided on an outpatient basis |
| f. Prosthetic | in most circumstances |
| | k. Podiatric |

Determine the medical necessity for, and the appropriateness of, certain ambulatory services and supplies in the areas specified in a through k above, in accordance with the Department's medical assistance regulations.

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Utilizing a professional standards review system, review retrospectively all claims for certain ambulatory services and supplies in the areas specified in a through i above; such review to be limited to those claims for which prior approval ordinarily is required but, due to circumstances beyond the control of the provider, was not obtained and the requirement for prior approval has been waived by MAB.

In addition to these services, the NMPSRO provides the Department with professional assistance in evaluating medical necessity of new and/or established therapeutic procedures, within the constraints of the regulations in the State's medical assistance manual.

PART II - UTILIZATION REVIEW ACTIVITIES OF THE STATE AGENCY

A. S/UR SUBSYSTEM

1. Objectives

Primary objectives in implementing the S/UR Subsystem are as follows:

- a. Develop a comprehensive statistical profile of health care delivery and utilization patterns of provider and recipient participants in the services covered by New Mexico's medicaid program.

Identify and investigate potential misutilization, and promote correction of actual misutilization of the Medicaid Program on the part of either provider or recipient.

Provide information to assist in detection and investigation of potential problems in the quality and quantity of medical services provided under the medicaid program.

2. Methods for developing essential information

- a. The State uses the S/UR subsystem of the federal MMIS.
- b. The State also uses certain MARS ranking reports to select providers for review. As of October 1978 the State has available and is using all elements of the SURS subsystem.

3. Procedures for using S/UR information

Qualified staff of the Medical Assistance Bureau.

- a. Select appropriate S/UR reports as specified in 2, above.
- b. Develop statistical profiles of health care delivery and utilization patterns, identify potential misutilization, identify defects in quality and quantity of services provided under the New Mexico Title XIX Program.

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- c. Carry out recommendations based on findings from S/UR reports and related factors; such recommendations to be consonant with New Mexico statutes, New Mexico Medicaid policies and procedures, federal statutes, federal Medicaid rules, regulations, and guidelines, and sound medical practice.
- d. Coordinate with Legal Services Bureau of DHS on all matters involving legal aspects, including rights of recipients. Coordinate fully with A.G.'s office on all matters involving legal aspects including rights of providers.
- e. Coordinate with local Income Support and Social Service staff as indicated in work with recipients and providers.
- f. Coordinate with appropriate professional organizations as indicated in work with providers.
- g. Support the NMPSRO and the fiscal agent in their efforts to use educational and counseling approaches as the method of choice in dealing with most problems.
- h. Arrange for further corrective action if necessary, such as but not limited to:
 - (1) Recipient may be brought under the Medical Management Program. (See Section C, below for discussion of the Medical Management Program),
 - (2) Provider may be asked to refund payment received for inappropriate services,
 - (3) Provider may be suspended from Medicaid participation,
 - (4) Provider may be referred to his professional association,
 - (5) Provider may be referred to his state licensing board,
 - (6) Provider may be referred to law enforcement authorities for prosecution for fraud.

B. Drug Utilization Review

Medical Assistance Bureau professional staff from the Operations and S/URS Sections perform utilization review of the Title XIX Drug Program. They review drug program policies and make recommendations to the Bureau on methods to ensure a quality drug

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program. They act as consultants on issues presented by the drug program administrator which may affect future priorities in the program. They also review candidates for the medical management program, based on the recipients drug use history.

C. MEDICAL MANAGEMENT PROGRAM

1. Objectives

The Medical Management program is designed to monitor recipients with a history of over-utilization of services provided by the Medicaid program. Objectives of the Medical Management program are:

- a. To identify over-utilization of services by recipients of medical benefits.
- b. To assure quality and appropriate care for recipients of medical benefits.
- c. To assist in identifying provider problems related to recipient over-utilization.

2. Organization and Procedures for Medical Management

The Surveillance and Utilization Review (SUR) Unit of the Medical Assistance Division has primary responsibility for placing recipients on the medical management program. Prospective candidates for medical management are identified through several sources:

- a. Recipients identified by the claims processing agent through appropriate audits and edits in their claims processing system.
- b. Recipients identified through sources outside the Medical Assistance Division, i.e., Income Support Division Specialists, private citizen, providers, etc.
- c. Recipients identified in the SUR reports, particularly those who have received numerous services, those who have been to several different providers and those for whom Medicaid has paid a large dollar amount.

3. Selection for Medical Management

The SUR staff analyze statistical reports and the claim histories of each candidate for Medical Management. If additional information is needed, other sources, including medical records or information maintained by the claims processing contractor, are analyzed.

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SUPERSEDES: TN - 82-18			

- a. If the analysis indicates that the individual's aggregate use of service was not medically necessary, the SUR staff develop a recommendation that the individual be assigned to Medical Management.
- b. The recommendation includes a description of the utilization problem, information analyzed in making the recommendation, type of restriction(s), designed provider(s), utilization objectives, effective date of the assignment, and date for reevaluation.
- c. After reviewing the SUR staff recommendation and supporting documentation, the Medical Director of the Medical Assistance Division determines whether the individual should be assigned to Medical Management.
- d. If the individual is to be assigned to Medical Management, the SUR staff notifies the recipient and the claims processing contractor of the assignment. The individual placed on Medical Management receives an identification card which indicates "Medical Management" and the name of the designated provider(s).

Part III - State Agency Monitoring of NMPSRO

It is the responsibility of Professional Standards Review Organizations to determine that services rendered are medically necessary and that the quality of the services meets acceptable professional standards of care. It is desirable, therefore, for states to be able to monitor the performance of PSROs so that they can determine that PSRO review is effective in utilization of services and that State dollars are being appropriately spent for necessary and quality care.

In response to the above the Medical Assistance Bureau has established a plan to monitor the performance of NMPSRO. The monitoring plan focuses on results of the NMPSRO review and avoids overseeing procedures used by the NMPSRO to do its review. In this way the monitoring process is entirely objective.

A. Objectives

1. To determine that the NMPSRO review is being carried out in a timely and accurate manner.
2. To determine that the NMPSRO review follows program policies and guidelines established by the Medical Assistance Bureau.
3. To determine the impact of the NMPSRO review on utilization of services and expenditures.

4. To identify areas of concern which should be addressed by the NMPSRO, the State Agency and the DHHS.
5. To ensure that State and Federal funds for institutional health care and ambulatory health care are being spent appropriately for medically necessary services and quality care.

These objectives are accomplished through several approaches which are discussed below.

B. AMBULATORY CARE MONITORING PLAN

I. Introduction

The Human Services Department contracts with the New Mexico Professional Standards Review Organization for specified services. The Ambulatory Care Monitoring Plan defines the monitoring procedures for the responsibilities identified in the scope of work contained in the contract. The Medical Assistance Bureau of the Human Services Department is responsible for monitoring:

1. Prior Approval Review - the performing of prior approval review for the medical necessity of ambulatory services as specified in the contract.
2. Pre-payment Claims Review - the review of claims of providers on review, emergency room claims and universal claims review for selected procedures.

II. Objectives of PSRO Monitoring

The objectives of the PSRO Ambulatory Monitoring Plan are to insure that the performance standards as specified in the contract are met. Specifically, the objective are as follows:

1. Monitor the timeliness of pre-payment claims review.
2. Monitor the timeliness and accuracy of quarterly statistical reports.
3. Monitor the timeliness of processing prior approval requests.
4. Monitor the review process for adherence to Medical Assistance Bureau program policies, guidelines, and criteria and the PSRO Ambulatory Care Review Manual, for the appropriate level of review, consistency of review and for appropriateness of review determination.

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III. Monitoring Methodology

The methodology to be employed in this plan consists of both on-site observation and the review of documents related to the monitoring objectives. In order to accomplish the monitoring, NMPSRO will provide the Medical Assistance Bureau with the following:

1. Advance notice of all scheduled review sessions with notice of all changes in such a schedule.
2. Advance notice of all meetings scheduled for provider groups, peer reviewers, ad hoc committee meetings and Ambulatory Review Committee meetings.
3. Access to files on Medicaid recipients, provider correspondence, professional peer review sessions, claims and prior approval requests scheduled for review, and claims and prior approval requests as handled by the review coordinator or review assistants.
4. Access to internal activity reports.
5. Access to the review sessions.

The following is the specific methodology to be used for each defined monitoring objective:

Objective 1 - Monitor the timeliness of prepayment claims review.

The timeliness of prepayment claims review will be monitored using the weekly aged claim lists produced by the fiscal agent, the process date of claims and worksheets being reviewed at review sessions, the process date of claims and worksheets being returned to the fiscal agent. The attendance at selected review sessions and other on-site visits will be used to collect this data.

Objective 2 - Monitor the timeliness and accuracy of quarterly statistical reports.

Reports will be reviewed for accuracy and appropriateness of methodology. Internal reports resulting in the preparation of quarterly reports as well as a

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sampling of documents will be used. NMPSRO may be required to furnish documentation regarding the content of any report or statistics produced. The timeliness will be considered using the date received by the Medical Assistance Bureau. The monitoring of this data shall be at the discretion of the Medical Assistance Bureau.

Objective 3 - Monitor the timeliness of the processing of prior approval requests.

The timeliness of processing prior approval requests will be monitored at the review sessions and other on-site visits. The date of receipt of the requests shall be considered with the date that the authorization is mailed to the provider. Attendance at selected review session and other on-site visits will be used to collect this data.

Objective 4 - Monitor the review process as described in the monitoring objectives.

Adherence to Medical Assistance Bureau Program policies, guidelines and criteria will be monitored by the attendance at selected review sessions, other on-site visits, and from a random selection of claims post payment supplied by the fiscal agent. The following shall be considered in monitoring the review process:

1. Claims and prior approval requests are given the level of review appropriate. Approvals, denials, and provider communications within the scope of responsibilities of the review assistants or review coordinator are to be handled at that level. Referrals to professional peer review, the Medical Assistance Bureau, and other review sources are to be appropriate.
2. Claims and prior approval requests are to be reviewed and processed according to the program benefits and limitations.
3. The consistency of review is recognized as being a product of consistent interpretation of program policy, Ambulatory Review criteria, proper instruction to the professional reviewers by PSRO,

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and proper functioning of the review assistant and review coordinator. These elements shall all be considered in monitoring for consistency of review.

4. The appropriateness of review determinations shall be monitored by considering the specific review decision in terms of common professional practice.

IV. On-site Reviews

The Medical Assistance Bureau will conduct on-site reviews, and attend review sessions and other necessary meetings with the recognition that the normal work flow of NMPSRO cannot be interrupted beyond what is necessary for the Medical Assistance Bureau to properly monitor performance. Recognizing also that the Medical Assistance Bureau is able to offer information regarding program policy and requirements, the following procedures will be followed at on-site visits:

1. Medical Assistance Bureau personnel may examine the material scheduled for review, attend the review session, or examine the material after the reviews are completed all at the discretion of the Medical Assistance Bureau.
2. Medical Assistance Bureau personnel in general will not discuss the review or program with the physician reviewers unless the reviewer specifically directs questions regarding program policy relevant to the review session to him or her. Medical Assistance Bureau personnel may clarify a service as not a program benefit if the review assistance fails to do so and the physician reviewer is approving a service which is not within the scope of the program.
3. Written notes will be taken at the review session regarding the review session regarding the appropriateness of the approvals, the level of review required, the adherence to Medical Assistance Bureau program policy and criteria, and the aged status of the material being reviewed.

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V. Reports to NMPSRO

The Medical Assistance Bureau will furnish to NMPSRO draft reports on their performance. NMPSRO will have 10 working days during which comments may be made to the Medical Assistance Bureau prior to finalizing the report. NMPSRO will receive a copy of the final report.

The State Agency will maintain regular periodic, informal contact with the PSRO and provide informal feed back on potential or existing problems. It is hopeful that many areas of concern or problems will be resolved at this level. However, at the discretion of the Medical Assistance Bureau NMPSRO may be required to produce a corrective action plan and/or document that specific problems are being resolved.

1. The Medical Assistance Bureau will inform the PSRO in writing of its concerns and will request a written explanation and/or the PSRO position on matters in question.
2. Upon receipt of the PSRO response, the Medical Assistance Bureau will review it and make a determination as to its satisfaction. If the State determines that the issues have been adequately explained and addressed by the PSRO, no further action will be necessary.
3. If the PSRO response is deemed not satisfactory, the Medical Assistance Bureau will request a meeting with the PSRO. If the issues can adequately be resolved at this meeting, the PSRO will confirm in writing any agreements and/or resolutions which result from the meeting and no further action will be required.
4. If the issues cannot be adequately resolved at this meeting the Medical Assistance Bureau will notify the PSRO in writing and request corrective action and response to the notification within 30 days.
5. If there has not been resolution of the problems within 30 days, the Medical Assistance Bureau will transmit all pertinent information to the Director of the Income Support Division for administrative action.

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Part IV - Special Provisions relating to IHS Hospitals

Indian Health Service Hospitals will be certified as Medicaid providers in the New Mexico Title XIX Program on the same basis as any other qualified provider. Medicare has implemented certain departures from reimbursement policies and procedures normally applied to Medicare hospitals in order to temporarily accomodate certain problems, primarily in the area of inadequate and untrained personnel in those institutions. Until these problems can be alleviated, Medicare and Medicaid will utilize per-diem rates established by the Office of Management and Budget for interim reimbursement and final settlement.

Directly related to the above procedure, the State of New Mexico has temporarily implemented the following procedures in order to allow IHS facilities to participate in the Title XIX Program.

- A. IHS Facilities will use a newly developed procedural code for all outpatient visits and will not be required to enter all services provided on an outpatient basis.

In order to accomplish utilization review on these claims it will be requiried that diagnosis be entered. This will enable the State to monitor overutilization by recipients and whether outpatient treatment is appropriate to the diagnosis. As staff can be augmented and trained normal claims submission will be required.

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STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY ACTAttachment 3.1-*PD*

STATE OF NEW MEXICO

*changed per
AT-82-30.
(PD)*

Methods of providing transportation.

Transportation required by clients to obtain needed medical care under the program is provided when such required transportation cannot be secured without charge through volunteer organizations such as fire departments, public ambulances and other public services, or from relatives.

The methods of providing transportation by the Agency are:

1. By reimbursing providers of transportation by ambulance if other types of transportation are contra-indicated.
2. By reimbursing providers of common carrier and other specialized types of transportation.
3. By providing petty cash to clients in compensation for cost of travel by private automobile.

State <i>NM</i>	DATE <i>1/4/74</i>	MD-73-30
FOR: <i>SA PMS CC</i>		
Type (FMS)		
Obsolete (Other)		

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

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Page 1
OMB No. 0938-0193

State/Territory: New Mexico

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The New Mexico Medicaid program covers those medically necessary major organ transplant services which are not considered unproven or experimental by the Medicaid program or its Utilization Review Contractor for the condition for which they are intended or used.

Kidney and cornea transplants are covered by the Medicaid program without prior approval. Written prior approval must be obtained for reimbursement for the following covered transplants services:

- 1) Heart;
- 2) Liver;
- 3) Heart-lung;
- 4) Lung; and
- 5) Bone Marrow.

A transplant is considered unproven or experimental if it meets any of the following conditions:

- 1) The procedure does not have final approval from the appropriate government regulatory agencies, if such exist.
- 2) The procedure is not currently recommended by the appropriate recognized national professional peer organization if such exists and if chartered to review the particular type of procedure.

STATE <u>New Mexico</u>	A
DATE REC'D <u>4-1-94</u>	
DATE APPV'D <u>4-26-94</u>	
DATE EFF <u>1-1-94</u>	
HCFA 179 <u>94-04</u>	

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MARCH 1987

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STANDARDS OF THE COVERAGE OF ORGAN TRANSPLANT SERVICES

- 3) As determined by the Medical Assistance Division, the current scientific evidence, published in appropriate professional peer reviewed journals, does not substantiate the following conclusions concerning the effect of the procedure on health outcomes:
- a) The procedure must improve the new health outcome.
 - b) The procedure must be at least as beneficial as any established alternatives.
 - c) The procedure must be associated with no more risk to the patient than any established alternatives or the risk to benefit ratio must be at least as favorable as established alternatives.
 - d) The improvement must be attainable outside the investigational setting.
- 4) A written informed consent required by the treating facility or a research protocol being executed by the treating facility makes reference to the procedure as being experimental, investigation educational, for a research study, or posing an uncertain outcome or having an unusual risk.
- 5) The procedure is the subject of an on-going phase, I, II or III clinical trial or an on-going review by an Institutional Review Board.

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>4-1-94</u>	
DATE APPV'D	<u>4-26-94</u>	
DATE EFF	<u>1-1-94</u>	
HCFA 179	<u>94-04</u>	

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STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

- 6) Local peer review of the procedure by the appropriate professional determined that the procedure falls outside accepted professional standards of health care.

To be reimbursed for services, facilities performing the procedures must be certified by the State's Licensing and Certification Bureau and/or by the Health Care financing Administration as state transplantation center.

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>4-1-94</u>	
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DATE EFF	<u>1-1-94</u>	
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE NEW MEXICO

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of Title XVII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. ☐ Individuals receiving SSI under Title XVI or State supplementation, who are categorically needy under the State's approved Title XIX plan.

Persons receiving benefits under Title II of the Act or under the Railroad Retirement System are included:

Yes ☐ No ☐

2. ☐ Individuals receiving SSI under Title XVI, State supplementation, or a money payment under the State's approved Title IV-a plan, who are categorically needy under the State's approved Title XIX plan.

Persons receiving benefits under Title II of the Act or under the Railroad Retirement System are included:

Yes ☐ No ☐

- ☒ All individuals eligible under the State's approved Title XIX plan.

- ☒ Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium billing arrangement with HCFA. This arrangement covers the following groups:

Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and B deductible and co-insurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.
2. All categorically - eligible Medicaid recipients.
- 3.

A	
STATE <u>NM</u>	
DATE REC'D <u>MAR 27 1989</u>	
DATE APP'D <u>AUG 2 1989</u>	
DATE EFF <u>JAN 1 1989</u>	
HCFA 179 <u>89-02</u>	

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COOPERATIVE ARRANGEMENTS WITH STATE HEALTH AND STATE VOCATIONAL REHABILITATION AGENCIES AND WITH TITLE V GRANTEES

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State Plan Under Title XIX of the Social Security Act
State of New Mexico
Standards for Institutions

APPROVED by DHEW/HCTA/MS

DATE: MAR 30 1979

TRANSMITTAL NO: 79-5

- A. The standards for institutions are in accordance with 42 CFR 431.610, formerly designated as 42 CFR 450.100; Public Law 92-223 for Intermediate Care Facilities; and Public Law 92-603 as it relates to care in Skilled Nursing Facilities and Intermediate Care Facilities. Standards for hospitals applicable under Part A of Title XVIII also apply to participating hospitals in the New Mexico Title XIX Program.
- B. Recipients Personal Funds Accounts - As a condition for participation in the New Mexico Medical Assistance Program, each SNF or ICF will establish and maintain an acceptable system of accounting for a recipient's personal funds when a Title XIX-Medicaid recipient requests that his personal funds be cared for by the facility. Requests for the facility to care or not care for Title XIX-Medicaid recipients' personal funds will be in writing and secured by ISD Form 386. This form must be retained in the recipient's file.

The Title XIX-Medicaid recipient's personal fund consists of a monthly maintenance allowance established by Department policy. Any income in excess of this allowance is computed according to policy applied, when applicable, towards the cost of the recipient's medical care at the facility. This amount is reported as a Medical Care Credit to the facility on ISD 383 by the County ISD Office whenever applicable.

It is very important that all facilities have definite and clear-cut procedures on the handling of Title XIX-Medicaid recipients' funds. These procedures must not allow the facility to commingle Title XIX-Medicaid recipients funds with facility funds and may be developed along the following guidelines.

1) Fund Custodians:

- a. Designate a full-time employee and an alternate as fund custodians for handling all Title XIX-Medicaid recipients' monies on a day-to-day basis.
- b. Designate an individual other than the persons having day-to-day responsibility to reconcile balances of the individual Title XIX Medicaid recipients' accounts with the collective bank account, to periodically audit and reconcile the petty cash fund, and to authorize checks for the withdrawal of funds from the bank account.

2) Bank Accounts:

- a. Establish a collective bank account for the deposit of all Title XIX-Medicaid recipients' private monies.

APPROVED by DHEW/HCTA/MS
DATE: MAR 30 1979
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- b. Recipients personal funds will be held separately and not be commingled with facility funds.
 - c. The account may be a regular checking account or an interest-bearing savings account. Unless the bank account accumulates to a substantial amount, a non-interest bearing account would be more advantageous.
- 3) Pro Rata Distribution of Interest:
- a. If an interest-bearing bank account is established, all interest earned must be pro-rated to each Title XIX-Medicaid recipient with funds in the account, and the amount entered in his individual account record.
 - b. For this pro rata distribution, use the balance recorded on the individual ledger account sheet on the last day of the month that interest was earned.
- 4) Individual Recipient's Account:
- a. Establish an account for each Title XIX-Medicaid recipient to record all transactions. It is suggested that this be maintained in a type of general ledger book commonly used for bookkeeping purposes although a card file or a looseleaf binder may be used.
 - b. For money received: Record the source, amount, and date of all monies received. Issue a receipt to the Title XIX-Medicaid recipient or his authorized representative for funds deposited, and retain a copy for the record. The copy could be maintained in a card file.
 - c. For money expended: Record the purpose, amount, and date of all disbursements to or on behalf of the Title XIX-Medicaid recipient. All monies spent either on behalf of the recipient or withdrawn by the recipient or his representatives should be supported by a receipt or signature on the individual ledger sheet.
 - d. If the individual recipient account reaches \$1,400.00 contact the local County ISD Office for instructions.
- 5) Reconciliation:
- a. Balances of the individual accounts, the collective bank account, and the petty cash fund should be reconciled on at least a monthly basis.
 - b. Provide the Title XIX-Medicaid recipient or his authorized representative with an accounting of his funds on at least a quarterly basis. (A copy of the individual account record would be the most expeditious method of providing statements.)

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DATE: MAR 30 1979

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6) Petty Cash Fund:

- a. A cash fund specifically for this use should be maintained in the facility to accommodate the small cash requirements of the recipients. Generally five dollars or less per individual recipient should be sufficient. However, the amount of money should be determined by the number of recipients using the service and the frequency and availability of bank service.
- b. Establish a Petty Cash Fund ledger to record all actions regarding these monies.
- c. To establish the fund: (a) Write a check against the collective bank account to the custodian. (b) Cash the check and deposit in locked cash box.
- d. To use: (a) Give the recipient or his authorized representative cash when small amounts of spending money are requested. (b) Enter on the individual ledger record amount disbursed. (c) Have recipient or representative sign on account record when receiving money or issue a receipt with a duplicate.
- e. To replenish: (a) Count the money left in the cash box. (b) Total all disbursements since the last replenishment. (The total of the disbursements plus cash on hand should equal the beginning amount). (c) Write a check against the collective bank account for the amount of the disbursement.
- f. To reconcile: At least monthly (a) Count money on hand; (b) total cash disbursed either from receipts or individual account records; (c) cash on hand plus total disbursements equals petty cash total.

7) Termination of the Recipient Account:

- a. Enter date of termination of account, and state reason for termination.
- b. Write a check against the collective bank account for the balance shown on the individual account record.
- c. Have recipient or his authorized representative sign the individual recipient account record as receipt of payment.
- d. If termination of the account is caused by death of a recipient, notify the local County ISD Office, so that timely action may be taken to terminate assistance.
- e. If the deceased recipient had no relatives, applicable state laws will prevail. The nursing home should consult with its attorney for proper handling of the account.

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8) Retention of Records:

All account records should be retained for at least 3 years or in case of an audit, until audit is completed.

9) Non-Acceptable Uses of Recipients' Personal Funds:

- a. Payment for services or supplies covered under the Title XIX Medicaid program.
- b. Differences in what providers bill and what Title XIX-Medicaid pays.
- c. Payment for services or supplies routinely provided by the facility such as linens and nightgowns.

10) State Monitoring of Recipients' Personal Funds:

- a. All files and records involving recipients' personal funds will be made available for inspection of authorized state personnel or federal auditors.
- b. HED Licensing and Certification Bureau will verify that a facility has a system of accounting for recipients' personal funds that includes the components described above. Failure to provide an acceptable accounting system will constitute a deficiency that must be corrected.
- c. DHS Audit and Audit Agent will accomplish a complete and thorough audit of recipients personal funds accounts on an over-a-year basis.

AGREEMENT

APPROVED by DHEW/HCFR/MS

DATE: MAR 30 1979

TRANSMITTAL NO: 79-5

PREAMBLE: This agreement is entered into between the Department of Human Services, hereinafter DHS and the Health and Environment Department, hereinafter HED, both parties being Departments in the Executive Branch of the government of the State of New Mexico, for the purpose of defining the coordination of certain functions in connection with provision of the services established under Title XIX (the Medicaid Program) of the Social Security Act.

WHEREAS DHS is the Single State Agency with authority to administer or supervise the administration of the State Plan under Title XIX of the Social Security Act, and

WHEREAS HED is the State authority responsible for establishing and maintaining standards for the operation of certain private or public health care facilities and agencies not including Christian Science sanatoria operated or listed and certified by the First Church of Christ Scientist, Boston, Massachusetts, hereinafter health care facilities, at which persons eligible for medical assistance under the Title XIX State Plan may receive care and services, and

WHEREAS State federal regulation, 42 C.F.R. 450.100(c) (formerly designated prior to September 1, 1977 as 45 C.F.R. 250.100 (c)), requires written agreement between DHS and HED.

NOW, THEREFORE, DHS and HED enter into the following agreement:

A. CERTIFICATION OF FACILITIES.

1. HED shall determine whether health care facilities meet the certification requirements for participation as providers of health care services in the Title XIX Program as set forth in federal regulations.
2. The HED staff making such determinations shall be in the Health Services Division and shall be the same staff responsible for such determinations for institutions or agencies participating under Title XVIII of the Social Security Act.
3. The federal certification standards, and such forms, methods and procedures as may be designated by the Administrator of the Health Care Financing Administration, shall be used in determining health care provider eligibility and certification as Title XIX health care providers.
4. Certification survey documents made by HED staff must:
 - (a) Identify the health care provider surveyed,
 - (b) Indicate whether each requirement for which survey is made is, or is not, satisfied; and
 - (c) Include documentation of all deficiencies.
5. HED shall provide to the Medical Assistance Bureau of DHS, following each certification survey, resurvey or special on-site inspection of a health care facility applying for participation or participating in the Title XIX program:
 - (a) Written notice as to the certification or recertification status of each such facility, including a report of all deficiencies found;
 - ~~(b) The surveyed facility's plan of correction or plan of compliance, together with a determination as to the acceptability of such plan when required by federal regulation;~~
 - (c) Copies of all waivers, if any, as requested, together with a summary setting forth the basis for such waivers, and a determination that the health and safety of the patients are not jeopardized which shall be used by DHS to determine whether it would be appropriate time limited agreement under the Title XIX State Plan;

- (d) Recommendation concerning the appropriate length of any proposed time limited agreement; and
- (e) Prompt and complete information when applications are received for participation, licensure or changes which would affect current accuracy of such information as to ownership, capacity, and category or which affect any provision of an agreement on the term of provider participation.

6. HED shall maintain on file all information and reports used in determining whether federal certification requirements for health care facilities participating in Title XIX as providers of health care services are being met. HED shall provide access to such files by the Department of Health, Education and Welfare and to DHS as may be necessary to meet other requirements under the Title XIX State Plan and for purposes consistent with DHS's effective administration of the Title XIX Program.

B. DETERMINATION OF COMPLIANCE WITH CIVIL RIGHTS ACT OF 1964. HED shall:

- 1. Perform federally required on-site certification surveys of participating health care facilities and shall document provider compliance with civil rights requirements by completion of a civil rights compliance report and shall advise DHS at the time of each certification or recertification of such compliance; and
- 2. Provide DHS a special report on any facility determined not to be in compliance with civil rights requirements, setting forth the basis for such determination.

C. PERSONNEL QUALIFICATIONS. HED shall:

- 1. Provide assurance that personnel performing on-site certification survey or inspection functions hereunder are appropriately classified under the New Mexico State Personnel system; and
- 2. Provide for consultation with architects or the New Mexico State Fire Marshall, as required, for technical interpretation of facility compliance with applicable provisions of the N.F.P.A's Life Safety Code. In addition to providing professional consultation services to DHS upon request,
- 3. To the extent feasible within HED and DHS staffing capability and agency workload HED shall endeavor to work with the DHS medical review team to resolve particular provider problems mutually recognized as hazards to the health and safety of recipients served.

D. PROFESSIONAL CONSULTATION SERVICES. HED shall:

Provide consultation to facilities unable to qualify for participation under the Title XIX regulations in those instances in which deficiencies:

- 1. Are not susceptible to corrective action as may be determined as an integral part of the certification survey process; and
- 2. Are of a nature within the expertise of the disciplines represented by HED personnel and consultants available to HED.

E. FISCAL ADMINISTRATION. HED shall:

- 1. Document time and effort of its employees who perform the certification surveying functions hereunder, and maintain files containing such documentation.
- 2. Report periodically to the DHS such time, effort and other costs in summary form in accordance with standard procedures of DHS and federal regulations for the purpose of appropriate cost allocations.

3. Identify by appropriate accounting code or other designation, vouchers submitted or other documents representing charges for transportation, meals, lodging and consultant fees attributable to the functions performed hereunder.
4. Provide for allocation of costs attributable to Title XIX in accordance with federal and state regulations for items 2 and 3 above in the event of required attendance at any certification surveyor training course by HED personnel.
5. Provide sufficient state matching funds necessary to secure full federal financial participation in the Title XIX portion of the survey and certification activities covered by this agreement.

F. DELEGATION OF AUTHORITY

APPROVED by DHEW/HCFR/MS
DATE: MAR 30 1979
TRANSMITTAL NO: 79-5

DHS specifically delegates to HED its authority for certification surveys and compliance in accordance with federal and state regulations as follows:

1. The performance of certification surveys, re-surveys, revisits and maintenance of appropriate documentation files;
2. The determination of whether and the issuance of permissible waivers;
3. The determination that the health care facilities are in conformance with utilization review procedures in those instances where utilization review has been assumed by P.S.R.O.
4. The determination whether participating health care facilities staffing are or are not in compliance with requirements.
5. The determination of whether any deficiencies or waiverable conditions represent a hazard to the health and safety of the patients served by the facility.

G. REGULATIONS AND INTERPRETATIONS. DHS shall:

1. Provide HED with information concerning proposed and final changes in Title XIX regulations, policies and interpretations, as such information is pertinent to the performance of services rendered by HED hereunder.
2. Furnish HED with copies of the on-site review reports developed by the DHS Medical Review - Independent Professional Review teams.
3. Negotiate required written agreements with recommended certified facilities.

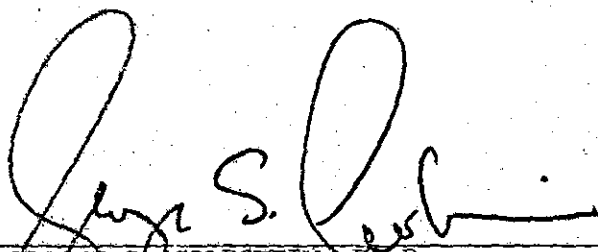
H. ADMINISTRATIVE DISCRETION.

1. DHS retains its sole responsibility for exercising administrative discretion in the administration and supervision of the Title XIX State Plan. Nothing in this agreement shall be construed as delegating to HED any of DHS's responsibility for exercising administrative discretion in the administration or supervision of the Title XIX State Plan, including the issuance of policies, rules and regulations or program matters.
2. In the performance of its functions under this agreement, HED shall not have any responsibility to review, change or disapprove any administrative decision of DHS, or otherwise substitute its judgment for that of DHS as to the application of Title XIX policies, rules, and regulations promulgated by DHS.
3. In any event, federal requirements governing certification of health care facilities as providers of health care under the Title XIX program shall bind both parties.

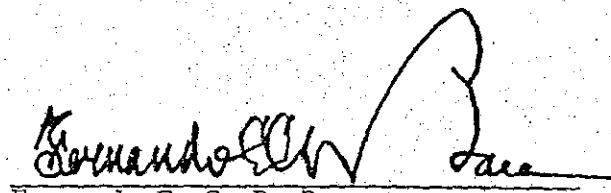
I. INDEMNIFICATION AND HOLD HARMLESS

Each party shall be solely responsible for fiscal or other sanctions occasioned by its own violation or alleged violation of federal requirements in the performance of this agreement and shall indemnify and hold harmless the other party therefrom.

APPROVED by DHEW/HCPA/MS
DATE: MAR 30 1979
TRANSMITTAL NO: 79-5



GEORGE S. GOLDSTEIN, Ph.D.
Secretary
Department of Health & Environment




Fernando E. C. De Baca
Secretary
Department of Human Services

7/6/78
Date

7/10/78
Date

Approved for Legal Content
Department of Health and Environment

Date



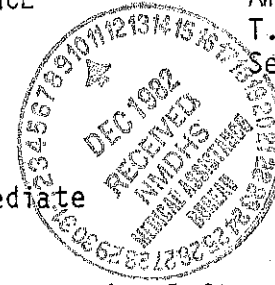
Approved for Legal Content
Department of Human Services

7/13/78
Date

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX
NEW MEXICO

Amendment 82-9
T.L. 82-9
September 2, 1982

Attachment 4.14-A
Utilization Review Plan for Intermediate
Care Facilities



From 1974 until January 31, 1979, The New Mexico Professional Standards Review Organization (NMPSRO) performed long term care admission and concurrent review for the NM Medicaid Program under a memorandum of understanding with the Department. The State Agency retained the responsibility for the Medical Review Team and Independent Professional Review on-site activities.

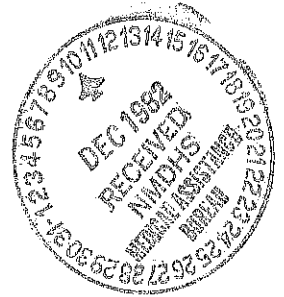
On February 1, 1979, the NMPSRO was nominated by HHS as a conditional PSRO with binding review authority in the area of long term care under Title XI of the Social Security Act. Under this authority the NMPSRO performed all admission review, concurrent review, and on-site quality of care for SNFs, ICFs, and ICF/MRs.

As a result of the loss of Federal funding for binding review of Long Term Care under Title XI on September 30, 1981, the responsibility for assuring that UR/UC review is carried out in Long Term Care facilities was shifted to the Human Services Department.

The Department has elected to contract with the NMPSRO to carry out the Long Term Care Utilization review function. The NMPSRO will carry out this function according to the New Mexico Plan for Long Term Care Review which is set forth in Part I.B. of Attachment 3.1-C of this State Plan. Please see that attachment for specific details relating to the Utilization Review Plan for Intermediate Care Facilities. Section A.2 of Article II of the current Human Services Department - Professional Standards Review Organization contract under which this responsibility is delegated to the PSRO is here attached as Supplement 1 to Attachment 4.14-A.

STATE	<u>NM</u>	A
DATE REC'D	<u>9/7/82</u>	
DATE APPV'D	<u>9/22/82</u>	
<u>NCEA 179</u>	<u>82-9</u>	

The NMPSRO will perform pre-admission, admission, continued stay and on-site quality of care review for all licensed long term care facilities in the State during the contract year. The NMPSRO will perform pre-admission, admission and continued stay review and on-site quality of care review for all acute care hospitals with swing beds. In carrying out LTC Review the NMPSRO shall utilize NMPSRO Physician Advisors, a Nurse Review Coordinator, Nurse On-Site Evaluators and when indicated seek the advice and counsel of the Director of Professional Affairs and appropriate authorities in the Medical Assistance Bureau. The LTC Review shall be carried out in accordance with the Human Services Department Long Term Care Review Plan.



STATE	NM
DATE REC'D	9/7/82
DATE APPV'D	9/22/82
HSEA 179	82-9

A

MEMORANDUM OF AGREEMENT

Amendment 81-8
T. L. 81-8
October 22, 1981

Between

STATE HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

And

STATE DEPARTMENT OF EDUCATION
VOCATIONAL REHABILITATION DIVISION

The Rehabilitation Act of 1973, as amended, and implementing regulations require State vocational rehabilitation agencies to assist eligible handicapped individuals to enter, return to, or remain in gainful employment, through the provision of various services. Many of these handicapped individuals are also eligible for Medicaid. Therefore, it is appropriate and necessary to define the cooperative roles of the Division of Vocational Rehabilitation and the State agency responsible for administration of the Medicaid Program in assuring the provision of services for these individuals.

This agreement is entered into between the Income Support Division of Human Services Department, hereinafter ISD, and the Division of Vocational Rehabilitation of the Department of Education, hereinafter DVR, for the purpose of defining the coordination of functions in connection with provision of the services available under both programs.

NOW, THEREFORE, ISD AND DVR enter into the following agreement:

A. PAYMENT FOR MEDICAL SERVICES

1. For any medical services covered under the Title XIX (Medicaid Program), and delivered in accordance with regulations of the Medicaid Program, ISD will assume first and primary responsibility for payment. However, benefit payments from other sources such as hospital or health insurance, or other third parties which are under obligation to provide such benefits for Medicaid eligibles, must be used before drawing on Medicaid funds.
2. DVR operates the New Mexico Rehabilitation Center at Roswell, its Northern New Mexico Rehabilitation Center at Las Vegas and the Psychological Services Unit in Albuquerque, all of which receive payment for medical services under separate provider agreements. Those payments are accepted as full payment for services rendered and the proceeds used to meet operating expenses.
3. ISD agrees to consider extending provider status to DVR for other services as it is demonstrated that DVR meets program requirements for participation in additional areas, and as it is demonstrated that DVR can assist in maximizing the delivery of comprehensive health care services to Medicaid eligibles.

B. EQUAL SERVICES

The DVR agrees to consider any Medicaid recipient for all possible services available to any handicapped individual under any other program which might meet in whole or in part the cost of certain services. The fact that an individual is eligible for Medicaid should not restrict that individual's eligibility to receive other services available.

ISD will reciprocate by considering any DVR recipient for all possible services available under the programs administered by ISD field offices. An individual's receipt of DVR services should not restrict that individual's eligibility to receive other available services.

C. COMMUNICATIONS BETWEEN ISD AND DVR

1. County ISD offices will refer all potential rehabilitation cases to the local DVR office if it appears that the individual may benefit from such services. All AFDC recipients determined to be incapacitated for purposes of participation in the WIN Program will be referred to DVR. In return, the local DVR offices will refer all individuals determined to be in need of financial, food, or medical assistance to the county ISD office if it appears that the individual may be eligible under the Programs administered by ISD.

APPROVED BY DHHS/MCFA/DPO
DATE: 12/1/81
TRANSMITTAL NO: 81-8

Arrangements for transmittal of referrals on a regular and frequent basis will be worked out between the county offices, with consideration given to expediency and maximum efficiency. Referrals made by ISD and DVR staff will contain:

- a) adequate identifying information to allow the receiving office to contact the individual referred; and,
- b) medical information as available and deemed appropriate. When such information is shared, the recipient's permission must be obtained for its release.

The receiving office will acknowledge all referrals and, when appropriate, outline services provided.

2. County offices for ISD and DVR will establish a liaison person for communications between the two agencies. Whenever possible, a backup person will be designated to serve this function in the liaison person's absence. The designation of a liaison person will not restrict communications between individual DVR and ISD workers who are mutually involved in providing services to a particular Medicaid recipient. Rather, the liaison person will function so as to maximize communications between the two agencies on both the individual case level as well as the office level. The ISD liaison person on the state level will be the supervisor of Program Development Unit of the Medical Assistance Bureau. The DVR liaison person on the state level will be the Assistant Chief of DVR Field Services.

D. TRAINING FOR DVR AND ISD STAFF

ISD agrees to develop training materials and provide training to appropriate DVR staff to assure they are knowledgeable about current Medical Assistance Program coverage and procedures. DVR agrees to develop training material and provide training to appropriate ISD staff to assure they are knowledgeable about services available through DVR and which ISD recipients are appropriate referrals for DVR services. Both DVR and ISD agree to complete the above training within 12 months of the effective date of this agreement.

E. EXEMPT DVR PAYMENTS

The DVR makes payments to individuals in training to help them meet the additional costs of training. These payments are made to meet needs not met by the financial assistance grant and are disregarded in their entirety in computation of financial assistance grants from ISD. In determination of eligibility for the Food Stamp Program, ISD shall consider any training allowance specifically intended for payment of tuition and mandatory fees to educational institutions in accordance with applicable food stamp guidelines.

F. EXPEDITING PRIOR APPROVALS FOR MEDICAID SERVICES

The Medical Assistance Bureau of ISD will assist DVR staff in expediting the prior approval process for medical services in instances in which it is demonstrated that an unnecessary delay has occurred in normal prior approval procedures. ISD will provide training to DVR staff on how to assist providers in obtaining prior approvals for medical services.

G. CONFIDENTIALITY

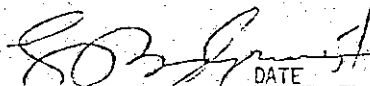
Pursuant to 42 CFR 431.300 et seq. and 42 CFR 51a.112, all information as to personal facts and circumstances obtained, and all records kept by either of the parties hereto shall constitute privileged communication, shall be held confidential, and shall not be divulged without the client's consent except as may be necessary to provide needed services to that client.

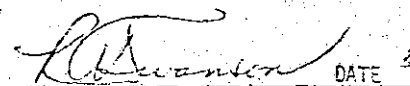
H. PERIOD OF AGREEMENT, RENEWAL, REVIEW AND AMENDMENT

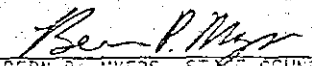
This Agreement shall become effective on May 1, 1981, and shall terminate June 30, 1982. This agreement will be reviewed and renegotiated on an annual basis. Periodic reviews and revisions in response to changes in State and/or Federal statutes may be initiated by either party to this agreement, with written notification of proposed amendments being made to the other party. Discussion of the proposed amendments will be undertaken as appropriate to ensure that the function and goals of both parties are duly considered. All amendments must be agreed upon mutually by written consent prior to finalization and implementation.

This memorandum of agreement is the basis for relations and cooperation between ISD and DVR.

In Witness Whereof, the parties hereto have set their hands.


DATE 11/2/81
LAWRENCE S. INGRAM, SECRETARY
DEPARTMENT OF HUMAN SERVICES


DATE 5/5/81
DR. ROBERT A. SWANSON, DIRECTOR
DIVISION OF VOCATIONAL REHABILITATION


DATE
BERN P. MYERS, STAFF COUNSEL
DIVISION OF VOCATIONAL REHABILITATION

STATE	New Mexico
DATE REC'D	9-12-79
DATE APP'V'D	2-14-80
PCO-11	79-10

AGREEMENT

A

Amendment 79-10
T.L. 79-10
Sept. 7, 1979. 1-533

This Agreement is entered into by and between the Department of Human Services, hereinafter referred to as "DHS" and the Health and Environment Department, hereinafter referred to as "HED".

ARTICLE 1: PERIOD OF AGREEMENT

This Agreement shall become effective on July 1, 1979 or upon approval of the Department of Finance and Administration whichever is later and shall terminate one (1) year after the last required signature has been obtained so long as notice of intent to terminate is received by the other agreeing party within sixty (60) days of said termination date; otherwise this Agreement shall be automatically renewed for successive State Fiscal Years.

ARTICLE 2: DEFINITIONS

The words quoted below will have the following meanings unless the context clearly requires otherwise:

- A. Medicaid means the program of medical assistance under Title XIX of the Social Security Act administered by DHS through its Income Support Division (ISD).
- B. Crippled Children's Service (CCS) means the program of medical assistance and Social Services under Title V of the Social Security Act administered by HED through its Health Services Division (HSD).
- C. Aid to Families with Dependent Children (AFDC) means the program of financial assistance under Title IVA of the Social Security Act administered by DHS through its ISD.
- D. Supplemental Security Income (SSI) means the program of financial assistance under Title XVI of the Social Security Act administered by the Social Security Administration.
- E. Supplemental Security Income-Disabled Children's Program (SSI-DCP) means the program of counseling, developing individual service plans and referring of disabled children under age 16 and providing medical, social, developmental, and rehabilitative services for disabled children under age 7 and those who have never attended public school authorized by Public Law 94-566, Section 1615 (b) administered by HED through its HSD.
- F. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) means a program of medical assistance in the form of early and periodic screening, diagnosis, and treatment under Title XIX of the Social Security Act administered by DHS through its ISD.

ARTICLE 3: STATUS OF CHILDREN

The programs set out above affect the following groups of children:

- A. All children who are under the age of 21 and who receive AFDC or SSI and who reside in New Mexico are eligible for Medicaid and EPSDT.
- B. Some children who are under the age of 21 and who reside in New Mexico are eligible for CCS.
- C. A small number of children who are under the age of 21 and who reside in New Mexico are eligible for both Medicaid and CCS.
- D. A small number of children who are under the age of 16 and who reside in New Mexico are eligible for SSI-DCP.

ARTICLE 4: PURPOSE

One purpose of this Agreement is to improve coordination in the providing of health care services to children eligible both for Medicaid and CCS with efforts specially directed to improving program management and evaluation in the EPSDT program.

STATE	NEW MEXICO	FILE NO.	79-10
DATE REC'D	9-12-79	DATE	Sept. 7, 1979
DATE APPV'D	2-14-80		A
PCO-11	79-10		

A second purpose of this Agreement is to authorize HED to provide diagnostic and treatment services in clinics conducted by the CCS program in the medical specialty areas of orthopedics, cardiology, cleft-palate, plastic surgery, and neurology to children under the age of 21 who are eligible for AFDC or SSI and who reside in New Mexico.

ARTICLE 5: SCOPE OF SERVICES AND STAFFING PLAN

HED will provide the professional services as set forth in Scope of Services and Contractual Services and Staffing Plan, EXHIBIT A, which is hereby incorporated and made a part of this Agreement.

ARTICLE 6: REIMBURSEMENT

HED will submit claims, at rates agreed upon in Exhibit A for services provided to the Fiscal Agent of the Medicaid (Title XIX) program. DHS will assure that the Fiscal Agent will process the claims in a timely manner and submit payments to HED to be credited to the account of CCS.

ARTICLE 7: MEDICAID (TITLE XIX) RESOURCES.

DHS will be the primary state resource for payment for care of Medicaid eligible children seen and/or referred by CCS specialty clinics for all services designated as covered services under Medicaid (Title XIX). However, payment benefits from other hospital or health insurance, or third parties which are under obligation to provide such benefits for Medicaid eligible children, must be used before drawing on Medicaid funds.

ARTICLE 8: COORDINATION OF EPSDT SERVICES

Within HED an SSI-DCP Unit has been set up to provide for counseling, development of individual service plans and referral of disabled children under age 16 and to provide medical, social, developmental, and rehabilitative services for disabled children under age 7 and those who never attended public school. This unit will assume responsibility for case management to assure that necessary EPSDT services are provided on a continuing basis to children eligible for this program which is operative in pilot project areas in New Mexico.

DHS, through its EPSDT program, will retain responsibility for case management of Medical eligible children receiving specialty clinic services.

ARTICLE 9: REFERRALS

HED will refer handicapped children receiving assistance or services under Title V to the DHS field offices when it appears that the child and his family may be eligible for assistance under Medicaid and would benefit from the receipt of such assistance.

DHS will refer any Medicaid (Title XIX) eligible child to the HED field offices when it appears that the child requires or may benefit from specialty clinic services and in those instances where the child requires or may benefit from Title V covered services not covered under Title XIX. Referrals may be made by DHS field office staff or EPSDT staff as appropriate.

HED will refer Medicaid eligible children to the local DHS offices to obtain transportation money to receive Title XIX covered services when no other source of transportation is available.

In those instances where a Medicaid eligible child is not in possession of a current Medicaid Identification Card, HED will not assume continuation of eligibility under Medicaid and will refer the child's parents to the DHS field office.

In those instances where HED does not know the Medicaid eligibility status of a child, DHS field office staff will ascertain the status and advise HED.

ARTICLE 10: JOINT EVALUATION

Program representatives from DHS and HED shall periodically jointly evaluate the program and discuss any problems that might arise between the CCS program, SSI-DCP, and the New Mexico Medicaid Assistance Program.

T.L. 79-10
Sept. 7, 1979

Appropriate representatives from DHS and HED will be the Supervisor of Program Development of ISD's Medical Assistance Bureau and the managers of HSD's CCS program and the manager of HSD's SSI-DCP.

Meeting will be scheduled at least every six (6) months.

ARTICLE CONFIDENTIALITY:

Pursuant to 42 CFR 431.300 et seq. and 42 CFR 51a.112, all information as to personal facts and circumstances obtained, and all records kept by either of the parties hereto shall constitute privileged communication, shall be held confidential, and shall not be divulged without the client's consent except as may be necessary to provide needed services to that client. HSD's Regulation Governing Public Access to Information shall also apply.

ARTICLE 12: Amendments

This Agreement shall not be altered, changed or amended by instrument in writing executed by the parties hereto.

ARTICLE 13: Scope of Agreement:

This Agreement incorporates all the Agreements, covenants, and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, Agreements and understandings have been merged into this written agreement. No prior Agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

DEPARTMENT OF HUMAN SERVICES

HEALTH AND ENVIRONMENT DEPARTMENT

Lawrence B. Ingram
Secretary

Date

George S. Goldslein, PH.D
Secretary

Date

APPROVED:

Julia Southerland
Julia Southerland,
Assistant Attorney General
Chief Attorney, DHS

Date

Geoffrey Sloan
Assistant Attorney General

Date

MA
State Contracts Officer
Department of Finance and Administration

Date

STATE <u>New Mexico</u>	A
DATE REC'D <u>9-12-79</u>	
DATE APPV'D <u>2-14-80</u>	
PCO-11 <u>79-10</u>	

EXHIBIT A

SCOPE OF SERVICES AND CONTRACTUAL SERVICES AND STAFFING PLAN

HSD will provide the following services under the Authority of this Agreement:

- 1) Provide services at CCS Specialty Clinics to children under the age of 21, who reside in New Mexico, and who are eligible for AFDC or SSI.

Services provided at CCS Specialty Clinics are:

- A) Orthopedics:
Medical services for diagnosis and treatment of orthopedic conditions.
- B) Cardiology:
Medical services for diagnosis and treatment of cardiac conditions.
- C) Cleft Palate:
Medical and dental services for diagnosis and treatment of Cleft Palate and Cleft Lip conditions.
- D) Plastic Surgery:
Medical services for diagnosis and treatment of conditions requiring plastic surgery.
- E) Neurology:
Medical Services for diagnosis and treatment of neurologic conditions.

- 2) Submit all claims for diagnosis and treatment promptly as each clinic is completed to the Title XIX Fiscal Agent for reimbursement, at the following rates:

Medical Services, Orthopedic: \$26.00
Medical Services, Cardiac: \$37.00
Medical Services, Cleft Palate: \$19.00
Medical Services, Plastic Surgery: \$25.00
Medical Services, Neurologic: \$70.00

The name of the child and the identification number issued by DHS will be entered on the claim form.

Co-payment fee(s) will be deducted from the above quoted rates except in EPSDT related services.

The reimbursement rate for each specialty area is a capitation fee and is to be the total reimbursement for all medical services provided per visit to each specialty clinic per child eligible for AFDC or SSI. HSD will use the following provider numbers and procedure codes in submitting claims:

	Provider Number	Procedure Code
Orthopedic	46789	00600
Cardiac	46698	00601
Cleft Palate	48157	00602
Plastic Surgery	48405	00603
Neurologic	46441	00605

- 3) Submit to DHS the name and identification number of each child diagnosed and treated and program reports as requested and available.
- 4) Coordinate with DHS the effort to meet requirements, deadlines, and reporting data required by involved Federal Agencies; and cooperate in the development of methods of exchange of information between DHS and HSD.

STATE <u>New Mexico</u>	A
DATE REC'D <u>9-12-79</u>	
DATE APPV'D <u>2-14-80</u>	
POC-11 <u>79-10</u>	

CONTRACTUAL SERVICES AND STAFFING PLAN

HED's Staffing Plan for services under the authority of this Agreement is as follows:

Orthopedic:	5 Orthopedic Physicians 1 Brace Shop Manager 1 Social Worker 3
Cardiac:	1 Pediatric Cardiologist (Physician) 1 Administrative Assistant (Clinic Coordinator) 1 Social Worker 2
Cleft Palate:	1 Pedodontist 1 Orthodontist 1 Plastic Surgeon 1 Ear, Nose, Throat Specialist (Physician) 1 Speech and Hearing Therapist
Plastic Surgery:	1 Plastic Surgeon 1 Speech and Hearing Therapist
Neurology:	1 Neurologist 1 Social Worker 2

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>9-12-79</u>	
DATE APPV'D	<u>2-14-80</u>	
PCO-11	<u>79-10</u>	

Amendment 81-8
T. L. 81-8
October 22, 1981

AGREEMENT

This Agreement is entered into by and between the Department of Human Services hereinafter referred to as "DHS" and the Health and Environment Department, hereinafter referred to as "HED".

RECITALS:

THAT, 1615b of the Social Security Act provides for the referral by the Social Security Administration (SSA) of blind or disabled Supplemental Security Income (SSI) recipients who are under age 16 to a designated State agency, under a State plan; and

THAT, pursuant to the applicable federal regulations 42CFR513 and the approved State plan, the Health Services Division of HED is the designated State agency; and

THAT, a unit of the Health Services Division the Supplemental Security Income-Disabled Children's Program (SSI-DCP) is to provide for counseling, development of individual service plans and referral of disabled children under age 16, and to provide medical, social, developmental, and rehabilitative services for disabled children under seven years and those who have never attended public school; and

THAT, the Income Support Division (ISD) of the Department of Human Services (DHS) administers Title XIX Medicaid Services and Medicaid is the primary source of medical care for SSI-DCP children, except in those instances when another party is determined liable for payment of care;

NOW, THEREFORE, DHS and HED in consideration of their mutual undertaking as hereinafter set forth, do now agree as follows:

ARTICLE 1 PERIOD OF AGREEMENT

This Agreement shall become effective October 1, 1979, and shall terminate one (1) year after the last required signature has been obtained so long as notice of intent to terminate is received by the other agreeing party within sixty (60) days of said termination date; otherwise this agreement shall be automatically renewed for successive Federal Fiscal Years.

ARTICLE 2 PURPOSE

One purpose of this agreement is to assure that the Title XIX program remain the primary resource for purchase of medical care for SSI-DCP and all services designated in Section 300-319 of the Income Support Division Medical Assistance Manual be made available.

SSI-DCP agrees to adhere to all administrative procedures designated in Volume I of the ISD Manual and to use the designated appeals mechanism, Section 275 and 306, to appeal eligibility and patient coverage decisions whenever appropriate.

SSI-DCP agrees to refer SSI-DCP clients whose specific service needs cannot be covered by ISD to the Crippled Children's Services Program.

ARTICLE 3 REFERRALS

The SSI-DCP clients will be referred to the local ISD field offices to obtain transportation money to enable provision of necessary services. In the case that the SSI-DCP client does not receive a monthly Medicaid identification card, parents of the client should inquire at the ISD field office.

ARTICLE 4 EXCHANGE OF REPORTS

The ISD will provide the SSI-DCP Administrator with the following reports:

1. The SDX Medical Eligible Registers printout monthly.
2. Utilization on a six month basis.

APPROVED BY DHHS/MCFA/DPO

12/7/81
TRANSMITTAL NO: 81-8

The SSI-DCP, upon request from the ISD will provide a list of SSI-DCP clients on a quarterly basis. The list will include the following information:

Name of child
Birthdate of child
Social Security number of child
Date of initiation of services by the DCP

ARTICLE 5 FINANCING SERVICES

No budget or fund transfers are required under this agreement. There will be no charges for transfer of materials or information between ISD and SSI-DCP, and each party shall bear its own costs.

ARTICLE 6 MECHANISM FOR ENSURING CONTINUING AND CLOSE COOPERATION

The ISD and SSI-DCP will each designate one staff member who will hold primary responsibility for all liaison activities between the two parties.

ARTICLE 7 LEVELS OF SERVICE

The ISD will assure that current levels of service to eligible SSI-DCP clients will not decrease. If the scope of services or other coverage is reduced in the overall New Mexico Title XIX program, these program changes would also apply to SSI-DCP clients.

ARTICLE 8 PERIODIC REVIEW OF AGREEMENT

This agreement will be reviewed on an annual basis.

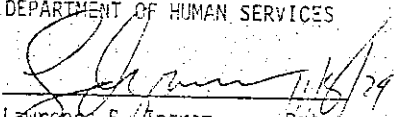
ARTICLE 9 CONFIDENTIALITY

Pursuant to 42 CFR 431.300 et seq. and 42 CFR 51a.112, all information as to personal facts and circumstances obtained, and all records kept by either of the parties hereto shall constitute privileged communication, shall be held confidential, and shall not be divulged without the client's consent except as may be necessary to provide needed services to that client.

ARTICLE 10 SCOPE OF AGREEMENT:

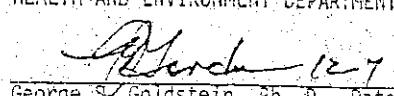
This Agreement incorporates all the Agreements, covenants, and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, Agreements and understandings have been merged into this written agreement. No prior Agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

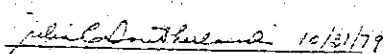
DEPARTMENT OF HUMAN SERVICES


Lawrence B. Ingram
Secretary

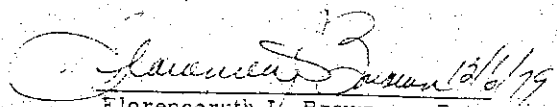
Date 11/16/79

HEALTH AND ENVIRONMENT DEPARTMENT


George S. Goldstein, Ph. D. Date 12-7


Julia Southerland
Chief Attorney, DHS

Date 10/31/79


Florence Ruth J. Brown
Chief Attorney, HSD

Date 12/6/79

APPROVED BY DHHS/NCFA/DPD

12/7/81

TRANSMITTAL NO: 81-8

STATE	<u>New Mexico</u>
DATE REC'D	<u>5-17-10</u>
DATE APPV'D	<u>8-11-10</u>
DATE EFF	<u>4-1-10</u>
HCFA 179	<u>10-06</u>

A

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:

- o 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
- o Individual's home- A home is any shelter used by an applicant/recipient or his/her spouse as the principal place of residence.
- o 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
- o 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.
- o 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: 8-11-10

Effective Date: 4-1-10

SUPERSEDES: NONE - NEW PAGE

- (c) assets subject to recovery are the sole income source for the heir(s);
- (d) the homestead is worth 50 percent or less than the average price of a home in the county where the home is located based on census data compared to the property tax value of the home; and
- (e) other compelling circumstances as determined by HSD or its designee.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective: If the representative requests a waiver due to an undue hardship the provisions below are used:

At application and recertification a client/client's representative is given an informational brochure on Estate Recovery which explains the Estate Recovery Process and the information relating to Hardship Waivers. A representative may request a waiver by completing the *Application for Hardship Waiver for Estate Recovery* form and attaching supporting documentation, of the potential hardship. The form and supporting documentation is reviewed by the department or its designee.

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness): *Medicaid may also waive recovery if it is not cost effective to recover from the estate. To be cost effective, the administrative cost of recovering from the estate shall be less than the total date-of-death value of the estate subject to recovery.*
7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

Information explaining estate recovery will be furnished to the applicant/recipient, personal representative, or designee during the application or recertification process. Upon the death of the Medicaid recipient, a notice of intent to collect (recovery) letter will be mailed to the recipient's personal representative with the total amount of claims paid by Medicaid on behalf of the recipient. The personal representative must acknowledge receipt of this letter in the manner prescribed in the letter within 30 days of receipt. Medical Assistance Division (MAD) or its designee will send notice of recovery to the probate court, when applicable, and to the recipient's personal representative or successor in interest. The notice will contain a statement describing the action MAD or its designee intends to take, reasons for the intended action, statutory authority for the action, amount to be recovered, an opportunity to apply for the undue hardship waiver and procedures involved in this process, and an explanation of Fair Hearing rights and timeframes. The request for an undue hardship waiver must be made within ninety (90) days of receipt of the notice of intent to collect (recovery). The representative of the estate has the right to request an administrative hearing on behalf of the estate within thirty (30) days from the date of MAD or its designee's notice of intended action against the estate.

STATE <u>New Mexico</u>	A
DATE REC'D <u>3-17-10</u>	
DATE APPV'D <u>8-11-10</u>	
DATE EFF <u>4-1-10</u>	
HCFA 179 <u>10-06</u>	

TN # 10-06
Supersedes TN # _____

Date Approved: 8-11-10

Effective Date: 4-1-10

SUPERSEDES: NONE - NEW PAGE

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

A. The following charges are imposed on the categorically needy:

Service	Deduct.	Type Charge Coins.	Copay	Amount and Basis for Determination
---------	---------	-----------------------	-------	------------------------------------

STATE	<i>New Mexico</i>	A
DATE REC'D	<i>11-23-92</i>	
DATE APP'VD	<i>12-16-92</i>	
DATE EFF	<i>10-1-92</i>	
HCFA 179	<i>92-19</i>	

TN No. *92-19*

Supersedes TN No. *85-10*

Approval Date *12/16/92*

Effective Date *10/1/92*

Amendment 85-10
T. L. 85-10
October 15, 1985

Revision: HCFA-PM-85-14 (BERG)
SEPTEMBER 1985

ATTACHMENT 4.18-A
Page 2
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

B. The method used to collect cost sharing charges for categorically needy individuals:

☐ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

APPROVED BY DHHS/HCFA/DPO

DATE: 1-30-86

TRANSMITTAL NO: 85-10

TN No. 85-10
Supersedes
TN No. 78-5

Approval Date 1-30-86

Effective Date 10-1-85

HCFA ID: 0053C/0061E

Amendment 85-10
T. L. 85-10
October 15, 1985

Revision: HCFA-PM-85-14 (BERC)
SEPTEMBER 1985

ATTACHMENT 4.18-A
Page 3
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Not Applicable

- E. Cumulative maximums on charges:

- ☐ State policy does not provide for cumulative maximums.
☐ Cumulative maximums have been established as described below:

Not Applicable

APPROVED BY DHHS/HCFA/DPO
DATE: 1-30-86
TRANSMITTAL NO: 85-10

TN No. 85-10
Supersedes

TN No. NEW

Approval Date 1-30-86
Date 10-1-85

Effective

HCFA ID: 0053C/0061E

April 1, 1974

Attachment 4.18-B

MSA-PI-74-6
February 26, 1974

State

New Mexico

The following enrollment fee, premium or similar charge is imposed on the medically needy:

Gross Family Income (per mo.)	Charge			Liability Period	Frequency of Charge
	Family Size				
	1 or 2	3 or 4	5 or more		
(1)	(2)	(3)	(4)	(5)	(6)
\$150 or less					
151 - 200					
201 - 250					
251 - 300					
301 - 350					
351 - 400					
401 - 450					
451 - 500					
501 - 550					
551 - 600					
601 - 650					
651 - 700					
701 - 750					
751 - 800					
801 - 850					
851 - 900					
901 - 950					
951 - 1000					
More than \$1000					

Amendment 74-4
April 1, 1974

MSA-PI-74-6
February 28, 1974

Attachment 4.18-B
Page 2

State New Mexico

Effect on recipient of non-payment of enrollment fee, premium or similar charge:

☐ Non-payment does not affect eligibility

☐ Effect is as described below:

Revision: HCFA-PM-85-14 (DERG)
SEPTEMBER 1985

Amendment 85-10
T. L. 85-10
October 15, 1985

ATTACHMENT 4.18-C
Page 1
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Not Applicable				

APPROVED BY DHHS/HCFA/DPO
DATE: 1-30-86
TRANSMITTAL NO: 85-10

TN No. 85-10
Supersedes
TN No. 84-4

Approval Date 1-30-86

Effective Date 10-1-85

HCFA ID: 0053C/0061E

Amendment 85-10
T. L. 85-10
October 15, 1985

Revision: HCFA-PM-85-14 (BERC)
SEPTEMBER 1985

ATTACHMENT 4.18-C
Page 2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

B. The method used to collect cost sharing charges for medically needy individuals:

☐ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

APPROVED BY DHHS/HCFA/DPO

DATE: 1-30-86

TRANSMITTAL NO: 85-10

TN No. 85-10

Supersedes

TN No. new

Approval Date 1-30-86

Effective Date 10-1-85

HCFA ID: 0053C/0061E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Not Applicable

- E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

Not Applicable

APPROVED BY DHHS/HCFA/DPO
DATE: 1-30-86
TRANSMITTAL NO: 85-10

TN No. 85-10
Supersedes
TN No. New

Approval Date 1-30-86

Effective Date 10-1-85

HCFA ID: 0053C/0061E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 4.18-D
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

TN No. 91-19
Supersedes None Approval Date JAN 15 1992 Effective Date OCT 1 1991
TN No. None HCFA ID: 7986E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APP'D	<u>JAN 15 1992</u>
DATE EFF	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

A

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 4.18-D
Page 2
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

C. State or local funds under other programs are used to pay for premiums:

☒

Yes

☐

No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

TN No. 91-19 Approval Date JAN 15 1992 Effective Date OCT 1 1991
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Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

- A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:
- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

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C. State or local funds under other programs are used to pay for premiums:



Yes



No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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~~SUPERSEDES: NONE~~ NEW PAGE

**METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES – INPATIENT HOSPITAL SERVICES**

The New Mexico Title XIX Program reimburses appropriately licensed and certified acute care hospitals for inpatient services as outlined in this plan. Procedures and policies governing state licensure, certification of providers, utilization review, and any other aspect of State regulation of the Title XIX Program not relating to the method of computing payment rates for inpatient services are not affected by this plan.

I. GENERAL REIMBURSEMENT POLICY

The State of New Mexico Human Services Department (hereafter called the Department) will reimburse inpatient hospital services in the following manner:

- A. Covered inpatient services provided to eligible recipients admitted to acute care hospitals and acute care inpatient units will be reimbursed at a prospectively set rate, determined by the methodology set forth in Section III of this plan, unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in subsections C through D below.
- B. Covered inpatient services provided to eligible recipients admitted to acute care hospitals and acute care units within hospitals located in border areas (within 100 miles of the New Mexico border, Mexico excluded) will be reimbursed at a prospectively set rate as described in Section III.C.16 of this plan unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in Subsection C through D below. Out of state hospitals (more than 100 miles from the New Mexico border, Mexico excluded) will be paid at the same rate as border hospitals or at a negotiated rate not to exceed the rate paid by federal programs such as Medicare. Negotiation of rates will only be allowed when the department determines that the hospital provides a unique service required by an eligible recipient.
- C. Inpatient services provided in rehabilitation and specialty hospitals and Medicare PPS-exempt distinct part units within hospitals will be reimbursed using the provisions and principle of reimbursement set forth in Public Law 97-248. This legislation, which was effective October 1, 1982, is commonly referred to as TEFRA (Tax Equity and Finance Reduction Act) and is described in Section II of this plan.

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Pediatric, psychiatric, substance abuse, and rehabilitation cases treated in non-exempt general acute care hospitals or non-PPS exempt units will be included in the PPS.

- D.** Indian Health Services hospitals will be reimbursed using a per diem rate established by the Federal Government.
- E.** New providers entering the Medicaid program will be reimbursed at the peer group median rate for the applicable peer group, until such time as rebasing occurs, unless the hospital meets the criteria for prospective payment exemption as described in subsection C and D above.
- F.** All hospital which meet the criteria in Section IV.A of this plan will be eligible for a disproportionate share adjustment.
- G.** Effective for discharges on or after April 1, 1992, and in accordance with Section 4604 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Department provides for an outlier adjustment in payment amounts for medically necessary inpatient services involving exceptionally high costs or long lengths of stay for children who have not attained the age of six years in disproportionate share hospitals, and for infants under age one in all hospitals. The outlier adjustment for these cases is described in Section III. F. of this plan.
- H.** Effective October 1, 2020, the Diagnosis Related Group (DRG) provider-specific rates described in New Mexico Disaster SPA 20-0005 are terminated. Thereafter, the DRG payment will revert to the reimbursement methodology outlined in subsections A through C of Methods and Standards for Establishing Payment Rates – Inpatient Hospital Services.

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I. Payment Adjustment for Provider Preventable Conditions

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19(A) of this State plan.

X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19(A) of this State plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

___ Additional Other Provider-Preventable Conditions identified below:

NOT APPLICABLE

Effective July 1, 2011, reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Provider-Preventable Conditions are defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any Health-Care Acquired Conditions (HCAC). For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number of days associated with diagnoses not present on admission for any HCAC. The number of reduced days shall be based on the average length of stay (ALOS) on the diagnosis tables published by the ICD vendor used by the New Mexico Medicaid program.

No payment shall be made for inpatient services for Other Provider Preventable Conditions (OPPCs). OPPCs include the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in Provider payment may be limited to the extent that the following apply:

- i. The identified provider-preventable conditions would otherwise result in an increase in payment.
- ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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II. PAYMENT METHODOLOGY FOR PPS-EXEMPT HOSPITALS AND EXEMPT UNITS WITHIN HOSPITALS

A. Application of TEFRA Principles of Reimbursement

1. The principles and methods identified in Public Law 97-248 provision (TEFRA), effective October 1, 1982, regarding allowable payment for inpatient hospital services, and any subsequent changes to such provision shall be used to determine:
 - ° The amount payable by the Department through its fiscal agent for services covered under the Medical Assistance Program and provided to Title XIX recipients; and
 - ° The manner of payment and the manner of settlement of overpayments and underpayments for inpatient services provided by hospitals for Title XIX reimbursement purposes, effective for all accounting periods which begin on or after October 1, 1983.
2. The inflation factor used in the calculations will be identical to that used by Medicare to update payments to hospitals which are reimbursed using the TEFRA methodology, except for services rendered during the period October 9, 1991, through September 30, 1992, for which the inflation factor will be .5% for urban hospitals and 1.5% for rural hospitals.
3. In accordance with Section 1902 (s)(3) of the Social Security Act effective July 1, 1991, the TEFRA rate of increase limit for inpatient hospital services will not apply to the delivery of such services to any individual who has not attained their first birthday (or in the case of such individual who is an inpatient on his first birthday until such individual is discharged).

B. Appeals

1. Hospitals may appeal the target rate and application of same, if circumstances beyond the hospitals' control have caused the reimbursement rates to fall at least five percent below actual allowable costs.
2. Such appeals must be filed in writing within 180 days of the notice of final settlement and must contain sufficient supporting documentation to demonstrate that the circumstances causing the situation were not

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within the control of the hospital and that the continued imposition of the target rate would cause a significant financial hardship.

3. The Department shall review the supporting documentation and, if appropriate, grant an exemption from or modification of the target rate. The Department's determination on the merits of the appeal will be made within 180 days of receipt of the appeal request, although the State may make a determination to extend such period to a specified date as necessary.

III. PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS

Payment for all covered inpatient services rendered to Title XIX recipients admitted to acute care hospitals (other than those identified in Section I, subsections C through E) on or after October 1, 1989 shall be made based on a prospective payment approach which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. The prospective rates for each hospital's Medicaid discharges will be determined by the Department in the manner described in the following subsections.

A. Services Included In or Excluded From the Prospective Payment Rate

1. Prospective payment rates shall constitute payment in full for each Medicaid discharge. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except as described below. Hospitals may submit a claim for payment only upon the final discharge of a patient or upon completion of the transfer of the patient to another acute care hospital.
2. The prospective payment rate shall include all services provided to hospital inpatients, including:
 - a. All items and non-physician services furnished directly or indirectly to hospital inpatients, including but not limited to 1) laboratory services; 2) pacemakers and other prosthetic devices including lenses and artificial limbs, knees and hips; 3) radiology services including computed tomography (CT) or magnetic resonance imaging (MRI) scans furnished to patients by a physician's office, other hospital or radiology

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clinic; 4) transportation, (including transportation by ambulance), to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services.

3. Services which may be billed separately include:

- a. Ambulance service when the patient is transferred from one hospital to another and is admitted as an inpatient to the second hospital.
- b. Physician services furnished to individual patients.

B. Computation of DRG Relative Weights

1. Relative weights used for determining rates for cases paid by DRG under the State Plan shall be derived, to the greatest extent possible, from New Mexico Medicaid hospital claim data. All such claims are included in the relative weight computation, except as described below.
2. Hospital claim data for discharges occurring from January 1, 1985 through approximately the end of calendar year 1988 are included in the computation and prepared as follows:
 - a. Claims are edited to merge interim bills from the same discharge.
 - b. All Medicaid inpatient discharges will be classified using the Diagnostic Related Group (DRG) methodology, a patient classification system that reflects clinically cohesive groupings of inpatient cases which consume similar amounts of hospital resources. Claims are assigned to appropriate DRGs using Version 6.0 of the Health Systems International DRG grouper software.
 - c. Claims included in the computation of DRG relative weights were restricted to those claims for cases to be included in the proposed PPS. Claims for services provided in PPS-exempt hospitals or units (or for services otherwise exempt from the PPS) were not used to compute DRG relative weights.
3. Charges for varying years are adjusted to represent a common year through application of inflation indices as described in Section III.C.8 of this plan.

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4. Initial relative weights are computed by calculation of the average Medicaid charge for each DRG category divided by the average charge for all DRGs.
5. Where the New Mexico Medicaid-specific claims and charge data are insufficient to establish a stable relative weight, a relative weight is imported from other sources such as the CHAMPUS or Medicare prospective payment systems. Weights obtained from external sources are normalized so that the overall case mix is 1.0.
6. The relative weights computed as described above shall remain in effect until the next year. At that time, the relative weights will be recalculated using whatever DRG Grouper version is currently in use by Medicare.

C. Computation of Hospital Prospective Payment Rates

1. Rebasing of Rates

Beginning October 1, 1997, the Department will discontinue the rebasing of rates every three years. Hospital rates in effect October 1, 1996 will be updated by the most current Market Basket Index (MBI) as determined by the Health Care Financing Administration (HCFA) for rates effective October 1, 1997. Thereafter, rates will be updated every October 1 using the MBI adjusted for any past forecast corrections.

2. Base Year Discharge and Cost Data

- a. The State's fiscal agent will provide the Department with Title XIX discharges for the provider's last fiscal year which falls in the calendar year prior to Year 1.

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- Effective for services on or after October 1, 1997, the rates that were in effect as of October 1, 1996 will be updated.
- Effective April 1, 2014, base rates will be increased for all Safety Net Care Pool (SNCP) qualifying hospitals by 124 percent. Effective July 1, 2014, those rates will decrease to an amount equal to the pre-April 1, 2014 rate times 1.62 (increasing the historical rate by 62 percent). For the University of New Mexico Hospital the rates will be increased by 90 percent and 45 percent, respectively.

In accordance with the above paragraph, hospital rates will be set as of April 1, 2014 and be effective for services performed on or after that date and until June 30, 2014. Revised rates will be set as of July 1, 2015 and be effective for services performed on or after that date until such time as the State makes future rate adjustments. Inpatient hospital rates base rates and capital pass through amounts are reduced 5% effective July 1, 2016. Inpatient hospital rates base rates and capital pass through amounts are increased by 14 percent for Safety Net Care Pool (SNCP) hospitals; 5 percent for the University of New Mexico Hospital; and 12 percent for all other in-state hospitals effective July 1, 2019. Except as otherwise noted in the state plan both governmental and private providers are paid the same. All rates are published on the Department's website at <http://www.hsd.state.nm.us/providers/fee-schedules.aspx> Notice of changes to rates will be made as required by 42 CFR 447.205.

- No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
- The rates will be updated annually for inflation, effective October 1 each year, using the methodology in paragraph C. I.
- Cost reporting periods ending in 1993 are used as the base year for the rates in effect as of October 1, 1996. The October 1, 1996 base year cost per discharge was determined from Title XIX discharges from audited or desk reviewed cost reports for reporting periods ending in calendar year 1993 and inflated forward to the midpoint of the federal fiscal year 1997 using the update factors specified in III.C.8- as described in paragraphs C.2.b. through C.13 below.
The operating cost per discharge and the excludable cost per discharge as of October 1, 1996 will be combined into one base year cost per discharge. The combined base year cost per discharge will be updated for inflation using the update factor in paragraph C. I.
- The excludable cost per discharge will be handled in the same manner as described in III.E.
- The methodology described in paragraphs C.2.b. through C.13 below represent the methodology in effect prior to October 1, 1997 and is retained intact in the state plan solely to document how the rates in effect as of October 1, 1997 were determined.

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- b. The State's audit agent will provide Title XIX costs incurred, reported, audited, and/or desk audited for the same period.
 - c. To calculate the total reimbursable inpatient operating costs from the cost and discharge data described above, the Department will:
 - Exclude estimated outlier discharges and costs as described in Section III.C.4 of this plan.
 - Exclude pass-through costs, as identified in Public Law 97-248 (TEFRA) provisions and further defined in subsection C.3 below.
 3. Definition of Excludable Costs Per Discharge; Reduction of Excludable Capital Costs
 - a. The approach used by the Department to define excludable costs parallels Medicare's approach. Excludable costs are defined according to the PPS or TEFRA methodology and include such costs as those associated with capital, organ acquisition, and certified nurse anesthetists.
 - b. The pass-through capital costs identified using TEFRA [provisions will be reduced in a manner similar to that employed by the Medicare PPS. For example, excludable capital costs for fiscal year 1989 will be reduced by 15 percent as required by Section 4006 of Public Law 100-203 (Omnibus Budget Reconciliation Act of 1987). However, any such reduction to pass-through capital costs will only apply to those costs incurred after October 1, 1989.
 4. Outlier Adjustment Factors

Hospital-specific outlier adjustment factors will be used to deduct outlier costs and cases from the total Medicaid inpatient operating costs and cases used in rate setting. These factors will be determined by using actual claim and cost data for outlier cases for the base year period. Only claims for cases to be paid by DRG will be included in the analysis used to determine this estimate. The definition of an outlier case can be found in Section III.F.1. of this plan.

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5. Calculation of Base Year Operating Cost Per Discharge

The total reimbursable inpatient operating cost (excluding pass-through costs and estimated outlier costs) is divided by the hospital's number of non-outlier Medicaid discharges to produce the base year operating cost per discharge. The base rate methodology is described below.

$$\text{BYOR} = \frac{\text{OC}}{\text{D}}$$

BYOR = Base year operating cost per discharge

OC = Total Title XIX inpatient operating cost for the base year, less excludable costs and estimated outlier costs

D = Medicaid discharges for the hospital's base year as provided by the Department's fiscal agent, less estimated outlier cases.

6. Possible Use of Interim Base Year Operating Cost Per Discharge Rate.

a. If the fiscal agent and audit agent have not provided the Department with a hospital's base year discharges and costs as of June 1 prior to Year 1, the Department will develop an interim operating cost per discharge base rate. This rate will be developed according to the normal base rate methodology, but using costs and discharges for the fiscal year prior to the base year.

b. When an interim rate is developed, the operating costs per discharge are first multiplied by an inflation index (as described in Section III.C.8 of this plan) to bring the costs to the midpoint of the base year. When the provider's actual base year costs and discharges become available, the Department will calculate a final base year operating cost per discharge using the normal base rate methodology. The rate that is computed from the final base year operating costs per discharge will apply to all discharges in Year 1, retroactive to the effective date of the interim rate.

7. Prohibition Against Substitution or Rearrangement of Base Year Cost Reports

a. A hospital's base year cost reports cannot be

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substituted or rearranged once the Department has determined that the actual cost submission is suitable. A submission shall be deemed suitable 180 days from the date of the Notice of Proposed Rate (NPR) issued by the State's intermediary in the absence of an appeal by the hospital to the intermediary and the State.

- b. In the event of such an appeal, the State must make a written determination on the merits of the appeal within 180 days of receipt, although the State may make a determination to extend such period to a specified date as necessary. Once such an appeal has been determined, the resulting base cost will be effective retroactively to Year 1 and will not be changed until subsequent rebasing of all hospitals has been completed.

8. Application of Inflation Factors

- a. The inflation factors used to update operating costs per discharge will be identical to those established by Congress and adopted for use by the Health Care Financing Administration (HCFA) to update Medicare inpatient prospective payment rates. The Medicare prospective payment update factor (MPPUF) is determined by HCFA, usually on an annual basis, and may differ depending upon the hospital type (urban, large urban, or rural) as defined by HCFA.
- b. Each hospital's base year operating cost per discharge will be indexed up to the common point of December 31 falling prior to Year 1, using the applicable Medicare prospective payment update factors (MPPUF) for that hospital for that period. That is, the inflation factors used will be identical to those established by Congress and adopted for use by HCFA to update Medicare inpatient prospective payment rates, including any established differential for urban and rural hospitals. Then this value will be indexed using the applicable MPPUF corresponding to the period beginning October 1 (prior to Year 1) and ending with the midpoint of operating Year 1. For Years 2 and 3, the inflation factors will be the applicable MPPUF as specified by HCFA.
- c. For the period October 9, 1991, through September 30, 1992, an exception to a. and b. above will be

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made. The inflation factor used to update rates for that period will be .5% for urban hospitals and 1.5% for rural hospitals.

9. Case Mix Adjustments for Base Year Operating Cost Per Discharge Rate

- a. The Department will adjust the operating cost per discharge rate to account for case-mix changes, based on the classification of inpatient hospital discharges according to the Diagnostic Related Group (DRG) methodology established and used by the Medicare program.
- b. For each DRG, the Department determines a relative value (the DRG relative weight) which reflects the charges for hospital resources used for the DRG relative to the average charges of all hospital cases. The Department's methodology for computing DRG relative weights was discussed earlier in Section III, subsection B. Case-mix adjustments will be computed using the methodology described below:

Case-Mix Computation

Each base year, a hospital's case-mix index will be computed by the Department and its fiscal agent as follows:

- All Title XIX discharges are assigned to appropriate DRGs.
- The case-mix index is computed for each hospital by summing the products of the case frequency and its DRG weight and dividing this sum by the total number of Title XIX cases at the hospital.

The case-mix adjustment is applied to the base year operating cost per discharge as described in Section III.C.10.d below.

10. Limitations on Operating Cost Prospective Per Discharge Rates

- a. Limitations on operating cost prospective base rates will be imposed using a peer group methodology. Effective October 1, 1989, hospitals will be placed in one of six possible peer groups

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(Teaching, Referral, Regional, Low-volume Regional, Community and Low-volume Community) based on the following criteria: bed size, case-mix, services available, population served, location, trauma designation, teaching status, and low-volume (i.e. less than 150 Medicaid discharges per year.)

At the time of the next rebasing year following October 1, 1989, the criteria regarding low-volume will be dropped along with the low-volume peer groups, thus leaving four possible peer groups for assignment: (Teaching, Referral, Regional and Community).

- b. The Department will determine the peer group assignment of each hospital, and appeal of such assignment will be allowed only as described in Section III.D.1 of this plan.
- c. A ceiling on allowable operating costs will be set at 110 percent of the median of costs for all hospitals in the peer group, after application of each hospital's case mix and indexing of the cost from the hospital's fiscal year end to a common point of December 31. These adjustments are made to equalize the status of each hospital for ceiling establishment purposes. The median shall be the midpoint of rates (or the average of the rates of the two hospitals closest to the midpoint).
- d. The case-mix equalization for each hospital in a peer group will be calculated as follows:

$$\text{PGR} = \frac{\text{BYOR}}{\text{CMI}}$$

PGR = Hospital rate equalized for peer group comparison

BYOR = Base year operating cost per discharge

CMI = Case-mix index in the base year

- e. The allowable operating cost per discharge rate (hospital-specific rate) will be the lower of:
 - o The ceiling for the hospital's peer group; or

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- The hospital rate resulting from the computation found in Section III.C.10.d. above.

11. Computation of Prospective Operating Cost Per Discharge Rate

The following formulas are used to determine the prospective operating cost per discharge rate for Years 1, 2, and 3:

Year 1

$$PDO1 = HSR \times (1 + MPPUF)$$

PDO1 = Per discharge operating cost rate for Year 1

HSR = The hospital-specific rate, which is the lower of the peer group ceiling or the hospital's rate, equalized for peer group comparison

MPPUF = The applicable Medicare prospective payment update factor as described in Section III.C.8

Year 2

$$PDO2 = PDO1 \times (1 + MPPUF)$$

PDO2 = Per discharge operating cost rate for Year 2

PDO1 = Per discharge operating cost rate for Year 1

MPPUF = The applicable Medicare prospective payment update factor as described in Section III.C.8

Year 3

$$PDO3 = PDO2 \times (1 + MPPUF)$$

PDO3 = Per discharge operating cost rate for Year 3

PDO2 = Per discharge operating cost rate for Year 2

MPPUF = The applicable Medicare prospective payment update factor as described in Section III.C.8

12. Computation of Excludable Cost Per Discharge Rate

Total Medicaid excludable cost, as identified in Public Law 97-248 (TEFRA), with excludable capital costs reduced as indicated in Section III.C.3, will be paid in the following manner:

- a. An excludable cost per discharge rate is computed

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using the following methodology:

ER = ECP/DCY

ER = Excludable Cost Per Discharge Rate

ECP = Excludable costs on the hospital's most recently settled cost report prior to the rate year, as determined by the audit agent

DCY = Medicaid discharges for the calendar year prior to the rate year, as determined by the Department's fiscal agent

b. The retrospective settlement will be determined based on the actual allowable amount of Medicaid excludable costs incurred by a hospital during the hospital's fiscal year.

13. Computation of Prospective Per Discharge Rate

The excludable cost per discharge, as described in Section III.C.12 above, will be added to the appropriate operating per discharge rates to determine the prospective rates.

14. Effective Dates of Prospective Rates

Rates will be effective for implementation October 1, 1989 and effective thereafter as of October 1 of each year for each hospital.

15. Effect on Prospective Payment Rates of a Change of Hospital Ownership

When a hospital is sold or leased, no change is made to the hospital's per discharge rate as a result of the sale or lease transaction.

16. Rate Setting for Border-Area Hospitals

Border-area hospitals will be reimbursed at median rate (including excludable cost pass-throughs) for the Regional peer group.

D. Changes to Prospective Rates

1. Appeals

Hospitals may appeal for a change in the operating component of the prospective payment rate, including a

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change in peer group assignment, as applicable. For an appeal to be considered, the hospital must demonstrate in the appeal that:

a. The following five requirements are satisfied:

- 1) The hospital inpatient service mix for Medicaid admissions has changed due to a major change in scope of facilities and services provided by the hospital.
- 2) The change in scope of facilities and services has satisfied all regulatory and statutory requirements which may be applicable, such as facility licensure and certification requirements and any other facility or services requirements which might apply.
- 3) The expanded services were a) not available to Medicaid patients in the area or b) are now provided to Medicaid patients by the hospital at a lower reimbursement rate than would be obtained in other hospitals providing the service.
- 4) The magnitude of the proposed (as appealed) prospective per discharge rate for the subsequent year will exceed 105 percent of the rate that would have otherwise been paid to the hospital.
- 5) In addition to requirements 1-4 above, appeals for rate adjustment will not be considered if cost changes are due to changes in hospital occupancy rate, collective bargaining actions, changes in hospital ownership or affiliation, or changes in levels of rates of increases of incurred cost items which were included in the base rate.

b. The appeal must provide a specific recommendation(s) regarding the magnitude of alterations in the appellant's prospective rate per discharge and peer group reassignment, as applicable. In making its decision on any appeal, the Department shall be limited to the following options:

- 1) Reject the appeal on the basis of a failure of the appellant to demonstrate necessary

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conditions and documentation for an appeal as specified in 1.a. above; or

- 2) accept all of the specific recommendations, as stated in the appeal, in their entirety; or
- 3) adopt modified versions of the recommendations as stated in the appeal; or
- 4) reject all of the recommendations in the appeal.

- c. Hospitals are limited to one appeal per year, which must be filed in writing by a duly authorized officer of the hospital no later than July 1 of each year. Within 15 calendar days of the filing date, the Department shall offer the appellant the opportunity for hearing of the appeal. If such a hearing is requested, it shall occur within 30 days of the filing date. The Department shall notify the appellant of the decision of the appeal in writing no later than September 15 of the year in which the appeal is filed.

E. Retroactive Settlement

1. Retroactive settlement may occur in those cases in which no audited cost reports were available at the time of rate setting and an interim rate was used. Retroactive settlement will only occur in those cases where adjustments to interim rates are required.

The Department's audit agent will determine the difference between payments to the hospital under the interim operating cost per discharge rate and what these payments would have been under the final rate. The audit agent will report the amount of overpayment or underpayment for each facility within 90 days of the effective date of the final rate. Retroactive settlements will be based on actual claims paid while the interim rate was in effect.

2. Underpayments: In the event that the interim rate is less than the final rate, the Department will include the amount of underpayment in a subsequent payment to the facility within 30 days of notification of underpayment.

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3. In the event that the interim rate exceeds the final rate, the following procedure will be implemented:

The facility will have 30 days from the date of notification of overpayment to submit the amount owed to the Department in full. If the amount is not submitted on a timely basis, the Department will begin withholding from future payments until the overpayment is satisfied in full.

4. Retroactive settlements for excludable costs will be handled in the same manner as described above.

F. Special Prospective Payment Provisions

1. Outlier Cases

Effective for discharges occurring on or after April 1, 1992, outlier cases are defined as those cases with medically necessary services exceeding \$100,000 in billed charges, or those with medically necessary lengths of stay of 75 days or more, when such services are provided to children who have not attained the age of six years in disproportionate share hospitals, and to infants under age one in all hospitals. Effective July 1, 2019 these cases will be removed from the DRG payment system and paid at an amount equal to 90% of the hospital's standardized cost. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost- to-charge ratio as calculated from the hospital's most recent cost report.

Utilization review will be performed on all outlier cases to determine the medical necessity of services rendered. Should this review determine non-medical necessity for all or part of the services, these services will be deducted from the billed amount prior to payment.

2. Payment for Transfer Cases

- a. All cases transferred from one acute care hospital to another will be monitored under the utilization review policy to ensure that the Department does not pay for inappropriate transfers.
- b. The following methodology will be used to reimburse the transferring and discharging hospitals for appropriate transfers if both hospitals and any hospital units involved are

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included in the PPS:

- 1) A hospital inpatient shall be considered "transferred" when he or she has been moved from one acute inpatient facility to another acute inpatient facility. Movement of a patient from one unit to another unit within the same hospital shall not constitute a transfer, unless the patient is being moved to a PPS exempt unit within the hospital.
 - 2) The transferring hospital will be paid the lesser of standardized costs or the appropriate DRG payment amount. Should the stay in the transferring hospital qualify for an outlier payment, then the case will be paid as an outlier as described in III.F. of this plan. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio.
 - 3) The receiving hospital which ultimately discharges the patient will receive the full DRG payment amount, or if applicable any outlier payments associated with the case. All other hospitals which admitted and subsequently transferred the patient to another acute care hospital during a single spell of illness shall be considered transferring hospitals.
- c. If the transferring or discharge hospital or unit is exempt from the PPS, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or unit.

3. Payment for Readmissions

Readmissions occurring within 15 days of prior acute care admission for a related condition will be reviewed to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the Department.

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4. Payment for Inappropriate Brief Admissions

Hospital stays of up to two days in length will be reviewed for medical necessity and appropriateness of care. (Discharges involving healthy mothers and healthy newborns are excluded from this review requirement). If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient discharge will be denied. If the inpatient claim is denied, the hospital is permitted to resubmit an outpatient claim for the services rendered. Such review may be further focused to exempt certain cases at the sole discretion of the Department.

5. Payment for Non-Medically Warranted Days

- a. Reimbursement for hospital patients receiving services at an inappropriate level of care will be made at rates reflecting the level of care actually received. The number of days covered by the Medicaid program is determined based only upon medical necessity for an acute level of hospital care.
- b. When it is determined that an individual no longer requires acute-level care but does require a lower level of institutional care, and when placement in such care cannot be located, the hospital will be reimbursed for "awaiting placement" days. Reimbursement will be made at the weighted average rate paid by the Department in the preceding calendar year for the level of care needed. There is no limit on the number of covered "awaiting placement" days as long as those days are medically necessary. However, the hospital is encouraged to make every effort to secure appropriate placement for the individual as soon as possible. During "awaiting placement" days, no ancillary services will be paid, but medically necessary physician visits will be reimbursed.

6. Sole Community Hospital Payment Adjustment

Effective for the quarter beginning July 1, 1993, in-state acute care hospitals that qualify as Sole Community Hospitals are entitled to receive a sole community hospital payment adjustment in accordance with the provisions specified below:

- a. To qualify for a sole community hospital payment adjustment, an acute care hospital must meet the Medicare classification criteria for a sole community hospital as set forth at 42CFR 412.92 as of July 1, 1993 and retain such qualification regardless of a subsequent change in their Medicare classification. The hospital must qualify for a sole community hospital designation in the month prior to the effective date for the sole community adjustment. If a hospital already has a sole community designation from Medicare, this designation will be accepted by the Medicaid program. If for some reason, the hospital elected not to apply for sole community hospital designation under Medicare but wishes to apply for Medicaid purposes only, such application must be made directly to the Medicaid program. The Medicaid program will review the application in accordance with the criteria contained at 42 CFR 412.92. Any new acute care general hospital entering the program who wish to qualify for a sole community hospital designation must meet all of the criteria contained at 42 CFR 412.92 (a) with the exception of being located more than 35 miles from other like hospitals. The new hospital must also be enrolled as a Medicaid provider for a minimum of one year in order to received the sole community hospital designation.
- b. For an in-state acute care hospital that qualifies as a sole community hospital in accordance with paragraph (a) above, the Department will made a quarterly sole community hospital payment at the end of each quarter. For the initial payment year (July 1, 1993, through June 30, 1994), the payment is the amount specified under paragraph (c) below. For subsequent years, the amount will be the amount calculated under paragraph (d) through (f) below. *
- c. For the initial payment year, the sole community hospital payment amount will be equal to the amount the hospital received from county government, either through the County Indigent Claims Act or by mill levy revenues dedicated to supporting the hospital's operating expenses, for calendar year 1992 (the base year) plus the inflation factor described in §III.C.8. of this plan. Verification of the base year amount will be made from the official report of expenditures by each county. Hospitals will have the opportunity to challenge the amount by filing an appeal with the Department within 30 days from the date they receive notice from the state of their sole community payment amount. If the hospital qualifies for the sole community designation later than the effective date of this plan amendment, the Medicaid program will prorate the sole community payment adjustment for the first quarter from the date of qualification to the end of that

* Pen & ink change made per State's request.

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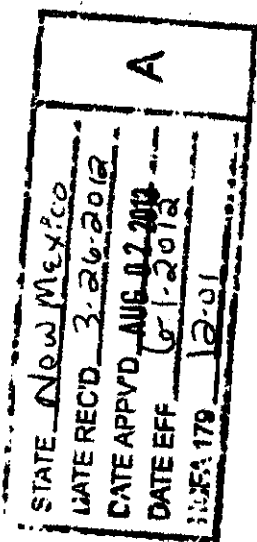
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quarter.

- d. For each subsequent plan year, the sole community hospital is required to submit to the Department, no later than January 15 for the subsequent state fiscal year, a sole community hospital payment request. If the hospital cannot meet the January 15 deadline, the hospital may submit a written request for up to 30 day extension. Such requests must be received prior to the January 15 deadline.
- e. The sole community provider payment request must be reviewed and approved by the county government in which the hospital is located. In order for the request to be valid, the county government's approval must be submitted with the hospital's request. If the hospital does not submit a valid request within the time frame identified above, it will not be eligible for a sole community provider adjustment for that year regardless of the hospital's status as a sole community hospital.
- f. For years subsequent to the initial payment year, the sole community hospital payment adjustment will be determined as follows:
- (i) for public hospitals for state fiscal years through state fiscal year 2012 (except for Miners Colfax Medical Center for state fiscal year 2012) and for private hospitals for state fiscal years through state fiscal year 2011, the Department will make base payments that will be the lesser of the amount paid by the Department for the previous year trended forward or the amount requested by the hospital and approved by the county government. The Department will use the market basket forecast published periodically in the CMS Regional Medical Services letter, or an amount mutually agreed upon by the hospital and the county government, to trend the previous year's payment.
 - (ii) for public and private hospitals for state fiscal years through state fiscal year 2011, the Department will calculate the Medicare payment limit (specified at 42 CFR 447) annually. If the base payments have not caused the upper limit to have been exceeded additional payments will be distributed by the Department based on hospital requests approved by the county government up to the upper payment limit. Should the amounts requested by the hospitals exceed the amount available under the upper payment limit, the amounts will be prorated and distributed based on the amount of the request received by the Department.
 - (iii) For private hospitals for state fiscal year 2012, the Department's payments applicable to the year shall be the amounts listed below, less the four quarterly amounts paid to those hospitals for state fiscal year 2012 pursuant to the provisions of the plan applicable to sole community provider payments in those quarters.



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Private Hospital Payments for 2012

Carlsbad Regional Hospital	\$2,885,081
Eastern New Mexico MC	\$192,380
Espanola Hospital	\$3,137,794
Gerald Champion Hospital	\$3,389,535
Lea Regional Hospital	\$90,305
Los Alamos Hospital	\$851,303
Mimbres Memorial Hospital	\$915,532
Mountain View Regional MC	\$1,593,106
Plains Regional Medical Center	\$1,714,068
Rehobeth McKinley Christian Hosp.	\$8,745,789
Roswell Hospital	\$687,621
Socorro General Hospital	\$3,483,302
St. Vincent's Medical Center	\$3,192,332

(iv) For Miners Colfax Medical Center for state fiscal year 2012, the Department's payments applicable to the year shall be \$917,128, less the four quarterly amounts paid to that hospital for state fiscal year 2012 pursuant to the provisions of the plan applicable to sole community provider payments for those quarters.

(v) For private hospitals for state fiscal year 2013, the Department's payments applicable to the year shall be the amounts listed below:

Private Hospital Payments for 2013

Alta Vista Hospital	\$360,062
Carlsbad Medical Center	\$ 3,284,544
Eastern NM Medical Center	\$ 2,557,820
Espanola Hospital	\$2,192,942
Gerald Champion Hospital	\$2,242,559
Lea Regional Hospital	\$1,755,324
Los Alamos Medical Center	\$513,672
Mimbres Memorial Hospital	\$1,789,294
Mountain View Regional Center	\$ 1,128,693

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Plains Regional Medical Center	\$3,109,506
Rehoboth McKinley Hospital	\$4,166,895
Roswell Hospital	\$1,261,555
Socorro General Hospital	\$2,071,347
St. Vincent's Medical Center	\$4,456,857

- (vi) For public hospitals (other than the State University Hospital) for state fiscal year 2013, the Department's payments applicable to the year shall be the amounts listed below:

Artesia Hospital	\$42,962
Cibola General Hospital	\$1,199,854
Dan C. Trigg Hospital	\$566,040
Gila Regional Medical Center	\$2,167,326
Guadalupe County Hospital	\$560,072
Holy Cross Hospital	\$749,113
Lincoln County Medical Center	\$500,747
Memorial Medical Center	\$ 4,360,647
Nor-Lea General Hospital	\$175,886
Roosevelt General Hospital	\$393,373
San Juan Regional Medical Center	\$4,173,338
Sierra Vista Hospital	\$490,974
Union County General Hospital	\$284,783
Miners Colfax Medical Center	\$228,603

- (vii) For private hospitals for state fiscal year 2014, the Department's payments applicable to the first half of the year shall be the amounts listed below:

Carlsbad Medical Center	\$1,590,651
Eastern NM Medical Center	\$1,223,163
Espanola Hospital	\$ 1,115,585
Gerald Champion Hospital	\$1,332,463

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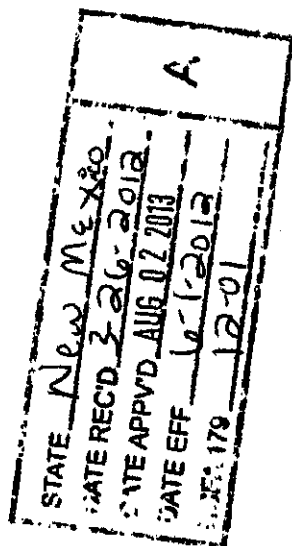
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Lea Regional Hospital	\$574,162
Los Alamos Medical Center	\$346,104
Mimbres Memorial Hospital	\$956,193
Mountain View Regional Center	\$760,495
Plains Regional Medical Center	\$879,323
Rehoboth McKinley Hospital	\$2,395,044
Roswell Hospital	\$ 221,761
Socorro General Hospital	\$1,219,399
St. Vincent's Medical Center	\$ 2,831,192

(viii) For public hospitals (other than the State University Hospital) for state fiscal year 2014 the Department's payments applicable to the first half of the year shall be the amounts listed below:

Artesia General Hospital	\$24,859
Cihola General Hospital	\$623,777
Dan C. Trigg Hospital	\$327,524
Gila Regional Medical Center	\$1,143,049
Guadalupe County Hospital	\$323,931
Holy Cross Hospital	\$ 275,222
Lincoln County Medical Center	\$184,573
Memorial Medical Center	\$2,055,120
Miners' Colfax Medical Center	\$114,302
Nor-Lea General Hospital	\$101,772
Roosevelt General Hospital	\$227,614
San Juan Regional Medical Center	\$2,096,246
Sierra Vista Hospital	\$284,089
Union County General Hospital	\$164,782



7. State Operated Teaching Hospital Adjustment

Teaching hospitals (as defined in section 4.19-A.III.F.8.a operated by

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the State of New Mexico or an agency thereof, shall qualify for an inpatient State Operated Teaching Hospital rate adjustment. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's Medicare-related upper payment limit (specified at 42 CFR 447.272). The Department will calculate the Medicare upper payment limit for State Operated Teaching Hospitals annually. If the upper payment limit has not been exceeded, additional payments will be distributed by the Department to the State Operated Teaching Hospital. The adjustment shall be calculated as follows

- a. Each federal fiscal year, the Department shall determine each State Operated Teaching Hospital's Medicare per discharge rate and Medicaid per discharge rate. The Medicare and/or Medicaid discharge rate will be adjusted to reflect any acuity differences that exist between the Medicare and Medicaid patients served. Acuity differences will be determined from the Medicare and Medicaid case-mix indices (CMI) for Medicaid discharges at the hospital using Medicare and Medicaid DRG weights in effect at the time (using data from the most recent state fiscal year for which complete data is available).
- b. The Medicaid per discharge rate shall be subtracted from the Medicare per discharge rate.
- c. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent state fiscal year. The result shall be the amount of the State Operated Teaching Hospital Adjustment for the current federal fiscal year.
- d. For federal fiscal year 2000, and subsequent federal fiscal years, payment shall be made on an annual basis before the end of the federal fiscal year.
- e. In the event that the State Operated Teaching Adjustment amount exceeds the Medicare-related upper payment limit for that year, the State Operated Teaching Hospital adjustment will be revised by the difference.

8. Indirect medical education (IME) Adjustment:

Effective August 1, 1992, each acute care hospital that qualifies as a teaching hospital will receive an indirect medical education (IME) payment adjustment which covers the increase operating or patient care costs that are associated with approved intern and resident programs.

- a. In order to qualify as a teaching hospital and be deemed eligible for an IME adjustment, the hospital must:
 - 1) Be licensed by the State of New Mexico; and
 - 2) Be reimbursed on a DRG basis under the plan; and
 - 3) Have 125 or more full time equivalent (FTE) residents enrolled in approved teaching programs.
- b. Determination of a hospital's eligibility for an IME adjustment will be done annually by the state, as of the first day of the provider's fiscal year. If a hospital meets the qualification for an IME adjustment after the start of its fiscal year, it will be deemed eligible for the IME adjustment beginning on the first day of the quarter after the date the qualifications were met.
- c. The IME payment amount is determined by multiplying DRG operating payments, which are DRG payments and outlier payments, by the IME adjustment factor computed by the following formula:

$$1.89 * ((1+R)^{405} - 1)$$

Where R equals the number of approved full-time equivalent (FTE) residents divided by the number of available beds (excluding nursery and neonatal bassinets). FTE residents are counted in accordance with 42 CFR 412.105(f) except that the limits on the total number of FTE residents in 412.105(f)(1)(iv) shall not apply and at no time shall exceed 450 residents. For purposes of this paragraph, DRG operating payments include the estimated average per discharge amount that would otherwise have been paid for Medicaid managed care enrollees if those persons had not been enrolled in managed care.

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- d. Quarterly IME payments will be made to qualifying hospitals at the end of each quarter. Prior to the end of each quarter, the provider will submit to the Department's audit agent the information necessary to make the calculation, i.e. number of beds, number of estimated residents for the quarter, and the Medicaid DRG amount. After review and adjustment, if necessary, the audit agent will notify the Department of the amount due to/from the provider for the applicable quarter. Final settlement of the IME adjustment amount will be made through the cost report; that is, the number of beds, residents, and DRG amounts used in the quarterly calculation will be adjusted to the actual numbers shown on the provider's cost report for those quarters.

9. Payment for Direct Graduate Medical Education (GME)

. Payments will be made quarterly to qualifying hospitals, at a rate determined by the number of resident full-time-equivalents (FTEs) in the various categories defined below, who worked at the hospital during the preceding year, and subject to an upper limit on total payments.

- a. To be counted for Medicaid reimbursement, a resident must be participating in an approved medical residency program, as defined by Medicare in 42 CFR 413.75(b). With regard to categorizing residents, as described in paragraph b of this section, the manner of counting and weighting resident FTEs will be the same as is used by Medicare in 42 CFR 413.79 except that the number of FTE residents shall not be subject to the FTE resident cap described in 413.79(b)(2).

Resident FTEs whose costs will be reimbursed by the Department as a medical expense to a Federally Qualified Health Center are not eligible for reimbursement under this section.

To qualify for Medicaid GME payments, a hospital must be licensed by the state of New Mexico, be currently enrolled as a

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Medicaid provider, and must have achieved a Medicaid inpatient utilization rate of 5 percent or greater during its most recently concluded hospital fiscal year. For the purposes of this section, the Medicaid inpatient utilization rate will be calculated as the ratio of New Mexico Medicaid eligible days, including inpatient days paid under Medicaid managed care arrangements, to total inpatient hospital days.

b. Approved resident FTEs are categorized as follows for MAD GME payment:

- 1) **Primary Care/Obstetrics resident.** Primary care is defined per 42 CFR 413.75(b).
- 2) **Rural Health Resident.** A resident is defined as participating in a designated rural health residency program. Residents enrolled in a designated rural health residency program will be counted as a rural health resident FTE for the entire duration of their residency, including those portions of their residency which may be served in a non-rural hospital or clinic. Should any resident meet the criteria for both rural health and primary care in this section, this resident will be counted as a rural health resident.
- 3) **Other approved resident.** Any resident not meeting the criteria in Items 1 or 2, above.

c. **MAD GME payment amount per resident FTE;**

- 1) The annual Medicaid payment amount per resident FTE with state fiscal year 2017 is as follows:

Primary Care/Obstetrics Resident:	\$41,000
Rural Health Resident:	\$52,000
Other Resident:	\$50,000
- 2) The per resident amounts specified in paragraph 9.c.1 will be inflated for state fiscal years beginning on or after July 1, 2017 using the annual inflation update factor described in paragraph 9.d.

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d. Annual Inflation Update Factor:

The Department will update the per resident GME amounts and the upper limit on GME for inflation using the global inflation factor located on Medicaid.gov

e. Annual Upper Limits on GME payments:

- 1) Total annual MAD GME payments will be limited to \$18,500,000 for state fiscal year 2017. This amount will be updated for inflation, beginning with state fiscal year 2018, in accordance with paragraph 9.d.
- 2) Total annual GME payments for residents in Category B.3, "Other," will be limited to the following percentages of the \$5,800,000 total annual limit (as updated for inflation in accordance with paragraph 9.d.)

State fiscal year 1999	58.3 percent
State fiscal year 2000	56.8 percent
State fiscal year 2001	53.3 percent
State fiscal year 2002	50.7 percent
State fiscal year 2003	48.0 percent
State fiscal year 2004	45.5 percent
State fiscal year 2005	43.0 percent
State fiscal year 2006	40.4 percent
State fiscal year 2017 and thereafter - No Limit	

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2) **Reporting and payment schedule:**

- 1) Hospitals will count the number of residents working according to the specification in this part during each fiscal year (July 1 through June 30) and will report this information to the Department by December 31. Counts will represent the weighted average number of residents who worked in the hospitals during the specified 12-month period. Hospitals may also add to this count any FTEs associated with newly approved residency programs that will be implemented on or before the start of the prospective GME payment year, to the extent that these FTEs are not already reflected in the weighted average counts of the preceding year. To illustrate, resident FTE amounts would be counted from 07/01/96 - 06/30/97 for the payment year 07/01/98 - 06/30/99.

The Department may require hospitals to provide documentation necessary to support the summary counts provided.

- 2) The Department will establish the amount payable to each hospital for the prospective payment period that will begin each July 1. Should total payments as initially calculated exceed either of the limitations in paragraph d, the amount payable to each will be proportionately reduced.
- 3) The annual amount payable to each hospital is divided into four equal payments. These payments will be made by the Department on or about the start of each prospective payment quarter.
- 4) Should a facility not report timely with the accurate resident information as required in paragraph 1, above, it will still be entitled to receive payment for any quarter yet remaining in the prospective payment year, after acceptable information has been submitted. However, payments to untimely reporting facilities will be limited to the amount of funds that remains available under the upper limits described in paragraph e, after prospective payment amounts to timely filing facilities have been established.

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IV. DISPROPORTIONATE SHARE HOSPITALS

To take into account the situation of hospitals serving a disproportionate number of low-income patients with special needs, a payment will be made to qualifying hospitals.

B. Criteria for Deeming Hospitals Eligible for a Disproportionate Share Payment

Determination of each hospital's eligibility for a disproportionate share payment for the Medicaid inpatient utilization rate as listed below, will be done annually by the department's audit agent, based on the hospital's most recently filed cost report. Hospitals which believe they qualify under the low income utilization rate must submit documentation justifying their qualification. This documentation should be submitted to the Department by March 31 of each year.

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In the case of a DRG hospital with a PPS exempt specialty unit, data from the entire facility will be considered to determine DSH status.

The following criteria must be met before a hospital is deemed to be eligible:

1. Minimum Criteria

- a. The hospital must have:
 - i. A Medicaid inpatient utilization rate greater than the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state; or
 - ii. A low-income utilization rate exceeding 25 percent. (Refer to subsection 2 for definitions of these criteria.)
- b. The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under Medicaid. In the case of a hospital located in a rural area (defined as an area outside of a Metropolitan Statistical Area (MSA), as defined by the U.S. Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.
- c. Subsection 1b does not apply to a hospital which meets the following criteria:
 - i. The inpatients are predominantly individuals under 18 years of age; or
 - ii. The hospital did not offer non-emergency obstetric services as of December 22, 1987.
- d. The hospital must have, at a minimum, a Medicaid inpatient utilization rate (MUR) of one percent.

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DISPROPORTIONATE SHARE HOSPITALS

A. Criteria for Deeming Hospitals Eligible for a Disproportionate Share Payment:

(3) The following criteria must be met before a hospital is deemed eligible:

(b) Definitions of Criteria:

- (i) Medicaid inpatient utilization: For a hospital, the total of its Medicaid inpatient days in a cost reporting period, divided by the total number of the hospital's inpatient days for the same period. These include both Medicaid managed care and Medicaid non-managed care inpatient days.
- (ii) Low-income utilization rate: For a hospital, the sum (expressed as a percentage) of the following fractions: The sum of total Medicaid inpatient and outpatient net revenues (this includes Medicaid managed care and non-managed care revenues) paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of net revenues of the hospital for inpatient and outpatient services (including the amount of such cash subsidies) in the same reporting period; and the total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, less the amount of the cash subsidies received directly from the state and local governments in that period reasonably attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. If this number is zero or less than zero, then it is assumed to be zero. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid state plan), that is, reductions in charges given to other third-party payers, such as HMOs, Medicare, or Blue Cross.

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- (iii) The Medicaid utilization rate (MUR) is computed as follows:

$$\text{MUR}\% = 100 \times \text{M/T}$$

M = Hospital's number of inpatient days attributable to patients who for these days were eligible for Medical Assistance under the State Plan. These include Medicaid managed care and non-managed care days.

T = Hospitals' total inpatient days.

- (iv) Newborn days, days in specialized wards, and administratively necessary days are included in this calculation. Additionally, days attributed to individuals eligible for Medicaid in another state are included. Medicaid inpatient days includes both Medicaid managed care and non-managed care patient days.

The numerator (M) does not include days attributable to Medicaid patients 21 or older in Institutions for Mental Disease (IMD) as these patients are not eligible for Medicaid coverage in IMDs under the New Mexico State Plan and can not be considered a Medicaid day.

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B. Inpatient Disproportionate Share Pools

Section 1923 of the Social Security Act allows qualifying hospitals to receive a disproportionate share payment, in addition to their allowable regular claims payments and any other payments to which they are entitled. This determination is performed annually as described in section IV.A. Qualifying hospitals will be classified in one of 3 disproportionate share hospital pools: Teaching PPS hospitals, non – teaching PPS hospitals, and PPS – exempt (TEFRA) hospitals. Hospitals may also qualify for a payment from a 4th pool: reserve pool as explained in this section IV.C. below.

1. To qualify as a teaching hospital and be eligible for the teaching hospital DSH payment, the hospital must:
 - a. Be licensed by the State of New Mexico; and
 - b. Reimbursed, or be eligible to be reimbursed under the DRG basis under the plan; and
 - c. Have 125 or more full – time equivalent (FTE) residents enrolled in approval teaching programs.
2. A non – teaching PPS (DRG) hospital qualifies if it is an instate acute care hospital reimbursed by or eligible to be reimbursed by prospective payment methodology.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

A	
STATE <u>New Mexico</u>	
DATE REC'D <u>3-26-2012</u>	
DATE APP'D <u>AUG 02 2013</u>	
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3. A PPS-exempt hospital (TEFRA) such as rehabilitation hospitals, children's hospitals, or free-standing psychiatric hospitals, qualify if it is reimbursed by or eligible to be reimbursed by TEFRA (Tax Equity and Finance Reduction Act) methodology as described in Section II of this policy.
4. The reserve pool is to compensate DSH qualifying hospitals which have had a disproportionate shift in the delivery of services between low-income and Medicaid-covered inpatient days in any given quarter. A hospital will qualify for payment from the reserve pool if its charity ratio, as described in paragraph A.2.b.ii, exceeds 20 percent. A qualifying hospital may receive a payment from the reserve pool in addition to its payment from one of the three other pools.

Disproportionate Share Hospital Payments

The DSH funds allocated to each pool are paid to qualifying hospitals based on the number of Medicaid discharges. These include both Medicaid managed care and non-managed care discharges. A discharge occurs when a patient dies in the hospital, is formally released from the hospital, or is transferred to another hospital or nursing home.

Payments are made quarterly, with the annual amount for the pool divided into four parts, and each part distributed after the end of each quarter based on Medicaid discharges during that quarter. The quarterly payment to each hospital qualifying for DSH pools 1, 2, or 3 will be computed by dividing the number of Medicaid discharges for that hospital by the total number of Medicaid discharges from all hospitals qualifying for that DSH pool and then multiplying this pro rata share by the quarterly allocation for the respective pool. This amount cannot exceed the OBRA 93 DSH limit, which is described in sections IV.E. and IV.F.

The Medical Assistance Division will review the allocation of DSH funds prior to the start of each State Fiscal Year and may re-allocate funds between pools at that time in consideration of shifts in the hospital utilization of Medicaid and low-income / indigent care patients.

In the event that it appears, through audit or otherwise, that a hospital in any year has received a payment that exceeds its OBRA 93 DSH limit, the amount of such excess payment shall be recovered and reallocated to other DSH-eligible hospitals to the extent that such reallocation would not result in payments to such other hospitals in excess of their OBRA 93 DSH limits for the year.

TN No. 12-01

Supersedes TN No. 97-04

Approval Date AUG 02 2013

Effective Date 6-1-2012

The amounts allocated to each pool for state fiscal year 98 are as listed below. The total allocations shall be adjusted in subsequent state fiscal years based on the Medicare Prospective Payment Update Factor (MPPUF) and/or the DSH budget as defined by HSD. The base year DSH budget for state fiscal year 98 is \$22,000,000.00.

- 1) The Teaching PPS hospital DSH pool is 56% of the overall DSH budget, as defined by HSD.
- 2) The Non-teaching PPS (DRG) hospital DSH pool is 22.5% of the overall DSH budget, as defined by HSD.
- 3) The PPS-exempt hospital (TEFRA) DSH pool is 1.5% of the overall DSH budget, as defined by HSD.
- 4) The reserve DSH pool is 20% of the overall DSH budget, as defined by HSD. Quarterly payments may be made directly from the reserve pool to hospitals qualifying for any of the other three DSH pools at the rate of N dollars per Medicaid discharge, where N is equal to the fraction described in paragraph A.2.b.ii of this section minus 20% multiplied by \$1750.

D. Request for DSH Payment Procedures

Hospitals must submit to the Department the number of Medicaid discharges (both managed care and fee for service discharges), which they have incurred 30 days after the end of each quarter. The Department will review the hospital's documentation supporting their discharge information. Any requests received later than 60 days from the end of the quarter will be denied as untimely.

E. DSH Limits

Pursuant to section 1923(g) of the Social Security Act, a limit is placed on the payment adjustment for any hospital. A hospital's payment adjustment determined under sections IV.B. through IV.D. shall not exceed that hospital's hospital-specific DSH limit, as determined under section IV.E. This limit is calculated as follows:

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DSH Limit=M+U

M= Cost of services to Medicaid patients, less the amount paid by the Medicaid program under the non-DSH payment provisions of this plan.

U= Cost of services to uninsured patients, less any cash payments made by them.

The cost of services will include both inpatient and outpatient costs for purposes of calculating the limit. The "costs of services" is defined as those costs determined allowable under this plan.

"Uninsured patients" are defined as those patients who do not possess health insurance or do not have a source of third party payment for services provided, including individuals who do not possess health insurance which would apply to the service for which the individual sought treatment. Payments made to a hospital for services provided to indigent patients made by the State or a unit of local government within the State shall not be considered to be a source of third party payment.

F. Limitations In New Mexico DSH Allotment

If the DSH payment amounts as described in section IV.C. through IV.E. above, exceed in any given year, the federal determined DSH allotment for New Mexico, the DSH allocations by pool will be reduced proportionately to a level in compliance with the New Mexico DSH allotment.

V. DETERMINATION OF ACTUAL, ALLOWABLE, AND REASONABLE COSTS

A. Adequate Cost Data

1. All hospitals must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The hospital will submit a cost report each year.

The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

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2. The cost finding method to be used by hospitals will be the step-down method. This method recognizes that services rendered by certain non-revenue-producing departments or centers are utilized by certain other non-revenue-producing centers/

All costs of non-revenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue-producing center serving the greatest number of other centers while receiving benefits from the least number of centers is apportioned first. Following the apportionment of the cost of the non-revenue-producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later.

Generally when two centers render services to an equal number, that center which has the greatest amount of expense will be allocated first.

B. Reporting Year

For the purpose of determining payment rates, the reporting year is the hospital's fiscal year.

C. Cost Reporting

At the end of each of its fiscal years, the hospital will provide to the department or its audit agent an itemized list of allowable costs (financial and statistical report) on the New Mexico Title XIX cost reporting form. The cost report must be submitted within 90 days after the close of the hospital's fiscal year. Failure to file a report within the 90 day limit, unless an extension is granted, will result in suspension of Title XIX payments, until such time as the report is received.

D. Retention of Records

1. Each hospital will maintain financial and statistical records of the period covered by such cost report for a period of not less than four years following the date of submittal of the New Mexico Title XIX cost report to the Department. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider will make such records available upon demand to representatives of the Department, the State of New Mexico Audit Agent, or the United States Department of Health and Human Services.

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2. The Department or its audit agent will retain all cost reports submitted by providers for a period of not less than three years following the date of final settlement of such reports.

E. Audits

1. Desk Audit: Each cost report submitted will be subjected to a comprehensive desk audit by the State's audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the Department.
2. Field Audit: Field audits will be performed on all facilities as per the auditing schedule established by Medicare. The purpose of the field audit of the facility's financial and statistical records is to verify that the data submitted on the cost report are accurate, complete, and reasonable. The field audits are conducted in accordance with generally accepted auditing standards. Field audits are of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost and to determine whether the expense attributable to such proper items of cost was accurately determined and reasonable.

After each field audit is performed, the audit agent will submit a complete report of the audit to the Department. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate, and reasonable. These audit reports will be retained by the Department for a period of not less than three years from the date of final settlement of such reports. Audits will be performed in accordance with applicable Federal regulations.

F. Overpayments

All overpayments found in audits will be accounted for on the HCFA-64 report in accordance with 42 CFR 433.300 through 42 CFR 433.322.

G. Allowable and Non-Allowable Costs

Allowable costs, non-allowable costs, and reasonableness of costs will be determined as on the basis of the HIM-15.

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VI. PUBLIC DISCLOSURE OF COST REPORTS

- A. As required by law, cost reports submitted by participating providers as a basis for reimbursement are available to the public upon receipt of a written request to the Medical Assistance program audit agent. Disclosure information is limited to cost report documents required by Social Security Administration regulations and, in the case of a settled cost report, the notice of program settlement.
- B. The request must identify the provider and the specific report(s) requested.
- C. The provider whose report has been requested will be notified by the Medical Assistance Program audit agent that its cost report has been requested, by whom the request was made, and that the provider shall have 10 days in which to comment to the requestor before the cost report is released.
- D. The cost for copying will be charged to the requestor.

VII. SEVERABILITY

If any provision of this regulations is held to be invalid, the remainder of the regulations shall not be affected thereby.

SUPERSEDES: NONE - NEW PAGE

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
- OTHER TYPES OF CARE

OMB No.: 0938-1136
CMS Form: CMS-10364

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Page 1

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (B) of this State plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below:
Effective July 1, 2011 reimbursement for services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Effective July 1, 2011, reimbursement for services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

No payment shall be made for services for Other Provider Preventable Conditions (OPPCs). OPPC is one category of Provider Preventable Conditions (PPC), as identified by the Centers for Medicare & Medicaid Services, and applies broadly to any health care setting where an OPPC may occur. OPPCs include the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

- i. The identified provider-preventable conditions would otherwise result in an increase in payment.
- ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

TN No. 11-06

Approval Date DEC - 8 2011

Supersedes TN No. New Page

Effective Date 07-01-11

CMS ID: 7982E

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Reimbursement Template -Physician Services Increased Primary Care Service Payment 42

CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

- ☒ The rates reflect all Medicare site of service and locality adjustments.
- ☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
- ☐ The rates reflect all Medicare geographic/locality adjustments.
- ☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:

Method of Payment

- ☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.
- ☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on the date of service as published in the agency's fee schedule described in Attachment 4.19B, page 3ab - 3b, item 9 (approved 07/09/2007) Physician Services of the State plan and the minimum payment required at 42CFR 447.405.

Supplemental payment is made: ☐ monthly ☒ quarterly

Primary Care Services Affected by this Payment Methodology

- ☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
- ☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes):

99339, 99340, 99363, 99358, 99359, 99360, 99364, 99366, 99367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99386, 99387, 99396, 99397, 99401, 99402, 99403, 99404, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99485, 99486, 99487, 99488, 99489, 99495, 99496, and 99499.

SUPERSEDES: NONE - NEW PAGE

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DATE EFF <u>1-1-13</u>
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(Primary Care Services Affected by this Payment Methodology - continued)

- ☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added):
99224, 99225 and 99226. All were added on 01/01/2011.

Physician Services - Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

- ☐ Medicare Physician Fee Schedule rate
☒ State regional maximum administration fee set by the Vaccines for Children program
☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

- ☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: _____.
- ☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: \$10.94.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

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Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at <http://www.hsd.state.nm.us/mad/PFeeSchedules.html> or under the 'Fee Schedules' section of the 'Provider' section of the Medical Assistance Division website.

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at <http://www.hsd.state.nm.us/mad/PFeeSchedules.html> or under the 'Fee Schedules' section of the 'Provider' section of the Medical Assistance Division website.

Supersedes Page: None

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PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 48 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of NEW MEXICO
POLICIES AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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State: New Mexico
Date Received: 06-30-2016
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Transmittal Number: NM 16-0004

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Physician Services
Increased Primary Care Service Payment
42 CFR 447.405, 447.410, 447.415 for dates of service beginning January 1, 2015
Through June 30, 2016

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

Through dates of service June 30, 2016, the state continues to reimburse for services provided by physicians meeting the requirements of 42 CFR 447.400(a) (with the exceptions noted below) at no less than the Medicare Part B fee schedule rate using the CMS Medicare physician fee schedule rate in effect for the date of service. If there is no applicable rate established by Medicare for the service, an enhanced primary care service payment rate is not applied.

- ☒ The rates reflect all Medicare site of service and locality adjustments.
- ☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
- ☐ The rates reflect all Medicare geographic/locality adjustments.
- ☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

Attestation Requirements:

For the Physician Services Increased Primary Care Services Payment, the state agency continues to follow the provider qualifying circumstances as described in 42 CFR 447.400(a) and used for the 2013-2014 increased payment program; that is, specified board certification or meeting the 60% threshold of services being primary care services identified by procedure codes.

Board Certification

New Mexico Medicaid-enrolled providers who attested and were approved for the 2013 and/or 2014 primary care provider (PCP) enhanced payments whose attestation is still in effect on December 31, 2014, who qualified because they met the board specialty requirements, and who continue to be an approved provider for the New Mexico Medicaid program, will continue to receive PCP enhanced payments until their board certification expires, at which point they will be required to submit documentation of their renewed board certification if the state agency cannot verify their renewal with their board.

Sixty Percent Claims Threshold

To facilitate provider attestation for 2013 and 2014, the state agency produced reports that measured the percent of the provider's Medicaid billing history, including both fee for service and managed care paid claims. These reports showed the percent of the provider's billing that was for the primary care E&M procedure codes, including vaccinations, as a percent of all claims. The state agency will perform this same calculation based on 2014 claims for providers whose approved 2013/2014 attestation was still in effect on December 31, 2014. Any currently attested provider who continues to be an approved provider for the New Mexico Medicaid program will continue to receive the PCP enhanced payment because of their previous attestation and agency approval as long as the provider continues to meet the threshold percentage of 60% primary care codes. This calculation would be performed again in each of the subsequent time periods in which the enhanced payment program is in effect.

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Any currently attested provider who does not meet the 60% threshold requirement will be notified that he or she must re-attest and must be re-approved as meeting the criteria in order to receive the PCP enhanced payment. This same process will be performed each time period that the PCP enhanced payment program continues subsequent to 2015.

Enhanced payment for primary care services is limited to providers who have enrolled through the state agency as approved providers for the Medicaid fee for service program, the Medicaid managed care programs, or both.

New Providers and Providers Attesting for the First Time:

Any provider not having an approved attestation in effect on December 31, 2014 must file a new attestation and be approved prior to receiving PCP enhanced payments for 2015. Any provider attesting for the first time for 2015 or subsequent time periods will not receive PCP enhanced payments for 2013 or 2014.

Attestation Timing Requirements:

A provider will receive increased PCP payments for dates of service beginning the first day of the month following the date the attestation is accepted by MAD.

Approvals of attestations for increased physician primary care services payment will end after May 31, 2016.

Provider Qualifications

Providers not previously allowed to qualify for the enhanced primary care payment increase per 42 CFR 447.400(a) will not be allowed to receive enhanced payments in 2015 or subsequent years, including:

- Providers whose services are reimbursed on the basis of an encounter rate, such as federally qualified health centers, rural health clinics, Indian health service and tribal 638 facilities, unless the service was paid at a fee schedule rate;
- Physician extenders, identified as physician assistants certified nurse practitioners, pharmacist clinicians, and certified nurse midwives unless their supervising physician attests to practicing in one of the specialty designations and qualifies with a board certification or meets the 60% primary care threshold. In the attestation, the supervising physician must accept professional responsibility and legal liability for the extenders; this is verified on the attestation form. The supervising physician must identify his or her NPI number and the form must have the supervising physician's signature.

Method of Payment

The state reimburses a supplemental amount equal to the difference between the Medicaid payment rate in effect on the date of service as published in the agency's fee schedule described in the State Plan Attachment 4.19B, pages 1 and 2, item I (Fee Schedule Pricing for Professional Services - Physician Services) and the CMS Medicare fee schedule in effect for the date the service was rendered. Initially, for calendar year 2015, the 2015 CMS Medicare fee schedule will be used. For each subsequent year this state plan provision is in place, the agency's fee schedule in effect for the date of service and the CMS Medicare fee schedule in effect for the date of service will be used.

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All increased physician primary care services payment end for dates of service after June 30, 2016. Increased payments on claims for services rendered prior to July, 2016, meeting all other requirements for increased payment, will be made when the claims are paid prior to October 1, 2016.

The funding for the primary care increase made in these extension years will be at the federal match rate associated with the category of eligibility of the recipient receiving the service and the service.

Supplemental payment is made: ☐ monthly ☒ quarterly

Initially, the enhanced payment amounts will be made as a lump sum payment to the provider until such time that (1) the fee for service enhanced payment can be added on to the claim at the time of payment, and (2) the enhanced payment rate can be incorporated into the managed care capitation rate which will include obtaining federal approval for both the rates and the process.

Primary Care Services Affected by this Payment Methodology

The codes that qualify for the PCP enhanced payment are those that are a covered benefit of the state Medicaid program in the Evaluation and Management Current Procedural Terminology (CPT) code range 99201 through 99499.

These are the codes that were included in the 2013 and 2014 primary care enhanced payment and will continue to receive the enhanced payment in 2015 and subsequent time periods when they are a benefit of the Medicaid program.

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2015 *through dates of service June 30, 2016*. All rates are published at <http://www.hsd.state.nm.us/providers/fee-for-service.aspx> under the 'Fee Schedules' section of the 'Provider' section of the website.

Vaccine Administration

The state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the state regional maximum administration fee set by the Vaccines for Children (VFC) program and therefore vaccine administration is not included as a primary care increase but is included in counting toward the 60% primary care services volume required for providers who do not meet the board certification requirements.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF NEW MEXICO

STANDARDS FOR ESTABLISHING PAYMENT RATES

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State: New Mexico

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I. Fee Schedule Pricing for Professional Services

Except as otherwise provided in this state plan, payment to providers on a fee for service basis is limited to the lesser of the actual charge or the fee schedule established by the Department.

There is no differentiation between governmental and non-governmental providers with regard to reimbursement for the same services. The fees are available in a published fee schedule, except as otherwise indicated.

A group practice or other legal entity including a licensed treatment and diagnostic center is reimbursed at the rate payable to the individual performing physician or provider.

Reimbursement for physician services furnished in institutional settings that are also ordinarily furnished in a physician's office is determined by using the Department's fee schedule for each professional service and multiplying the allowed amount by .60.

This reimbursement methodology is applicable only to a practitioner's professional services in settings for which Medicare reduces the practitioner's payment to a facility based rate.

Payment for the professional component of a radiology service performed in an inpatient, outpatient or office setting will not exceed 40 percent of the allowed amount payable for the complete procedure in an office setting. Nuclear medicine, radiation oncology, CT scans, and arteriogram are excluded from this limitation.

Supplemental Payments will be made in addition to payments otherwise provided under the state plan to physicians, dentists and mental health professionals who qualify for such payments under the criteria outlined below in part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in parts (b) and (c) of this section. The average commercial rate is updated quarterly.

- a. To qualify for a supplemental payment under this section, the provider must meet the following criteria.
 - i. Be a licensed physician, dentist or mental health professional enrolled in the New Mexico Medicaid program; and
 - ii. Be a member of a practice plan under contract to provide professional services at a state-owned academic medical center as determined by the Department.
- b. For providers qualifying under part (a) of this section, a quarterly supplemental payment will be made equal to the difference between Medicaid payments otherwise made to these providers and the average rate paid for the services by commercial insurers.

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The average commercial rates are determined by:

- i. Calculating a commercial payment to charge ratio for all services paid to the eligible providers by commercial insurers using the providers' claims-specific data from the most currently available fiscal year period.
 - ii. Multiplying the Medicaid charges by the commercial payment to charge ratio to establish the estimated commercial payments to be made for these services; and
 - iii. Subtracting the interim Medicaid payments already made for these services to establish the supplemental payment amount.
- a. Providers eligible under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made on a quarterly basis subject to available claims data.

A. Medical and Dental Services

Medical and dental services are reimbursed on a fee schedule basis and include physicians, dentists, radiologists, and radiological facilities, licensed treatment and diagnostic centers and family planning clinics, podiatrists, optometrists, certified nurse midwives and certified nurse practitioners working under the direction of a physician.

Preventive services provided to alternative benefit plan recipients not otherwise covered under standard Medicaid benefits are also reimbursed using this methodology including annual preventive care physicals, expanded nutritional and dietary counseling, and expanded skin cancer and tobacco use counseling. Electroconvulsive therapy services provided to alternative benefit plan recipients not otherwise covered under standard Medicaid benefits are paid at the Medicare fee schedule rate.

Services rendered under the supervision of one of the above providers are paid at the fee schedule rate for the supervising provider when the service is performed by one of the following: a dietician; clinical pharmacist; physician assistant; dental hygienist; nurse; certified nurse practitioner; or, clinical nurse specialist.

Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of **January 1, 2020** and are effective for services provided on or after that date. All rates are published at <http://www.hsd.state.nm.us/providers/fee-schedules.aspx>.

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Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's dental fee schedule rates were set as of July 1, 2019 and are effective for services provided on or after that date. All rates are published at <http://www.hsd.state.nm.us/providers/fee-schedules.aspx> Notice of changes to rates will be made as required by 42 CFR 447.205.

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Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. Effective October 1, 2019 the agency's telehealth and teleconsultation services fee schedule rates are set at 90 percent of the Medicare fee schedule and are effective for services provided on or after that date. All rates are published at <http://www.hsd.state.nm.us/providers/fee-schedules.aspx> Notice of changes to rates will be made as required by 42 CFR 447.205.

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A. Other Practitioners Services

1. Behavioral health professional services are reimbursed on a fee schedule basis applicable to psychologists, counselors, therapists, licensed alcohol and drug abuse counselors, behavioral health agencies, licensed independent social workers and psychiatric clinical nurse specialists.

Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of October 1, 2019 and are effective for services provided on or after that date. All rates are published at <http://www.hsd.state.nm.us/providers/fee-schedules.aspx>.

Non-independent behavioral health practitioners who are required by state law to be supervised are not paid directly for their services. Rather, payment is made to the supervising practitioner, or the appropriate group, licensed treatment and diagnostic center or agency to which the behavioral health worker belongs.

2. Independently practicing certified Nurse Practitioners and Clinical Nurse Specialists are reimbursed at 90% of the physician fee schedule as described in Item I. A of Attachment 4.19 B, including preventive services for alternative benefit plan recipients.

Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of January 1, 2019 and are effective for services provided on or after that date. All rates are published at <http://www.hsd.state.nm.us/providers/fee-schedules.aspx>.

3. Certified nurse anesthetists and anesthesiology assistants are reimbursed a rate per anesthesia unit for the procedure and for units of time for medically directed and non-medically directed services.

Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of March 31, 2014 and are effective for services provided on or after that date. All rates are published at <http://www.hsd.state.nm.us/providers/fee-schedules.aspx>.

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4. Licensed Midwives (Lay Midwives): Payments to licensed midwives are reimbursed at 77% of the physician fee schedule as described in Item I. A of Attachment 4.19 B for global delivery codes; payments for other codes are reimbursed at 100% of the physician fee schedule

The agency's fee schedule rates implemented a first phase reduction effective August 1, 2016, and a second phase effective January 1, 2017 for services provided on or after those dates. All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services Department, Medical Assistance Division Providers, Fee for Service, Under Fee Schedule at <http://www.hsd.state.nm/providers/fee-schedules.aspx> Notice of changes to rates will be made as required by 42 CFR 447.205.

C. Other Services

1. **Ambulatory Surgical Centers Services** - Free standing ambulatory surgical centers are paid at the Medicare fee schedule. For procedures not covered by Medicare, the Department establishes a fee schedule amount equivalent to the amount allowed for procedure of similar complexity.

The agency's fee schedule rates were set as of March 31, 2014, and are effective for services provided on or after that date. All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services Department, Medical Assistance Division, Providers, Fee for Service, under Fee Schedules, at: <http://www.hsd.state.nm.us/providers/fee-schedules.aspx> Notice of changes to rates will be made as required by 42 CFR 447.205.

2. **Renal Dialysis Facilities** - Renal dialysis facilities are paid at the Medicare fee schedule. For procedures not covered by Medicare, the Department establishes a fee schedule amount equivalent to the amount allowed for procedure of similar complexity.

The agency's fee schedule rates were set as of March 31, 2014, and are effective for services provided on or after that date. All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services Department, Medical Assistance Division, Providers, Fee for Service, under Fee Schedules, at: <http://www.hsd.state.nm.us/providers/fee-schedules.aspx> Notice of changes to rates will be made as required by 42 CFR 447.205.

3. **Licensed Birth Centers** - Licensed birth centers are paid at the Medicaid fee schedule. The agency's fee schedule rates were set as of February 25, 2017, and are effective for services provided on or after that date. All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services Department, Medical Assistance Division, Providers, Fee for Service, under Fee Schedules, at: <http://www.hsd.state.nm.us/providers/fee-schedules.aspx> Notice of changes to rates will be made as required by 42 CFR 447.205.

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4. **Accredited Residential Treatment Centers for Adults with Substance Use Disorders** – Reimbursement is made at a daily rate established by the agency state audit agent after analyzing the costs to provide services. Room and board costs are not included in the rate and are not reimbursable. Cost that are considered in the rate are: direct service costs, direct supervision costs, therapy costs including all salaries, wages, and benefits associated with health care personnel, admission discharge planning, clinical support costs, non-personnel operating costs including expenses incurred for program related supplies and general administration costs.
5. **Crisis Triage Centers** – Reimbursement is made at service rates that are uniquely determined for each provider based on provider costs as determined by the state agency contracted audit agency. Costs are determined by considering: direct service costs, direct supervision costs, therapy costs including all salaries, wages and benefits associated with health care personnel, clinical support costs, non-personnel operating costs and general administration costs.

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D. Physical Therapy, Occupational Therapy and Services for Individuals with Speech, Hearing, and Language Disorders

1. Physical therapy, occupation therapy, and speech and language pathology services (including audiologists) are reimbursed on a fee schedule basis. Habilitation services for ABP recipients are also reimbursed using this methodology.

The agency's fee schedule rates were set as of March 31, 2014 and are effective for services provided on or after that date. All rates to the fee schedule are published on the New Mexico Human Services Department website under Providers, Fee for Service, Fee Schedules at: <http://www.hsd.state.nm.us/providers/fee-schedules.aspx> Notice of changes to rates will be made as required by 42 CFR 447.205.

2. Physical therapy, occupational therapy and speech and language pathology services provided by a therapy assistant are reimbursed on a fee schedule basis. Habilitation services for ABP recipients are also reimbursed using this methodology.

The agency's fee schedule rates were set as of March 31, 2014 and are effective for services provided on or after that date. All rates to the fee schedule are published on the New Mexico Human Services Department website under Providers, Fee for Service, Fee Schedules at: <http://www.hsd.state.nm.us/providers/fee-schedules.aspx> Notice of changes to rates will be made as required by 42 CFR 447.205.

E. Special rehabilitation services (Family Infant Toddler program early intervention services)

Special rehabilitation services (Family Infant Toddler program early intervention services) are reimbursed on a fee schedule basis.

Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of July 1, 2020 and are effective for services provided on or after that date. All rates are published at: <http://www.hsd.state.nm.us/providers/fee-schedules.aspx> Notice of changes to rates will be made as required by 42 CFR 447.205.

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F. Direct Medical Services for Local Education Agencies

Local education agencies (LEAs) are reimbursed for the following direct medical services: behavioral health services, case management, nursing services, nutritional counseling, occupational therapy, physical therapy, speech-language services (including audiology services); and transportation services.

For the purpose of making interim Medicaid payments to local education agency (LEA) providers, the New Mexico Medicaid School-Based Services Fee Schedule will be applied to claims submitted to the Medicaid Management Information System (MMIS) for the above services. All rates and any updates or periodic adjustments to the fee schedule are published on the New Mexico Human Services Department website under Providers > Fee for Service > Fee schedules, at: <http://www.hsd.state.nm.us/providers/fee-schedules.aspx>. Notices of changes to rates will be made as required by 42 CFR 447.205.

For transportation services, an interim rate will be determined based on a rate that represents the actual cost of providing the transportation service, upon final approval of the SPA and cost allocation plan.

(a.) Direct Medical Services Payment Methodology:

Beginning with cost reporting period July 1, 2015, the New Mexico Medical Assistance Division will begin settling Medicaid reimbursement for direct medical services at cost for all Local Education Agencies (LEAs). This reimbursement at cost methodology will include a quarterly Random Moment Time Study, an annual cost report and reconciled settlement. If payments exceed Medicaid-allowable costs, the excess will be recouped. Once the first year's cost reports are received, and each subsequent year, HSD/MAD will examine the cost data for all direct medical services to determine if an interim rate change is justified.

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-eligible clients in the LEA, the following steps are performed:

1. Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services personnel listed in the descriptions for the covered Medicaid services delivered by school districts.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, direct materials, supplies, and equipment.

Medical devices and equipment are only allowable for the provision of direct medical services. These direct costs are accumulated on the annual cost report, resulting in total direct costs. The cost report contains the scope of the cost and methods for cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

2. The net direct costs for each service is calculated by applying the direct medical services percentage from the CMS-approved time study to the direct cost in 1 above.

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A time study which incorporates a CMS-approved methodology is used to determine the percentage of time medical service personnel spend on IEP-related medical services, and general and administrative time. This time study will assure that there is no duplicate claiming relative to claiming for administrative costs.

3. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. New Mexico public school districts use predetermined fixed rates for indirect costs. The Public Education Department (PED) is the cognizant agency for the school districts, and approves unrestricted indirect cost rates for school districts for the US Department of Education (USDE). Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.
4. Net direct costs and indirect costs are combined.
5. Medicaid's portion of total net costs is calculated by multiplying the results from Item 4 by the ratio of the total number of Medicaid students with an Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP) receiving services to the total number of students with an IEP or an IFSP.

(b.) Transportation Services Payment Methodology

Effective dates of services on or after July 1, 2015, providers will be paid on an interim cost basis. Providers will be reimbursed interim rates for school based health services, specialized transportation services at the lesser of the providers billed charges or the interim rate. This reimbursement at cost methodology will include an annual cost report and reconciled settlement. On an annual basis, a cost reconciliation and cost settlement will be processed for all over and under payments. Transportation to and from school may be claimed as a Medicaid services when the following conditions are met:

1. Special transportation is specifically listed in the IEP as a required service;
2. A medical service is provided on the day that specialized transportation is provided; and
3. The service billed only represents a one-way trip

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education. The cost identified in the cost report includes the following:

- 1) Bus Drivers
- 2) Bus Aides/Monitors
- 3) Mechanics
- 4) Substitute Drivers

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- 5) Fuel
- 6) Repairs and Maintenance
- 7) Rentals
- 8) Contract Use Cost
- 9) Vehicle Depreciation

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The source of these costs will be audited Chart of Accounts data kept at the school district and the Public Education Department (PED) level. The Chart of Accounts is uniform throughout the State of New Mexico. Costs will be reported on a cash basis.

- 1) A rate will be established and applied to the total transportation cost of the school system. This rate will be based on the *Total IEP/IFSP Special Education Department (SPED) Students in the District Receiving Transportation*. The result of this rate (%) multiplied by the *Total District or Public Education Department Transportation Cost* for each of the categories listed above will be included on the cost report. It is important to note that this cost will be further discounted by the ratio of *Medicaid Eligible IEP/IFSP SPED Students Receiving Transportation* divided by the total number of *IEP/IFSP SPED Students in the District Receiving Transportation*
- 2) Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. New Mexico school systems use predetermined fixed rates for indirect costs. The PED is the cognizant agency for the school systems, and approves unrestricted indirect cost rates for the school systems for the US Department of Education (USDE). Only Medicaid allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.
- 3) Net Direct Costs and Indirect costs are combined.

(c.) Certification of Funds Process

On an annual basis, each provider will certify through its cost report its total Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

(d.) Annual Cost Report Process

For Medicaid services listed in Amendment 93-27 State Supplement A to Attachment 3.1A pg. 5d #14 provided in schools during the state fiscal year, each LEA provider must complete an annual cost report. The cost report is due on or before April 1 following the reporting period.

The primary purposes of the cost report are to:

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1. Document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology.
2. Reconcile any interim payments to its total CMS-approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual Cost Report includes a certification of funds statement to be completed, certifying the provider's costs/expenditures. All filed annual Cost Reports are subject to desk review by the New Mexico Medicaid Agency or its designee.

(e.) The Cost Reconciliation Process

The cost reconciliation process must be completed by the New Mexico HSD/MAD within twenty-four months of the end of the reporting period covered by the Cost Report. The total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to any LEA provider's Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

(f.) The Cost Settlement Process

EXAMPLE:

For services delivered for the period covering July 1, 2015 through June 30, 2016, the annual Cost Report is due on or before April 1, 2017, with the cost reconciliation and settlement processes completed no later than June 30, 2018.

If a provider's interim payments exceed the certified costs for Medicaid services provided in schools to Medicaid clients, the provider will remit the federal share of the overpayment at the time the cost report is submitted. The New Mexico HSD/MAD will submit the federal share of the overpayment to CMS within 60 days of identification.

If the certified costs of a LEA provider exceed the interim payments, the New Mexico HSD/MAD will pay the federal share of the difference to the provider in accordance with the final certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

State: New Mexico
Date Received: 09/28/15
Date Approved: 05/26/16
Effective Date: 07/01/15
Transmittal Number: 15-0015

II. Payment for Prescribed Drugs.

For the New Mexico Medicaid Fee-for-Service program,

1. Payment:

Reimbursement for the drug ingredient cost shall be the lowest of:

- a. The Affordable Care Act Federal Upper Limit (FUL) plus the professional dispensing fee (PDF);
- b. The National Average Drug Acquisition Cost (NADAC) plus the PDF;
- c. The Wholesaler's Average Cost (WAC) + 6% plus the PDF;
- d. The pharmacy's reported ingredient cost plus the PDF; or
- e. The usual and customary charge (U&C).

The PDF is \$10.30.

When the drug item is for a brand name drug that is also a multi-source drug, the Actual Acquisition Cost, (AAC) will be calculated using the generic equivalent of the brand name drug unless the prescriber has written in his or her own hand "brand medically necessary" on the prescription in which case reimbursement will be at the AAC of the NADAC for the brand name drug item plus a \$10.30 PDF, not to exceed the pharmacy's U&C.

2. Allowed Fees in Addition to the Professional Dispensing Fee (PDF)

Reimbursement for compounding fees is limited to the provider's usual additional charge for compounding not to exceed \$12.00.

3. Payment Provisions for Blood Clotting Factors

Reimbursement for clotting factors will be at the lower of the submitted ingredient cost or WAC plus 6%, plus a \$10.30 PDF, not to exceed the pharmacy's U&C.

4. Payment Provisions for 340B Drugs

Payment to 340B covered entities for drugs purchased at 340B prices authorized under Section 340B of the Public Health Services Act will be at the 340B actual acquisition cost plus a \$10.30 PDF, not to exceed the pharmacy's U&C.

5. Payment Provisions for Drugs Acquired under Federal Supply Schedule (FSS) Pricing

Payment for drugs purchased at FSS prices will be at the FSS actual acquisition cost of the drug plus a \$10.30 PDF, not to exceed the pharmacy's U&C.

6. Payment to Indian Health Service Pharmacies and Tribal 638 Healthcare Pharmacies

Reimbursement for the drug ingredient cost shall be the lowest of:

- a. The Affordable Care Act Federal Upper Limit (FUL) plus the professional dispensing fee (PDF);
- b. The National Average Drug Acquisition Cost (NADAC) plus the PDF;
- c. The Wholesaler's Average Cost (WAC) + 6% plus the PDF;
- d. The pharmacy's reported ingredient cost plus the PDF; or
- e. The usual and customary charge (U&C).

The PDF is \$10.30.

State: New Mexico

Received Date: 29 June, 2017

Approved Date: 20 March, 2018

Effective Date: 1 April, 2017

Transmittal Number: NM 17-0003 PHARM

When the drug item is for a brand name drug that is also a multi-source drug, the AAC will be calculated using the generic equivalent of the brand name drug unless the prescriber has written in his or her own hand "brand medically necessary" on the prescription in which case reimbursement will be at the AAC of the NADAC for the brand name drug item plus a \$10.30 PDF, not to exceed the pharmacy's U&C.

7. Payment for Drugs Not Distributed by a Retail Community Pharmacy and Distributed Through the Mail (such as Specialty Drugs)

Reimbursement for the drug ingredient cost shall be the lowest of:

- a. The Affordable Care Act Federal Upper Limit (FUL) plus the professional dispensing fee (PDF);
- b. The National Average Drug Acquisition Cost (NADAC) plus the PDF;
- c. The Wholesaler's Average Cost (WAC) + 6% plus the PDF;
- d. The reported ingredient cost plus the PDF; or
- e. The usual and customary charge (U&C).

The PDF is \$10.30.

When the drug item is for a brand name drug that is also a multi-source drug, the AAC will be calculated using the generic equivalent of the brand name drug unless the prescriber has written in his or her own hand "brand medically necessary" on the prescription in which case reimbursement will be at the AAC of the NADAC for the brand name drug item plus a \$10.30 PDF, not to exceed the U&C.

8. Drugs Not Distributed by a Retail Community Pharmacy (Such as a Long-Term Care Facility)

Reimbursement for the drug ingredient cost shall be the lowest of:

- a. The Affordable Care Act Federal Upper Limit (FUL) plus the professional dispensing fee (PDF);
- b. The National Average Drug Acquisition Cost (NADAC) plus the PDF;
- c. The Wholesaler's Average Cost (WAC) + 6% plus the PDF;
- d. The reported ingredient cost plus the PDF; or
- e. The usual and customary charge (U&C).

The PDF is \$10.30.

State: New Mexico
Received Date: 29 June, 2017
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Transmittal Number: NM 17-0003

When the drug item is for a brand name drug that is also a multi-source drug, the AAC will be calculated using the generic equivalent of the brand name drug unless the prescriber has written in his or her own hand "brand medically necessary" on the prescription in which case reimbursement will be at the AAC of the NADAC for the brand name drug item plus a \$10.30 PDF, not to exceed the U&C.

9. Investigational Drugs

The New Mexico Medicaid program does not cover investigational drugs.

10. Physician Administered Drugs

Physician administered drugs are reimbursed at the Average Sales Price (ASP) determined by CMS and posted on the federal "ASP Drug Pricing Files" webpage, (updated quarterly). A professional dispensing fee is not paid. An administration fee, set at the Medicare rate, is paid only when the drug item is a vaccine covered under the Vaccines for Children program.

Outpatient Hospital Services

- III. For outpatient hospital services provided by approved Title XIX hospitals for reimbursement purposes, effective for all accounting periods which begin on or after October 1, 1983, the amount payable by the Medicaid program through its fiscal agent for services provided to Title XIX recipients and covered under the Medicaid program, the manner of payment and the manner of settlement of overpayments and underpayments shall be determined under the methods and procedures provided for determining allowable payment for outpatient hospital services under Title XVIII of the Social Security Act.

Effective April 1, 1992, for those services reimbursed under Title XVIII allowable cost methodology, the Medicaid program reduces the Title XVIII allowable costs by 3 percent. The interim rate of payment shall be applicable to all hospitals approved for participation as Title XIX hospitals in the Medical Assistance Program.

Effective for dates of service on or after November 1, 2010, outpatient hospital services, which are not designated as Critical Access Hospitals, are reimbursed at an outpatient prospective payment system (OPPS) rate using Medicare Ambulatory Payment Classification (APC) groups and reimbursement principles. Effective for dates of service beginning July 1, 2016, the OPPS rates are reduced by 3%. Effective for dates of service beginning July 1, 2019, the OPPS rates are increased by 25 percent for Safety Net Care Pool (SNCP) hospitals; 10 percent for the University of New Mexico Hospital; and 18 percent for all other in-state hospitals. Except as otherwise noted in the state plan both governmental and private providers are paid the same. All rates are published on the Department's website at <http://www.hsd.state.nm.us/providers/fee-schedules.aspx> Notice of changes to rates will be made as required by 42 CFR 447.205.

A Critical Access Hospital, a designation made by Medicare following the Medicare Rural Hospital Flexibility Program created by the federal government in the Balanced Budget Act of 1997, will be paid at a percentage of the state developed fee schedule rates that equals the cost to charge ratio reported by the hospital to the Medicare program prior to February 1, for 2012, and reduced by 3% effective July 1, 2016. Effective July 1, 2019, the rate will be increased based on the paragraph above. For Critical Access Hospitals that are also SNCP hospitals, the rate will be increased by 25%. For all other Critical Access Hospitals, the rate will be increased by 18%.

In no case can the reimbursement for outpatient hospital services exceed reasonable cost as defined under Medicare Title XVIII.

- a. Reimbursement for clinical diagnostic laboratory services are subject to the upper payment limits described in 1903(i)(7) of the Social Security Act. Except as otherwise noted in the plan, state developed fee schedule rates are set at 94% of the Medicare rate and are the same for both governmental and private providers. All rates are published on the Department's website at: <https://www.hsd.state.nm.us/providers/fee-schedules.aspx>
- b. Effective for dates of service on or after December 1, 2009 through October 31, 2010, outpatient hospital radiology technical component services are reimbursed at a fee schedule rate equivalent to the fee schedule rate for non-hospital based radiology facilities. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

The rates were developed by (1) multiplying the cost to charge ratio for each hospital by the billed charges for radiology technical component services to arrive at the approximate cost settled amount paid for each radiology technical

Attachment 4.19 B
Page 6a Outpatient Hospital Services

component service; (2) comparing the cost settled amount for each procedure code to the current Medicare APC rates and to the current Medicaid radiology fee schedule for free standing radiology facilities which is set at 101.85% of the Medicare 2006 fee schedule applicable to free standing radiology facilities. The reimbursement levels were arrayed in order of the highest to the lowest. The highest reimbursement level was the cost settled amounts; the lowest level of reimbursement was the Medicare APC rates. The reimbursement level using 101.85% of the Medicare 2006 fee schedule for freestanding radiology facilities was the middle rate. In anticipation of radiology payments being converted to an APC type of reimbursement, the middle rate was adopted as a first step in moving toward APC rates. All rates are published on the Department's website at: <http://www.hsd.state.nm.us/mad/PFeeSchedules.html>

Effective for dates of service on or after November 1, 2010, outpatient hospital radiology technical component services are reimbursed at an outpatient prospective payment system (OPPS) rate using Medicare Ambulatory Payment Classification (APC) groups and reimbursement principles. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All rates are published on the Department's website at: <http://www.hsd.state.nm.us/mad/PFeeSchedules.html>

- c. Effective for dates of service December 1, 2009 through October 31, 2010, emergency room services are reimbursed at an interim rate based on the provider's most recent cost settlement, subject to retroactive adjustment to allowable and reasonable cost minus 3 percent. The interim outpatient reimbursement rate is 50%.

Effective for dates of service on or after November 1, 2010, outpatient hospital emergency room services are reimbursed at an outpatient prospective payment rate using Medicare Ambulatory Payment Classification (APC) groups and reimbursement principles. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All rates are published on the Department's website at: <http://www.hsd.state.nm.us/mad/PFeeSchedules.html>

- d. Emergency room services and ancillary services are subject to review prior to payment. Services which are denied as not medically appropriate for diagnosis or treatment of the condition may not be billed to the recipient.

Emergency room services rendered in conjunction with an inpatient admission are included on the claim form with charges for inpatient care. In such cases, emergency room services will be reimbursed in accordance with the inpatient reimbursement methodology.

SUPERSEDES: TM- 92-16

STATE <u>New Mexico</u>	A
DATE REC'D. <u>12-30-09</u>	
DATE APPV'D <u>1-27-11</u>	
DATE EFF <u>11-1-10</u>	
HCFA 179 <u>09-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of NEW MEXICO
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
- OTHER TYPES OF CARE

Attachment 4.19 – B
Page 6aa

Hospital based rural health clinic services are paid at the provider's encounter rate established by Medicare that is in effect for the date of service. When a hospital based rural health clinic receives the annual rate notification from CMS, the provider forwards a copy of that notice to the state agency which then implements that rate for the provider for Medicaid payments. There is no retroactive cost settlement. The effective date of this change is July 1, 2015.

State: New Mexico Date Received: 24 June, 2015 Date Approved: 3 November, 2015 Effective Date: 1 July, 2015 Transmittal Number: 15-11

- e. Outpatient hospital dental services provided to recipients under anesthesia are reimbursed at an outpatient prospective payment rate using Medicare Ambulatory Payment Classification (APC) groups and reimbursement principles at an amount which does not exceed federal upper payment limits. The agency's rates for dental services were set as of December 1, 2015 and are effective for dates of service on and after that date. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All rates are published on the Department's website at: <http://www.hsd.state.nm.us/mad/PFeeSchedules.html>

State: New Mexico
Date Received: 12/2/15
Date Approved: 3/1/16
Effective Date: 12/1/15
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New Mexico

ATTACHMENT 4.19-B

PAGE 6b

IV. Reimbursement Methodology for Family Planning Services

- (a) Payment for family planning services is made in accordance with the provisions contained in Section 4.19-B item I (payment to providers on a fee for service basis), Item II (prescribed drugs), item III (outpatient hospital services), item VI (laboratory services), item VIII (federally qualified health centers and rural health clinics), and 4.19-D (inpatient hospital reimbursement); depending on the service and the provider type. For all providers which are physician-directed and are approved to provide family planning services under this state plan, the upper payment limits will not be in excess of a fee schedule approved by the single state agency, for each of the professional services authorized as benefits.

SUPERSEDES: NONE - NEW PAGE

STATE <u>New Mexico</u>	A
DATE REC'D <u>12-21-10</u>	
DATE APPV'D <u>2-24-11</u>	
DATE EFF <u>2-1-11</u>	
HGFA 179 <u>10-12</u>	

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VI. Clinical Diagnostic Lab Services

Laboratory services are covered under the laboratory benefit. Payment for clinical diagnostic laboratory services does not exceed payment levels specified by Section 1903(i) of the Social Security Act which is the Medicare fee schedule on a per test basis.

Beginning July 1, 2001, the Medicare fee schedule, as updated, is implemented as the Medicaid fee schedule.

For items and services for which there is not a Medicare fee schedule amount, the fee schedule is established by the state agency with consideration given to payment practices of other third party payers, comments from providers and appropriate professional societies, typical invoice costs from providers, comparison of fee schedule amounts for similar services and items, and/or the usual charges of the providers for services to non-Medicaid patients.

The agency's fee schedule rates for services and items for which there is not an established Medicare fee were set as of March 21, 2011, and are effective for services provided on or after that date.

All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services Department, Medical Assistance Division, Provider Enrollment and Program Policy, Fee for Service, under Fee Schedules, at: <http://www.hsd.state.nm.us/mad/feeschedules.html>

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Changes to the fee schedule are made with public notice, following the requirements of 42 CFR 447.205.

VII. Prescribed dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist:**(1) Dentures**

Dentures are covered under the service benefit of "Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses Prescribed by a Physician Skilled in Diseases of the Eye or by an Optometrist". Payment for dentures is made at the lesser of the provider's billed charge or the current Medicaid fee schedule.

The Medicaid fee schedule is established by the state agency with consideration given to payment practices of other third party payers, comments from providers and appropriate professional societies, typical invoice costs from providers, comparison of fee schedule amounts for similar services and items and/or the usual charges of the providers for services to non-Medicaid patients.

The agency's fee schedule rates were set as of March 21, 2011, and are effective for services provided on or after that date. All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services

SUPERSEDES: NONE - NEW PAGE

STATE <u>New Mexico</u>	A
DATE REC'D <u>3-15-11</u>	
DATE APPV'D <u>6-13-11</u>	
DATE EFF <u>3-1-11</u>	
HCFA 179 <u>11-01</u>	

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Department, Medical Assistance Division, Provider Enrollment and Program Policy, Fee for Service, under Fee Schedules, at:
<http://www.hsd.state.nm.us/mad/feeschedules.html>

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Changes to the fee schedule are made with public notice, following the requirements of 42 CFR 447.205.

(2) Prosthetic and Orthotic Devices

Prosthetic devices and orthotics are covered under the service benefit of "Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses Prescribed by a Physician Skilled in Diseases of the Eye or by an Optometrist".

Payment for prosthetic devices is made at the lesser of the provider's billed charge or the current Medicaid fee schedule.

Payment for orthotics (which are supportive prosthetic devices as described in CFR 440.120(c)), is made at the lesser of the provider's billed charge or the current Medicaid fee schedule.

Beginning July 1, 2001, the Medicare fee schedule, as updated by Medicare, is implemented as the Medicaid fee schedule.

For items and services for which there is not a Medicare fee schedule amount, the fee schedule is established by the state agency with consideration given to payment practices of other third party payers, comments from providers and appropriate professional societies, typical invoice costs from providers, comparison of fee schedule amounts for similar services and items, and/or the usual charges of the providers for services to non-Medicaid patients.

The agency's fee schedule rates for services and items for which there is not an established Medicare fee were set as of March 21, 2011, and are effective for services provided on or after that date.

All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services Department, Medical Assistance Division, Provider Enrollment and Program Policy, Fee for Service, under Fee Schedules, at:
<http://www.hsd.state.nm.us/mad/feeschedules.html>

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

SUPERSEDES: NONE - NEW PAGE

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>3-13-11</u>	
DATE APPV'D	<u>6-13-11</u>	
DATE EFF	<u>3-1-11</u>	
HCFA 179	<u>11-01</u>	

Changes to the fee schedule are made with public notice, following the requirements of 42 CFR 447.205.

(3) Medical Supplies, Oxygen, Durable Medical Equipment, Parenteral and Enteral Nutritional Products Suitable for Use in the Home

Medical Supplies, Oxygen, Durable Medical Equipment, Parenteral and Enteral Nutritional Products are covered under the home health agency benefit for recipient use in their residence. Payment for these items is made at the lesser of the provider's billed charge or the current Medicaid fee schedule.

Beginning July 1, 2001, the Medicare fee schedule, as updated, is implemented as the Medicaid fee schedule. For items of DME provided in Medicare Competitive Bidding Areas (CBAs) where rates for specific items have been competitively bid under the Medicare program, the rate is set at the lower of the following:

1. The Medicare single payment amount specific to the geographic area where the item is being provided, that are in effect as of January 1 each year, and updated on a quarterly basis (April 1, July 1, October 1) as needed; or
2. The non-rural and rural DMEPOS fee schedule rate.

If there is no competitively bid payment rate for an item of DME in a CBA, reimbursement for DME provided in non-rural areas is set at the Medicare DMEPOS fee schedule rate for New Mexico geographic, non-rural areas that are in effect as of January 1 each year.

For items of DME provided in rural areas, the rate is set at the Medicare DMEPOS fee schedule rate for New Mexico geographic, rural areas, set as of January 1 each year.

For items and services for which there is not a Medicare fee schedule amount, the fee schedule is established by the state agency with consideration given to payment practices of other third party payers, comments from providers and appropriate professional societies, typical invoice costs from providers, comparison of fee schedule amounts for similar services and items, and/or the usual charges of the providers for services to non-Medicaid patients.

Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of March 21, 2011 and are effective for services provided on or after that date. All rates are published at <http://www.hsd.state.nm.us/providers/fee-schedules.aspx>.

Changes to the fee schedule are made with public notice, following the requirement of 42 CFR 447.205.

When there is no applicable fee schedule, payment is limited to the provider's acquisition invoice cost plus a percentage. For durable medical equipment, medical supplies and nutritional products for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than \$1,000 dollars, payment is limited to the provider's actual acquisition cost plus 20 percent. For items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is \$1,000 or greater, payment is limited to the provider's actual acquisition cost plus 10 percent. For custom specialized wheelchairs and their customized related accessories: payment is limited to the provider's actual acquisition cost plus 15 percent.

(4) Eyeglasses and vision appliances

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Eyeglasses and vision appliances are covered under the service benefit of "Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses Prescribed by a Physician Skilled in Diseases of the Eye or by an Optometrist". Payment for eyeglasses and vision appliances are made at the lesser of the provider's billed charge or the current Medicaid fee schedule.

Beginning July 1, 2001, the Medicare fee schedule, as updated, is implemented as the Medicaid fee schedule.

For items and services for which there is not a Medicare fee schedule amount, the fee schedule is established by the state agency with consideration given to payment practices of other third party payers, comments from providers and appropriate professional societies, typical invoice costs from providers, comparison of fee schedule amounts for similar services and items, and/or the usual charges of the providers for services to non-Medicaid patients.

The agency's fee schedule rates for services and items for which there is not an established Medicare fee were set as of March 21, 2011, and are effective for services provided on or after that date.

All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services Department, Medical Assistance Division, Provider Enrollment and Program Policy, Fee for Service, under Fee Schedules, at: <http://www.hsd.state.nm.us/mad/feeschedules.html>

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Changes to the fee schedule are made with public notice, following the requirements of 42 CFR 447.205.

SUPERSEDES: TN- 04-06

STATE <u>New Mexico</u>	A
DATE REC'D <u>3-15-11</u>	
DATE APP'D <u>6-13-11</u>	
DATE EFF <u>3-1-11</u>	
HCFA 179 <u>11-01</u>	

VIII. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

- a. Reimbursement- FQHCs and RHCs must submit claims for reimbursement on the UB-92 claim form or its successor. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Interim and final reimbursement for FQHC and RHC services are made by the Medical Assistance Division (MAD) based on submitted claims. Effective January 1, 2001, FQHCs and RHCs will be reimbursed under a prospective payment system (PPS) that conforms to the provisions of the Benefits Improvement and Protection Act (BIPA) 2000.
- b. Interim PPS rate for FQHCs and RHCs:
FQHCs and RHCs will receive an interim payment rate during the transition to the PPS. The interim rate will be the rate in effect December 31, 2000, updated in accordance with the FQHC and RHC payment regulations in effect on December 31, 2000. These rates are facility specific and will remain in force until such time as the PPS base period rate for each FQHC and RHC has been established. This interim rate will be inflated by the Medicare Economic Index (MEI) each October 1st, starting with Federal Fiscal Year 2002.
- c. Base Rates for the Prospective Payment System (PPS):
Once FQHC and RHC cost reports filed for periods ending in calendar years 1999 and 2000 are finalized, the PPS base rates will be established for each FQHC and RHC. The PPS base rate per encounter for each FQHC and RHC will be calculated as follows:

A				
STATE	New Mexico			
DATE REC'D	3-5-01			
DATE APP'VE	6-12-01			
DATE EFF	1-1-01			
HCFA 179	NM 01-02			

The allowable cost per encounter from cost reports filed for periods ending in calendar years 1999 and 2000 will be indexed (inflated) from the mid-point of the cost reporting period to the mid-point of the base rate period. The base rate period will be from January 1, 2001, through September 30, 2001. The simple average rate from these two cost reports will be the PPS base rate.

An Example of the Base Period Rate Calculation Follows:

Cost Report Period	Allowable Cost Per Encounter	MEI Inflation	Inflated Cost
1/99 - 12/99	\$ 120.00	6%	\$ 127.20
1/00 - 12/00	\$ 125.00	4%	\$ 130.00

Encounter Simple Average (Base Period Rate) \$ 128.60

Once the base period rate for each FQHC and RHC has been calculated, any claims paid for dates of service on or after January 1, 2001, that were paid an interim rate, will be reprocessed. This reprocessing will adjust the payment on each claim to the PPS base rate amount.

d. Updates to PPS base rates:

Beginning in Federal Fiscal Year (FFY) 2002, and each year thereafter, each FQHC and RHC payment amount (on a per visit basis) will be increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services. This adjustment to the PPS rate will be effective each October 1.

e. Alternative Payment Methodology (APM)

An alternative payment methodology will be implemented effective April 1, 2003. This alternative methodology will re-index the PPS rates effective March 31, 2003 by the cumulative percentage difference between the increase in the Medical Care Component of the Consumer Price Index-Urban (CPI-U) for the 12 months in the calendar year 2001 and the increase in the Medicare Economic Index (MEI) effective for calendar year beginning January 1, 2002, and the increase in the Medical Care Component of the CPI-U for the 12 months in calendar year 2002 and the increase in the MEI effective for the calendar year beginning January 1, 2003. The new rates will be effective April 1, 2003. Beginning in Federal Fiscal Year 2021, the Department will calculate the APM by trending the PPS rate by the greater of either the MEI or the CPI-U. Providers must be notified of the APM rate and must agree to receive the APM. This APM will be at least equal to PPS.

Dental APM

Effective October 1, 2019, an alternative payment methodology will be paid for FQHC dental encounters. The alternative payment methodology is based on the national average cost of a dental encounter as established by the Health Resources and Services Administration (HRSA) Uniform Data system for 2017. Beginning in Federal Fiscal Year 2021, the Department will calculate the dental APM by trending the dental APM effective October 1, 2019 by the greater of either the MEI or the CPI-U. Providers must be notified of the dental APM rate and must agree to receiving the dental APM. The dental APM will be at least equal to PPS.

f. Change in Scope of Services

Once the PPS rates are determined as outlined in this section, adjustments to those rates will reflect changes in the scope of services will be made upon the written request of the provider and approval by the Medical Assistance Division (MAD). A provider's request for a PPS rate adjustment due to a change in scope of service must be received no later than 90 days after the provider's fiscal year end during which the change in scope of service occurred. The provider should notify MAD in advance of any impending changes. The provider will be required to submit data supporting that a change in the scope of service transpired. This documentation will include FQHC and RHC information report and any other supporting documentation considered necessary by MAD or its designee.

A minimum of six months should have elapsed since the change in the scope occurred to ensure the change was not temporary and that there is sufficient information upon which to base a rate adjustment. If the change in scope of service occurred in the last six months of a FQHC's and RHC's fiscal period, MAD may require the FQHC and RHC to submit and additional information report, covering at least six months since the change in scope of service transpired, to obtain the information necessary to evaluate the request.

MAD and/or its designee will review the request and determine if an adjustment to the established PPS rate is merited. The following criteria will be used to evaluate each FQHC request for a rate adjustment due to a change in scope of service. MAD's final determination will be communicated to the FQHC and RHC in writing.

TN No. NM 19-0016

Approval Date 04-30-20

Supersedes TN No. NM 03-002

Effective Date 10-01-2019

1. MAD or its designee will evaluate each request for a rate revision due to a change in scope of service. If it is determined that a significant change in the scope of service has occurred, the reasonable incremental cost per encounter from this change will be added to the PPS rate and a new rate established. This new rate will be effective on the date the change in scope of service has not transpired, no adjustment will be made to the encounter rate.
2. The events that could create a change in the scope of services are defined to include, but are not limited to, such things as significant expansion or remodeling of an existing clinic, the opening of an additional satellite clinic (new site), addition of new services, deletion of existing services, or other changes in the scope/intensity of services offered by a clinic that significantly increase or decrease the clinic's costs, relative to its PPS rates. A change in scope of services will not be considered to have transpired unless it increases or decreases an FQHC's and RHC's cost per encounter by more than 2.5%.

g. Managed Care Wrap-Around Payments:

MAD will pay a supplemental 'wrap-around' payment for managed care organization (MCO) encounters. FQHCs and RHCs must submit invoices, on a regular basis (at least quarterly), but no more frequently than monthly, which identify the number of encounters per each MCO. Supporting documentation must be provided upon request.

1. Interim Wrap-Around Payment Percentages:

MAD will pay a percentage of the FQHCs and RHCs PPS rate as the wrap-around payment. MAD will determine this payment percentage, with input from its designee and from each FQHC and RHC. MAD's determination will be communicated to each FQHC in writing. Wrap-around payments will be made directly by MAD, not as a pass through from the managed care entity.

2. Final Settlement of MCO Encounters:

On an annual basis MCO encounters will be settled. This process will be done to reconcile MCO encounter payments to the PPS rate(s). To perform this reconciliation total payments due will be calculated by multiplying MCO encounters by the PPS rate(s). MCO payments and Interim Wrap- Around payments received during the period will then be subtracted from the total amount due. Any over or under payment

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determine from this reconciliation will be made as a lump sum settlement.

The provider must submit the documentation required to perform the final settlement within 150 days of their fiscal year end. The reconciliation will then be performed by MAD or its designee within 150 days of receipt of all required information

3. Change in MCO Payments:

If a clinic renegotiates its payment rates with an MCO, the clinic is required to notify MAD that this occurred within 30 days of the effective date of this change. Upon receipt of this information, MAD may re-determine the FQHCs and RHCs interim wrap-around percentage. MAD may also periodically request MCO payment / rate information from the MCOs to determine if the interim wrap-around payment percentage should be reestablished.

h. Initial Rate for New FQHCs and RHCs:

The initial PPS rate for new FQHC and RHC providers will be established either by reference to payment rates to other clinics in the same or adjacent areas with similar caseloads, or in the absence of such other clinics, through cost reporting methods. Once the initial PPS rate for the new FQHC and RHC is determined, it shall be updated in accordance with other provisions of this rule.

A new (additional location, established by an existing FQHC and RHC participating in the Medicaid program, will receive the same PSP rate as the parent company or organization establishing the additional clinic, unless it can demonstrate a significant change in scope or intensity of services, as defined in section VIII.f has occurred. This provision does not, however alleviate the clinic's responsibility to be licensed and to otherwise comply with Medicaid certification and other requirements for participating in the Medicaid program.

i. Information Reporting Requirements:

1. Annual Filing Requirements for FQHCs and RHCs:

All FQHCs and RHCs will be required to file an annual information report with MAD. This report is for general information purposes of MAD. The

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The reports could be used to assist in the evaluation of a change in scope of service, to assist in setting the initial PPS rate for a new FQHC and RHC, and for other purposes.

j. Alternate Payment Methodology for Primary Care Residencies:

Beginning January 1, 2016, FQHCs that train primary care resident physicians at the FQHC are eligible for an alternate payment methodology that will enhance the PPS rate.

A primary care resident physician is an individual with a New Mexico post graduate training license who is enrolled in a New Mexico primary care residency program.

The alternate payments are limited to the six FQHCs with the highest percentages of Medicaid recipients, based on data from the health center Uniform Data System (UDS) for the previous calendar year. The Department will post this information on its website on an annual basis.

- i. In order to be eligible for the alternate payment, the FQHC must complete an agreement with the state agency under which the FQHC will report, on a quarterly basis, the hours worked by primary care resident physicians and the percentage of patients treated at the FQHC who are Medicaid eligible at the time of service. The agreement will include a statement that both the FQHC and the Department agree to all provisions for the alternate payment and require an attestation from the FQHC that enhanced funding paid under this provision will not supplant or duplicate residency funding paid by the Medicare program. Prior to the Department's approval of the agreement, the FQHC must provide their agreement with the sponsoring hospital.

For each FQHC:

Medicaid FTE = Total FTEs x ratio of Medicaid patients to all patients

- ii. The alternate payment is made through a settlement process based on the number of hours worked by primary care resident physicians, which is multiplied by the resident physician's hourly rate, and which is multiplied by the ratio of the Medicaid encounters to all encounters for the time period.
- iii. The payment to an FQHC for primary care resident physicians will not exceed an FQHC's Medicaid share for training primary care resident physicians, as calculated in subparagraph (i), above; divided by the total of all participating FQHCs' Medicaid share for training primary care resident physicians, which results in a percentage.
- iv. Alternate payments made in accordance with this methodology will be distributed on a quarterly basis.

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- IX. Payment for hospice service is made according to the reimbursement rate schedule and local adjustment methodology as outlined in the State Medicaid Manual, Hospice services, Section 4306 – 4308, less 1.5 percent.

Payment to a hospice for inpatient care has the following limitation: The aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during the same period.

The benefit does not exercise an option to cap overall reimbursement made to a hospice during the cap period. When hospice care is furnished to an individual residing in a nursing facility, the hospice is paid an additional amount on routine home care and continuous home care days furnished by the facility. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility equals at least 95 percent of the per diem rate that would have been paid to the nursing facility for that individual in that facility under this State Plan. For dually eligible recipients residing in a Medicaid-reimbursed long term care facility and electing Medicare hospice, Medicaid will reimburse the hospice for drug and respite care co-payments as well as room and board services.

Payment to a hospice for physician services is made in accordance with the usual Medicaid reimbursement policy for physician services as the usual Medicaid reimbursement policy for physician services as outlined in Section I of this attachment. Physician services include direct care services furnished to individual hospice patients by hospice employees and physician services furnished under arrangements made by the hospice unless the patient care services were furnished on a volunteer basis.

Payment for services related to the terminal illness or related conditions and unique to Title XIX will be made according to the reimbursement policies set forth in the New Mexico Medicaid Program manual.

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

STATE: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER
TYPES OF CARE

- Item X. a. Payment of Targeted Case Management Services for individuals who are chronically mentally ill.

Development of Fee Schedule:

To establish a fee schedule amount, the Department initially used cost studies developed by a consulting firm to determine the average actual costs to providers to perform case management services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. To assure salaries were reasonable, allowed costs for salaries for case managers were based on that of a state social worker adjusted for two years tenure at 4% per year and caseloads were based on a 1:30 staff/consumer ratio.

Using these factors, an amount was determined that was further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to case management responsibilities with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examined rates being charged by providers who were already rendering services to other agencies and payers; and, (2) evaluated the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee was also verified by comparing the fee to the case management fees paid by several other states' Medicaid programs for similar services.

Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined the rates are in conformance with OMB Circular A-87.

Case Management is reimbursed according to a fee schedule. The level of the fee is evaluated annually. In all cases, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.

SUPERSEDES: TN- 92-22

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MEDICAL ASSISTANCE PROGRAM

STATE: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER
TYPES OF CARE

- Item X. b. Payment of Targeted Case Management Services for adults who are developmentally disabled.

Development of Fee Schedule:

To establish a fee schedule amount, the Department initially used cost studies developed by a consulting firm to determine the average actual costs to providers to perform case management services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. To assure salaries were reasonable, allowed costs for salaries for case managers were based on that of a state social worker adjusted for two years tenure at 4% per year and caseloads were based on a 1:30 staff/consumer ratio.

Using these factors, an amount was determined that was further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to case management responsibilities with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examined rates being charged by providers who were already rendering services to other agencies and payers; and, (2) evaluated the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee was also verified by comparing the fee to the case management fees paid by several other states' Medicaid programs for similar services.

Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined that the rates are in conformance with OMB Circular A-87.

Case Management is reimbursed according to a fee schedule. The level of the fee is evaluated annually. In all cases, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.

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- Item X. c. Payment of Targeted Case Management Services for pregnant women and their infants for up to 60 days after their birth.

Development of Fee Schedule:

To establish a fee schedule amount, the Department initially used cost studies developed by a consulting firm to determine the average actual costs to providers to perform case management services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. To assure salaries were reasonable, allowed costs for salaries for case managers were based on that of a state social worker adjusted for two years tenure at 4% per year and caseloads were based on a 1:30 staff/consumer ratio.

Using these factors, an amount was determined that was further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to case management responsibilities with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examined rates being charged by providers who were already rendering services to other agencies and payers; and, (2) evaluated the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee was also verified by comparing the fee to the case management fees paid by several other states' Medicaid programs for similar services.

Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined the rates are in conformance with OMB Circular A-87.

Case Management is reimbursed according to a fee schedule. The level of the fee is evaluated annually. In all cases, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER
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- Item X. d. Payment of Targeted Case Management Services for children up to age three.

Development of Fee Schedule:

To establish a fee schedule amount, the Department initially used cost studies developed by a consulting firm to determine the average actual costs to providers to perform case management services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. To assure salaries were reasonable, allowed costs for salaries for case managers were based on that of a state social worker adjusted for two years tenure at 4% per year and caseloads were based on a 1:30 staff/consumer ratio.

Using these factors, an amount was determined that was further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to case management responsibilities with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examined rates being charged by providers who were already rendering services to other agencies and payers; and, (2) evaluated the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee was also verified by comparing the fee to the case management fees paid by several other states' Medicaid programs for similar services.

Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined the rates are in conformance with OMB Circular A-87.

Case Management is reimbursed according to a fee schedule. The level of the fee is evaluated annually. In all cases, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.

SUPERSEDES: TN- 92-22

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- Item X. e. Payment of Targeted Case Management Services for individuals who are traumatically brain injured.

Development of Fee Schedule:

To establish a fee schedule amount, the Department considered prevailing charges and the existing fee schedule for services similar to case management responsibilities with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examined rates being charged by providers who were already rendering services to other agencies and payers; (2) evaluated the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks; and (3) examined cost data from providers to substantiate their cost to provide the service. Cost considerations included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration.

Cost data was used to assure the reasonableness of the fee schedule rate only; a provider is not reimbursed on the basis of cost. The reasonableness of the fee was also verified by comparing the fee to the case management fees paid by several other states' Medicaid programs for similar services.

Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined the rates are in conformance with OMB Circular A-87.

Case Management is reimbursed according to a fee schedule. The level of the fee is evaluated annually. In all cases, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.

SUPERSEDES: TN- 93-18

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- Item X. c. Payment of Targeted Case Management Services for adult individuals who have been abused, neglected or exploited.

The Medicaid client case management unit rate is determined by dividing the adjusted field services budget by the total Medicaid client case management eligibles. Because field service personnel perform non case management services and they service non Medicaid clients, the total field service budget is adjusted to exclude all field service related costs not related to case management activities. It is further adjusted to exclude non Medicaid eligible case management clients. A random sampling of the field workers time is performed to assist in computing the amount to adjust. This unit rate is reviewed every year and adjustments made as necessary to reflect any over or under payments from the prior year, and is performed within three months after the closing of the subject year.

The Department used a case management rate methodology developed and applied by the Children, Youth and Families Department (CYFD) to determine the actual costs to providers. Allowable are salaries plus fringe benefits, costs for supervision, costs for indirect administration. A fee for service cost was determined which will be billed using a monthly unit rate. Claims are prepared by CYFD and transmitted to the Human Services Department on a monthly basis.

Reimbursement for case management services is consistent with the requirements of Section 1902 (a) (30) of the Act and 42 CFR 447.200 which stipulates that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined that the rates are in conformance with OMB Circular A-87.

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DATE RECD	July 3, 1995
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DATE EFF	August 1, 1995
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STATE: New Mexico
DATE RECEIVED: March 31, 2014
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Item XII. Transportation

Transportation providers are reimbursed at the lesser of the following:

- a. their usual and customary charge, not to exceed their tariff rates as approved by the state corporation commission; or
- b. the Department fee schedule.

The fee schedule base rate for ground ambulance includes reimbursement for the initial fifteen (15) miles of transport, non-reusable supplies, IV solution, emergency drugs and oxygen.

Effective November 15, 2020, air ambulance procedure codes will be reimbursed at seventy-five percent of the Medicare Air Ambulance fee schedule rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of November 15, 2020 and is effective for services provided on or after that date. All rates are published <https://www.hsd.state.nm.us/providers/fee-schedules.aspx>

Item XIII. Services for EPSDT Participants

- a. Services Included in the State Plan

Services included in the state plan are described in Attachment 3.1-A. Payment for these services for treating a condition identified during a screen or partial screen is made using the same methodology described in the corresponding section of the state plan.

- b. Services Not Otherwise Included in the State Plan

Payment for services described in Attachment 3.1-A, Item 4.b. (EPSDT) and not otherwise covered under the state plan but reimbursed pursuant to OBRA 1989 provisions which require the state to treat a condition identified using a screen or partial screen, whether or not the service is included in the state plan, is made as follows:

1. The following services are considered to be professional services and are reimbursed on a fee for service basis according to the fee schedule in attachment 4.19-B, I.
 - (a) Therapy by a speech-language therapist, physical therapist, or occupational therapist, not covered under the state plan
 - (b) Other rehabilitative services and therapy services not covered under the state plan because they are considered maintenance rather than restorative.

- (c) Private duty nursing services, Christian science nurse services, and personal care services.
- (d) Services by licensed master's level practitioners including psychologists, counselors, and social workers, and other individually licensed practitioners.
- (e) Chiropractic services.
- (f) Orthodontic services and other dental services not otherwise covered in the state plan.
- (g) Services provided by school districts and local education agencies. Reimbursement will be at the same rate as other providers of the specific service rendered.
- (h) Services provided by Licensed Alcohol and Drug Abuse Counselors (LADACs).

2. **Inpatient Institutional Services**

Inpatient services provided by JCAHO accredited institutions are reimbursed using the methodology for specialty hospitals according to the reimbursement principles of 4.19-A.

3. **Outpatient Institutional Services**

Outpatient services provided by JCAHO accredited institutions are reimbursed using the methodology for outpatient hospital according to the reimbursement principles of 4.19-B, III.

4. **Rural Health Clinic and Federally Qualified Health Center Services**

Services by these providers are reimbursed in accordance with the reimbursement methodology described in 4.19-B, Item VIII.

5. **Durable Medical Equipment, Supplies, Prosthetics, and Orthotics**

These items are reimbursed in accordance with the reimbursement methodology described in 4.19-B, Item VII.

6. **Case Management**

Case management services are reimbursed in accordance with the reimbursement methodology described in 4.19-B, Item X.

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SUPERSEDES: TN - 92-21

7. Psychosocial Rehabilitation

Reimbursement methodology for Psychosocial Rehabilitation services is determined by the setting/service. A multidisciplinary team establishes the level of need for each individual based upon acuity. Services provided are dependent upon the acuity level established. In residential settings, reimbursement is a daily rate based upon the acuity level. For non-residential services, the rate may be either hourly or daily, depending upon the service but does not differentiate by acuity level.

For all psychosocial rehabilitation services, provider cost information was analyzed in detail and total cost of service separated into categories associated with that service. To determine the percentage of total cost of service for each category, a range of percentages was derived from costs obtained from each provider and finally a weighted average applied.

Payment for Residential Treatment Centers and Group Homes is based on a resource model that defines the treatment and supervisory needs of the individuals served. This resource model was developed by the state in conjunction with a national consulting firm under contract to the Department. Rate setting decisions were made based upon the results of the consulting firm's reimbursement methodology study presented to the Department in February of 1994. Cost reports will be required from each provider in federal fiscal year 1996 and annually thereafter in order to determine appropriateness of reimbursement rates. The cost reports will be used to adjust provider rates as found necessary beginning in federal fiscal year 1997.

Provider cost information was analyzed in detail and total cost of service was separated into the following ten categories.

(1) Direct Service. These costs include all salaries, wages and benefits associated with personnel who provide daily face-to-face service to residents. Direct service staffing ratios were determined for each level of recipient for various times of day in each setting. The wage rate was based upon a Psychological Technician II classification in the New Mexico State Personnel System.

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(2) Direct Supervision. Costs include all salaries, wages and benefits associated with personnel whose primary responsibilities are to oversee and coordinate the activities of the direct service staff and residents. A direct supervision wage rate and span of control was determined using a Psychological Counselor III in the State system.

(3) Therapy costs include all salaries, wages and benefits associated with personnel whose primary activities include providing face-to-face therapy services. This category only includes costs for therapy provided by personnel on the provider agency payroll. An average caseload for therapists was derived and the wage based upon that of a Clinical Social Worker.

(4) Admission/Discharge Planning. These costs include salaries, wages and benefits associated with personnel whose sole function is to serve as a liaison between the residential program and social workers, State agencies and other residential/foster care programs. Personnel performing these activities are paid at the Social Worker Range 21 level.

(5) Clinical support costs include all salaries, wages and benefits associated with personnel whose primary activities serve to support the residential program from a clinical/programmatic perspective as opposed to an administrative perspective. Included are clinical directors, assistant clinical directors, training directors, nurses and persons who perform other types of clinical program support and coordination activities. The wage level used was that of a Psychologist III with varying caseload factors for each level of client.

(6) Education related costs include salaries, wages and benefits for personnel who serve as teachers or teacher's aides in classroom setting for the residents. These costs were then excluded from consideration in the reimbursement rate for non-accredited Residential Treatment Centers and Group Homes.

(7) Non-personnel operating costs include expenses incurred for program related supplies, transportation, and training. These were derived using 8% of total cost for all service types and levels.

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(8) Room & Board. This includes rent, depreciation, and utilities related to room and board, plus food, clothing, allowance, etc. Also included are wages, salaries and benefits associated with personnel whose primary activities are to support the room & board of the residents. These costs were then excluded from consideration in the reimbursement rate for Residential Treatment Centers and Group Homes.

(9) General administration costs include non-room and board related depreciation and interest or rent supporting this service, plus salaries, wages and benefits for central office personnel and other non-personnel costs. Also included are medical records, quality assurance and utilization review personnel costs. These are set at 15% of total costs.

(10) Consultation related costs include doctors, specialists and nurses who provide services to a residential program on a part-time "contract" or "consultative" basis. Consultation costs are a percentage of total costs which vary according to the setting and level of care provided to the client. Consultation service costs that are not billed directly to the provider, but rather to the State, are not included.

Payment for Treatment Foster Care and Behavioral Management services was derived from a model based on the resources required to meet the standards of the Department. This model was developed by the state in conjunction with a national consulting firm under contract to the Department. Rate setting decisions were made based upon the results of the consulting firm's reimbursement methodology study presented to the Department in May 1994. Rates do not duplicate costs reimbursed through foster care funds authorized by Title IVE of the Social Security Act. Periodic rate studies will be performed to determine appropriateness of reimbursement rates. The rate studies will be used to adjust provider rates, as found necessary, beginning in federal fiscal year 1997.

Treatment Foster Care. Provider cost information was analyzed in detail and total cost of service was separated into the following categories.

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SUPERSEDES: NONE - NEW PAGE

(1) Family Payment. Reimbursement is made to the TFC agency which employs the families. Parent(s) in the Treatment Family are required to have the experience and training which allows them to participate in the therapy and treatment of the child. The daily reimbursement rate falls within the range of a state level Psychological Technician II.

(2) Room & Board. The amount allowed for this is based upon the rate Children, Youth and Families Department allows for its regular foster parents. These costs were then excluded from consideration in the reimbursement rate for Treatment Foster Care.

(3) Treatment Coordinators. Costs include all salaries, wages and benefits associated with personnel whose primary responsibilities are to oversee and coordinate the activities of the treatment family. A direct supervision wage rate and span of control was determined using a Psychological Counselor III in the State system.

(4) Therapy costs include all salaries, wages and benefits associated with personnel whose primary activities include providing face-to-face therapy services. This category only includes costs for therapy provided by personnel on the provider agency payroll. An average caseload for therapists was derived and the wage based upon a Clinical Social Worker.

(5) Clinical supervision and support costs include all salaries, wages and benefits associated with personnel whose primary activities serve to support the treatment foster care program from a clinical/programmatic perspective as opposed to an administrative perspective. Included are clinical directors, assistant clinical directors, training directors, nurses and persons who perform other types of clinical program support and coordination activities. The wage level used was that of a Psychologist III.

(6) Consultation related costs include doctors, specialists and nurses who provide services to individuals in treatment foster care on a part-time "contract" or "consultative" basis. Consultation costs are a percentage of total costs which vary according to the setting and level of care provided to the client. Consultation service costs that are not billed directly to the provider, but rather to the State, are not included.

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(7) Non-personnel operating costs include expenses incurred for program related supplies, training, transportation, and costs related to office space. These were derived using a percentage of total cost.

(8) Administrative support costs include salaries, wages and benefits for agency personnel and other non-personnel costs. Also included are medical records, quality assurance and utilization review personnel costs.

(9) Alternate Care costs are for those days in which the child is placed with a temporary family. This family is required to have the training and experience of the regular Treatment Family and is reimbursed at the same rate.

Behavior Management Services. Providers of this service as well as staff in State agencies were interviewed in order to determine appropriateness of fee for service rates.

(1) Direct Service. These costs include the salary, wage and benefits associated with the Behavior Management Services Specialist who provides fact-to-face services to the individual. It was determined that there would be, on average, thirty billable hours per week. The BMS Specialist salary is comparable to that of a Psychological Technician II in the State system.

(2) Direct supervision costs include salaries, wages and benefits associated with personnel whose primary responsibilities are to oversee and coordinate the activities of the Behavior Management Services specialist staff and recipients. A direct supervision wage rate and span of control was determined using a Psychological Counselor III in the State system.

(3) Non-personnel operating costs include expenses incurred for program related supplies, training, transportation, and costs related to office space. These were derived using a percent of total cost.

(4) General administration costs include salaries, wages and benefits for central office personnel and other non-personnel costs. Also included are medical records, quality assurance and utilization review costs. These are set at a percentage of total costs.

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HCFA 179	<i>92-11</i>	

SUPERSEDES: NONE - NEW PAGE

May 1, 1992

Payment for Day Treatment services was derived from a model based on the resources required to meet the standards of the Department. The model was developed by the state in conjunction with a national consulting firm and applied by the Department of Health to address "Psychosocial Rehabilitation-Integrated Program Model", services similar in terms of activities, providers, and location to Day Treatment. Rate setting decisions were made based upon the results of a methodology study completed by the Department of Health. Periodic rate studies will be performed to determine appropriateness of reimbursement. The rate studies will be used to adjust provider rates, as found necessary, beginning in federal fiscal year 1997.

Day Treatment. Provider cost information was analyzed and total cost of service was separated into the following categories.

(1) Direct Service. These costs include all salaries, wages and benefits associated with personnel who provide daily face-to-face service to the recipient. Direct service staffing ratios were determined. The wage rate was based upon a Vocational Rehabilitation Counselor 2 in the State Personnel system.

(2) Direct Supervision. Costs include all salaries, wages and benefits associated with personnel whose primary responsibilities are to oversee and coordinate the activities of the direct service staff. A span of control was set and a wage rate determined using a Social Worker Supervisor 2 in the State system.

(3) Clinical supervision and support costs include all salaries, wages and benefits associated with personnel whose primary activities serve to support the day treatment program from a programmatic and clinical perspective as opposed to an administrative perspective. Included are clinical directors, assistant clinical directors, training directors, nurses and persons who perform other types of clinical program support and coordination activities. The wage level used was that of a Psychologist III.

(4) Consultation related costs include doctors, specialists and nurses who provide services to a day treatment program on a part-time "contract" or "consultative" basis. Consultation costs are a

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STATE	DATE REC'D
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06-11-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW MEXICO
AND STANDARDS FOR ESTABLISHING PAYMENT RATES
--OTHER TYPES OF CARE

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Page 22a¹

Autism Intervention Services (AIS)

Autism Intervention Services (AIS) are reimbursed on a fee schedule basis.

Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of January 1, 2019 and are effective for services provided on or after that date. All rates are published at <http://www.hsd.state.nm.us/providers/fee-schedules.aspx>.

Notice of changes to rates are made as required by 42 CFR 447.205.

1

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State: New Mexico
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Approval Date 06-26-19

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percentage of total costs. Consultation service costs that are not billed directly to the provider, but rather to the State are not included.

(5) Non-personnel operating costs include expenses incurred for program related supplies, transportation, and training. These were derived using a percentage of total cost.

(6) General administration costs include salaries, wages and benefits for central office personnel and other non-personnel costs. Also included are medical records, quality assurance and utilization review personnel costs. These are set at 10% of total costs.

8. Special Rehabilitation Services

Development of Fee Schedule:

To establish a fee schedule amount, the Department uses cost studies developed by a consulting firm to determine the average actual costs to providers to perform special rehabilitation services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration.

Using these factors, an amount was determined that was further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to special rehabilitation services with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examines rates being charged by providers who are already rendering services to other agencies and payers; and, (2) evaluates the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee is also verified by comparing the fees to those paid by several other state Medicaid programs for similar services.

Reimbursement for special rehabilitation services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined the rates are in conformance with OMB Circular A-87.

The fee schedule rate is re-evaluated every two years. In all cases, when making changes to the fee schedule, there is no differentiation between public and private providers with regards to reimbursement for the same service. The fees are available in a published fee schedule.

SUPERSEDES: TN- 93-27

STATE <u>New Mexico</u>	A
DATE REC'D <u>7-2-04</u>	
DATE APPV'D <u>9-23-04</u>	
DATE EFF <u>7-1-04</u>	
HCFA 179 <u>04-07</u>	

9. Rehabilitative Services – Assertive Community Treatment

Development of Fee Schedule:

To establish a fee schedule amount, the Department uses cost studies to determine the average actual costs to providers to perform Assertive Community Treatment services. Allowable costs included salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. The rates do not include room and board.

Using these factors, an amount is determined that is further evaluated for reasonableness considering prevailing charges and the existing fee schedule for services similar to Assertive Community Treatment services with regards to complexity, time, and level of responsibility. Specifically, the Department (1) examines rates being charged by providers who are already rendering services to other agencies and payers; and, (2) evaluates the reasonableness of the rates by comparing the complexity of the task and the necessary training and experience of staff who carry out the task with payment levels for comparable tasks. The reasonableness of the fee is also verified by comparing the fees to those paid by other state Medicaid programs for similar services.

Reimbursement for Assertive Community Treatment services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It is also determined the rates are in conformance with OMB Circular A-87.

The fee schedule rate is re-evaluated every two years. The payment rates result in public and private providers receiving the same payment for the same service. The fees are available in a published fee schedule.

SUPERSEDES: NONE - NEW PAGE

STATE <u>New Mexico</u>	A
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DATE APP'D <u>6-1-05</u>	
DATE EFF <u>2-1-05</u>	
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
- OTHER TYPES OF CARE

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I. Medication Assisted Treatment (MAT) Reimbursement:

Reimbursement for dispensing or administering methadone or other narcotic replacement or opioid agonist drug items is made at \$13.30. Included in this rate is the administration or dispensing of the drug item, the cost of methadone, development of a treatment plan and recipient assessment performed within the facility, drug and HIV testing, and counseling as required by 42 CFR part 8, *Certification of Opioid Treatment Programs*. Drug items other than methadone may be billed and reimbursed separately and are paid at the Medicaid fee schedule rate.

The agency's fee schedule rates were set as of September 1, 2012, and are effective for services provided on or after that date. All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services Department, Medical Assistance Division at <http://www.hsd.state.nm.us/mad/> under the Fee Schedules section. Notice of changes to rates will be made as required by 42 CFR 447.205.

The initial medical examination and additional medical services rendered by a practitioner, laboratory services performed at outside laboratories, and counseling services beyond the minimum service required by 42 CFR part 8, are reimbursed separately when the services and the provider of the services meet the requirements specified in other sections of the state plan.

STATE <u>New Mexico</u>	A
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DATE EFF <u>1 Sep, 2012</u>	
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TN No. 12-06(A)
SUPERSEDES: NONE - NEW PAGE
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State New MexicoPage 24REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

For service covered by the OMB rate provided to Native Americans by a qualified facility operated by the Indian Health Service, the applicable rate will be paid as published and specified in the the Federal Register.

STATE	<i>New Mexico</i>	A
DATE RECD	<i>03-31-00</i>	
DATE APPVD	<i>06-22-00</i>	
DATE EFF	<i>01-01-00</i>	
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Attachment 4.19 B

Page 25

Item XVI Tobacco Cessation Services

Tobacco Cessation Counseling Services

To maximize the effectiveness of tobacco cessation medications, counseling services are available for Medicaid beneficiary use in conjunction with cessation medication.

The rates are effective for tobacco cessation services on or after October 1, 2011 and were established at the Medicare rate for the same service. All rates and any updates or periodic adjustments to the fee schedule are published on the agency's website for the New Mexico Human Services Department, Medical Assistance Division, Provider Enrollment and Program Policy, Fee for Service, under Fee Schedules, at:
<http://www.hsd.state.nm.us/mad/feeschedules.html> Notice of changes to rates will be made as required by 42 CFR 447.205.

Assurances - Cost Sharing Exemption for Tobacco Cessation Services

The State assures that cost-sharing is prohibited for tobacco cessation services for pregnant women. In accordance with Section 1916(a)(2)(B) and section 1916A(b)(3)(B)(iii) of the Act, the State does not permit cost sharing for services furnished to pregnant women, if such services are related to the pregnancy or to any other medical condition which may complicate the pregnancy. The State assures that the prohibition on cost-sharing for pregnant women specifically includes "counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb))."

STATE <u>New Mexico</u>	A
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Page 1
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item A of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item of this attachment, for those groups and payments listed below and designated with the letters "NR".
4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item of this attachment (see 3. above).

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Supplement 1 to ATTACHMENT 4.19-B
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs: Part A SP Deductibles SP Coinsurance

Part B SP Deductibles SP Coinsurance

Other Part A SP Deductibles SP coinsurance

Medicaid

Recipients Part B SP Deductibles SP coinsurance

Dual Part A SP Deductibles SP Coinsurance

Eligible

(QMB Plus) Part B SP Deductibles SP Coinsurance

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TN No. 91-19

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF NEW MEXICO

ATTACHMENT 4.19-C RESERVE BEDS

Six reserve bed days per calendar year will be covered for every long term care resident for hospitalization without prior approval. Three reserve bed days per calendar year will be covered for a brief home visit without prior approval.

Six reserve bed days will be allowed with prior approval for visits which enable the recipient to adjust to a new environment as part of the discharge plan.

SUPERSEDES: TN- 80-12

STATE	<u>New Mexico</u>	A
DATE REC'D	<u>6-28-10</u>	
DATE APPV'D	<u>9-24-10</u>	
DATE EFF	<u>6-15-10</u>	
HOTA 179	<u>10-02</u>	

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

STATE <u>New Mexico</u>	A
DATE REC'D <u>1-5-98</u>	
DATE APP'D <u>8-27-98</u>	
DATE EFF <u>10-1-97</u>	
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Plan # 97-07
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ATTACHMENT 4.19-D

The State has in place a public process which complies with the requirements
Of Section 1902(a)(13)(A) of the Social Security Act

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Cost Related Reimbursement of Nursing Facilities

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- I. General Reimbursement policy
- II. Definitions
- III. Determination of Actual, allowable and reasonable costs
And setting of prospective rates
- IV. Establishment of Prospective per diem rates
- V. Establishment of ceilings
- VI. Imputed Occupancy
- VII. Adjustments to Base Year Costs
- VIII. Implement. of Nursing Home Reform Requirements 10-1-1990
- IX. Payment of Reserve Bed Days
- X. Reconsideration procedures for long term care determinations
- XI. Public Disclosure of Cost reports
- XII. Severability

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Comparison in certification Requirements

Part II

Cost Related Reimbursement of ICF/MR Facilities

P. 1

- I. General Reimbursement policy
- II. Definitions
- III. Determination Actual, allowable & reasonable costs
- IV. Establishment of prospective per diem rates
- V. Establishment of ceilings
- VI. Adjustment to base year costs
- VII. Reserve Bed Days
- VIII. Reconsideration procedures base yr determinations
- IX. Public disclosure of cost reports
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
- NURSING FACILITIES AND
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

OMB No.: 0938-1136
CMS Form: CMS-10364

Attachment 4.19 - D
Page ii

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (D) of this State plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below:

Reimbursement for services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Effective July 1, 2011, reimbursement for services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

No payment shall be made for services for Other Provider Preventable Conditions (OPPCs). OPPC is one category of Provider Preventable Conditions (PPC), as identified by the Centers for Medicare & Medicaid Services, and applies broadly to any health care setting where an OPPC may occur. OPPCs include the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

- i. The identified provider-preventable conditions would otherwise result in an increase in payment.
- ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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COST RELATED REIMBURSEMENT OF NURSING FACILITIES

The New Mexico Title XIX Program make reimbursement for appropriately licensed and certified Nursing Facility (NF) services as outlined in this material.

I. GENERAL REIMBURSEMENT POLICY:

The Human Services Department will reimburse Nursing Facilities (effective October 1, 1990, the SNF/ICF distinction is eliminated; see section VIII) the lower of the following, effective July 1, 1984:

A. Billed Charges;

B. The prospective rate as constrained by the ceilings (Section V) established by the Department as described in this plan.

II. DEFINITIONS

Accrual Basis of Accounting – Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected. The expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

Cash Basis of Accounting – Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

Governmental Institution – A provider of services owned and operated by a federal, state or local governmental agency.

Allocable Costs – An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

Applicable Credits – Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase

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discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the Federal Government to finance hospital activities or service operations should be treated as applicable credits.

Charges. -- The regular rates established by the provider for services rendered to both beneficiaries and to other paying patients whether inpatient or outpatient. The rate billed to the Department shall be the usual and customary rate charged to all patients.

Cost Finding. -- A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.

Cost Center. -- A division, department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

General Service Cost Centers -- Those cost centers which are operated for the benefit of other general service areas as well as special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.

Special Service Cost Centers. -- Commonly referred to as Ancillary Cost Centers. Such centers usually provide direct identifiable services to individual patients, and include departments such as the physical therapy and supply departments.

Inpatient Cost Centers. -- Cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

RCC. -- This is the Ratio of Charges to Charges. The bases or charges used in the RCC formula vary as to the costs to be allocated. The ratios may be expressed as follows:

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Superseded TN 98-20

1. ratio of beneficiary charges to total charges on a departmental basis.
2. ratio of beneficiary charges for ancillary services to total charges for ancillary services.
3. ratio of total patient charges by patient care center to the total charges of all patient care centers.

Provider -- The entity responsible for the provision of services. The provider must have entered into a valid agreement with the Medicaid program for the provision of such services.

Facility -- The actual physical structure in which services are provided.

Replacement Facility -- A facility which replaces a facility that was participating in Medicaid on July 1, 1984, or whose construction received Section 1122 approval by July 1, 1984, and where the basic structure of the facility to be replaced is at least twenty-five years old and has been in continuous use as a Skilled Nursing or Intermediate Care facility for at least twenty-five years or which facility has been destroyed by catastrophic occurrence and rendered unusable and irreparable, or condemned by eminent domain.

Closed Facility -- A facility which has been either voluntarily or involuntarily terminated from participation in the Medicaid program not to include termination for construction of a replacement facility.

Replaced Facility -- The facility replaced by a replacement facility as defined above.

Related Organization -- Organizations related to the provider by common ownership or control as defined by the provisions of the Medicare Provider Reimbursement Manual (HIM-15).

Imputed Occupancy -- The level of occupancy attributed for the purpose of calculating the reimbursement rate.

Owner -- The entity holding legal title to the facility.

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HCA 179	<i>92-07</i>	

III. DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS AND SETTING OF PROSPECTIVE RATES

A. Adequate Cost Data

1. Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.
2. Cost finding -- the cost finding method to be used by NF providers will be the step-down method. This method recognizes that services rendered by certain non-revenue-producing departments or centers are utilized by certain other non-revenue-producing centers. All costs of non-revenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the non-revenue-producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greater amount of expense will be allocated first.

- B. Reporting Year -- For the purpose of determining a prospective per diem rate related to cost for NF services, the reporting year is the provider's fiscal year. The provider will submit a cost report each year.
- C. Cost Reporting -- At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable cost (financial and statistical report) on the N.M. Title XIX cost reporting form. This itemized list must be submitted within 90 days after the close of the provider's cost reporting year. Failure to file a report within the 90-day limit,

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unless an extension is granted prior to the due date, will result in termination of Title XIX payments. Extensions must be requested in writing from the Medical Assistance Division prior to the due date of the cost report.

In the case of a change of ownership the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The Department will withhold the last month's payment to the previous provider as security against any outstanding obligations to the Department. The provider must notify the Department 60 days prior to any change in ownership.

D. Retention of Records.

1. Each NF provider shall maintain financial and statistical records of the period covered by such cost report for a period of not less than four years following the date of submittal of the New Mexico Title XIX cost report to the State Agency. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider shall make such records available upon demand to representatives of the State Agency, the State Audit Agent, or the Department of Health and Human Services.
2. The State Agency or its audit agent will retain all cost reports submitted by providers for a period of not less than three years following the date of final settlement of such reports.

E. Audits

1. Audits will be performed in accordance with 42 CFR 447.202.

Desk Audit. Each cost report submitted will be subjected to a comprehensive desk audit by the state audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the State Agency.

Field Audit. Field Audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's

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financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost and to determine whether the expenses attributable to such proper items of cost were accurately determined and reasonable.

After each field audit is performed, the audit agent will submit a complete report of the audit to the State Agency. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate and reasonable in accordance with the State Plan. These audit reports will be retained by the State Agency for a period of not less than three years from the date of final settlement of such reports.

- F. Overpayments. All overpayments found in audits will be accounted for on the HCFA-64 report to HHS no later than the second quarter following the quarter in which found.
- G. Allowable Costs. The following identifies costs that are allowable in the determination of a provider's actual, allowable and reasonable costs. All costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.
 - 1. Cost of meeting certification standards. These will include all items of expense that the provider must incur under:
 - a. 42 CFR 442.
 - b. Sections 1861(j) and 1902(a)(28) of the Social Security Act;
 - c. Standards included in 42 CFR 431.610;
 - d. Cost incurred to meet requirements for licensing under state law which are necessary for providing NF service.

2. Costs of Routine Services. Allowable costs shall include all items of expense that providers incur to provide routine services, known as operating costs.

a. Operating Costs include such things as:

- (1) Regular room.
- (2) Dietary and nursing services.
- (3) Medical and surgical supplies (including syringes, catheters, ileostomy, and colostomy supplies).
- (4) Use of equipment and facilities.
- (5) General services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas.
- (6) Items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans.
- (7) Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, bandaids, laxatives and fecal softeners, aspirin, antacids, OTC ointments, and tongue depressors.
- (8) Items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen administration equipment, and other durable equipment.
- (9) Special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician.
- (10) Laundry services including basic personal laundry.

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- (11) Oxygen for emergency use -- The Department will allow two options for the purchase of oxygen for patients for whom the attending physician prescribes oxygen administration on a regular or on-going basis:
- a) The long term care facility may purchase the oxygen and include it as a reimbursable cost in its cost report. This is the same as the method of reimbursement for oxygen administration equipment; or
 - b) The Department will make payment directly to the medical equipment provider in accordance with procedures outlined in Medical Assistance Manual Section 310.08, Medical Supplies, and subject to the limitations on rental payments contained in section 310.0805 (B).
- (12) Managerial, administrative, professional, and other services related to the providers operation and rendered in connection with patient care.
- b. Facility costs, for purpose of specific limitations included in this plan, include only depreciation, lease costs, and long-term interest.
- (1) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated useful life of the assets.
- a) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.
 - b) Historical cost is the actual cost incurred in acquiring and preparing an asset for use.
 - c) Fair market value is the price for which an asset would have been purchased on the date of acquisition in

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an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American Institute of Real Estate Appraisers (MAI) and who is acceptable to the Department.

d) In determining the historical cost of assets where an on-going facility is purchased, the provisions of Medicare Provider Reimbursement Manual (HIM-15), Section 104.14 will apply.

e) Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American Hospital Association Chart of Accounts for Hospitals.

(2) Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.

(3) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

c. Gains and Losses on Disposition

Gains or losses on the disposition of depreciable assets used in the program are calculated in accordance with Section 130 and 132 of HIM-15. Disposition of a provider's depreciable assets which effectively terminates its participation in the program shall include the sale, lease or other disposition of a facility to another entity whether or not that entity becomes a participant in the program. The amount of gain on the disposition of depreciable assets will be subject to recapture as allowed by HIM-15.

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- d. Depreciation, interest, lease costs, or other costs are subject to the limitations stated in Section 2422 of HIM-15 regarding approval of capital expenditures in accordance with Section 1122 of the Social Security Act.
- e. Facility costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.

H. Non-Allowable Costs

- 1. Bad debts, charity, and courtesy allowances: bad debts on non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs.
- 2. Purchases from related organizations: cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall identify such related organizations and costs in the State's cost reports.
- 3. Return on equity capital.
- 4. Other cost and expense items identified as unallowable in HIM-15.
- 5. Interest paid on overpayments as per Medical Assistance Manual Section 307.
- 6. Any civil monetary penalties levied in connection to intermediate sanctions, licensure, certification, or fraud regulations.

IV. ESTABLISHMENT OF PROSPECTIVE PER-DIEM RATES

Prospective per diem rates will be established as follows and will be the lower of the amount calculated using the following formulas, or the ceiling:

A. Base Year

Rebasing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as Year 1, Year 2, and Year 3. Because rebasing is done every three years, operating year 4 will again become Year 1, etc.

Cost incurred, reported, audited and/or desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year 1 will be used to re-base the prospective per diem rate. Rebasing of costs in excess of 110% of the previous year's audited cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.

For implementation Year1 (effective July 1, 1984) the base year is the provider's last available audited cost report prior to January 1, 1984.

Rebasing will occur out of cycle for rates effective January 1, 1996, using the provider's FYE 1994 audited cost report. The rate period January 1, 1996, through June 30, 1996, will be considered Year 1. The rate period July 1, 1996, through June 30, 1997, will be considered Year 2, and the rate period July 1, 1997, through June 30, 1998, will be considered year 3. The rebasing cycle will resume for rates effective July 1, 1998, and continue as described in the first paragraph of this section.

Effective for dates of service on or after July 1, 2015, each private nursing facility's existing "Low Level of Care" rate is increased 4%.

B. Inflation factor to recognize economic conditions and trends during the time period covered by the provider's prospective per diem rate.

The index used to determine the inflation factor will be the Health Care Financing Administration Nursing Home Market Basket Index (NHI).

Each provider's operating costs will be indexed up to a common point of 12/31 for the base year, and then indexed to a mid-year point of 12/31 for operating Year 1. For the out of cycle rebasing occurring for rates effective January 1, 1996,

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through June 30, 1996, the mid-year point for indexing for operating Year 1 will be 3/31.

The inflation factor for the period July 1, 1996, through June 30, 1997, will be the percentage change in the NHI for the previous year plus 2 percentage points. For each rate period thereafter, the inflation factor will be the change in the NHI for the previous year.

C. Incentives to Reduce Increase in Costs

As an incentive to reduce the increases in the costs of operation, the Department will share with the provider

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in accordance with the formula described below the savings below the operating cost ceiling in effect during the state's fiscal year.

$$I = [1/2(M - N)] \leq \$2.00$$

Where

M = Current operating cost ceiling per diem

N = Allowable operating per diem rate based on the base year's cost report

I = Allowable incentive per diem

D. Calculation of the Prospective Per Diem Rate

The following formulas are used to determine the prospective per diem rate:

Year 1

$$PR = BYOC \times (1 + NHI) + I + FC$$

Where

PR = Prospective per diem rate

BYOC = Allowable base year operating costs as described in A above, and indexed as described in B above.

NHI = The change in the NHI as described in B above

I = Allowable incentive per diem

FC = Allowable facility costs per diem

Years 2 and 3

$$PR = (OP + I) \times (1 + NHI) + FC$$

Where

PR = Prospective per diem rate

OP = Allowable operating costs per diem

I = Allowable incentive per diem

NHI = The change in the NHI as described in B above.

FC = Allowable facility costs per diem

E. Effective Dates of Prospective Rates

Rates are effective July 1 of each year for each facility.

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F. Calculation of Rates for Existing Providers that do not have 1983 Actuals, and for Newly Constructed facilities entering the program after July 1, 1984

For existing and for newly constructed facilities entering the program that do not have 1983 actuals, the provider's interim prospective per diem rate will become the sum of:

1. The applicable facility cost ceiling.
2. The operating cost ceiling.

After six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report. This will be audited to determine the actual operating and facility cost, and retroactive settlement will take place. The provider's prospective per diem rate will then become the sum of:

1. The lower of allowable facility costs or the applicable facility cost ceiling
2. The lower of allowable operating costs or the operating cost ceiling

Such providers will not be eligible for incentive payments until the next operating Year 1, after rebasing.

G. Changes of provider by sale of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

1. The lower of allowable facility costs determined by using the Medicare principles of reimbursement, or the facility cost ceiling.
2. The operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

Such providers will not be eligible for incentive payments until the next operating Year 1, after rebasing.

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H. Changes of provider by lease of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

1. The lower of allowable facility costs or the facility cost ceiling, as defined by this plan.
2. The operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

Such providers will not be eligible for incentive payments until the next operating Year 1, after rebasing.

I. Sale/leaseback of an existing facility

When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

J. Replacement of an existing facility

When an existing facility is replaced, the provider's prospective rate will become the sum of:

1. The lower of allowable facility costs or the facility cost ceiling as defined by this plan.
2. The operating cost plus incentive payment paid to the provider prior to the construction of the replacement facility.

K. Replaced facility re-entering the Medicaid Program

When a facility is replaced by a replacement facility and the replaced facility re-enters the Medicaid program either under the same ownership or under different ownership, the provider's prospective rate will become the sum of:

1. The median operating cost for its category.
2. The lower of allowable facility costs or the applicable facility cost ceiling.

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Such providers will not be eligible for incentive payments until the next operating year 1, after rebasing.

L. Closed facility re-entering the Medicaid Program

1. When a facility has been closed and re-enters the Medicaid Program under new ownership, it shall be considered a change of ownership and either G or H, which ever is applicable, will apply.
2. When a facility has been closed and re-enters the Medicaid program within 12 months of closure under the same ownership, the provider's prospective rate will be the same as prior to the closing.
3. When a facility has been closed and re-enters the Medicaid program more than 12 months after closure, under the same ownership, the provider's prospective rate will be the sum of:
 - a) the median operating cost for its category
 - b) the lower of allowable facility costs or the applicable facility cost ceiling.

Providers of such facilities will not be eligible for incentive payments until the next operating year 1, after rebasing.

V. ESTABLISHMENT OF CEILINGS

The following categories are used to establish ceilings used in calculating prospective per diem rates:

1. State-owned and operated NF
2. Non-state-owned and operated NF

The Department determines the status of each provider for exclusion or inclusion in any one category.

Ceilings will be separately established for each category as described above, and separately established for the two areas of allowable costs, i.e. operating costs and facility costs. The operating cost ceiling will be calculated using the base year costs for Year 1. For Years 2 and 3, the operating cost ceiling will not be recalculated. It will be indexed forward using the appropriate inflation factor. The

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facility cost ceiling of \$11.50 will be trended forward in Year 2 beginning July 1, 1985, by NHI minus 1 percentage points and then annually by the NHI.

A. Operating Costs

The ceiling for operating costs will be established at 110% of the median of allowable costs for the base year, indexed to 12/31 of base year.

B. Facility Costs

For existing, replacement, and newly constructed facilities, including remodeling of a facility to become a long term care facility, facility costs will be limited as follows:

1. Any facility that is participating in Medicaid by July 1, 1984, or has been granted Section 1122 approval by July 1, 1984, for construction (including bed additions to such facilities) will be paid the lower of actual allowable facility costs or the applicable facility cost ceiling for implementation Year 1. The facility cost ceiling will be eleven dollars and fifty cents (\$11.50).
2. Any new facility not approved July 1, 1984, under Section 1122 for construction (including bed additions to such facilities) will be paid the lower of actual allowable facility costs or the median of facility costs for all other existing facilities which are in the same category.
3. Effective for leases executed and binding on both parties on or after January 1, 1988, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor an annual rate of return on the fair market value of the facility equal to one time the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for the twelve months prior to the date the facility became a provider in the New Mexico Medicaid program. The rates of interest for this fund are published in both the Federal Register and the Commerce Clearing

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House (CCH). The basis of the total investment will be subject to the limitations described in 1 and 2 above.

The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective and the reasonableness of such clauses will be determined by the inflation factor described in section IV, B, of these regulations.

Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider and is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with the geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the Department the name of the appraiser, a copy of his/her certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the Department.

4. For newly constructed facilities, reconstruction of a facility to become a long term care facility, and replacement facilities entering the Medicaid program on or after January 1, 1988, the total basis of depreciable assets shall not exceed the median cost of construction of a nursing home as listed in the Robert S. Means construction index, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to enter the New Mexico Medicaid program. The costs of construction referred to herein is expected to include only the cost of the building and fixed equipment. A reasonable value of land and major moveable equipment will need to be added to obtain the value of the entire facility.
5. When an existing facility is sold, facility costs per day will be limited to the lower of:
 - a. Allowable facility costs determined by using the Medicare principles of reimbursement or

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- b. The facility cost ceiling.
- 6. When an existing facility is leased, the facility costs per day will be limited to the lower of:
 - a. Actual allowable facility costs, or
 - b. for facilities owned or operated by the lessor for 10 years or longer, the applicable facility cost ceiling, or
 - c. for facilities owned or operated by the lessor less than 10 years, 110% of the median of facility costs for all providers in the same category.
- 7. When a replaced facility re-enters the Medicaid program either under the same ownership as prior to the replacement or under different ownership, facility costs per day will be limited to the lower of
 - a. Actual allowable facility costs or
 - b. The median of facility costs for all other existing facilities which are in the same category.

VI. IMPUTED OCCUPANCY

In order to insure that the Medicaid program does not pay for costs associated with unnecessary beds as evidenced by under-utilization, allowable facility costs will be calculated by imputing a 90% occupancy rate. This provision will apply to:

- 1. Any new facility certified for participation in the Medicaid program on or after January 1, 1988.
- 2. Existing facilities, if the number of licensed or certified beds increases on or after January 1, 1988. In such cases, occupancy will be imputed for all beds.
- 3. Replacement facilities, certified for participation in the Medicaid program on or after January 1, 1988, if the replacement facility contains a higher number of licensed or certified beds than the facility being replaced.

4. Any replaced facility which re-enters the Medicaid program on or after January 1, 1988, either under the same ownership or different ownership.
5. Any closed facility which re-enters the Medicaid program on or after January 1, 1988.

Facility costs will be adjusted and the resulting rate change will become effective when any of the above occurs. Providers operating such facilities shall submit appropriate information regarding facility costs so that the rate adjustment can be computed.

VII. ADJUSTMENTS TO BASE YEAR COSTS

Since rebasing of the prospective per diem rate will take place every three years, the Department recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:

- A. Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, social security taxation of 501(c)(3) corporations, minimum wage change, property tax increases, etc.)
- B. Additional costs incurred as a result of uninsurable losses from catastrophic occurrences.
- C. Additional costs of approved expansion, remodeling or purchase of equipment.

Such additional costs must reach a minimum of \$10,000 incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The provider is encouraged to submit such rebasing requests before the cost is actually incurred if possible. The Department will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect: 1) beginning with the month the cost was actually incurred if prior approval was obtained, or 2) no later than 30 days from the date of the approval if retroactive approval was obtained.

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At no time will rebasing in excess of the applicable operating or facility cost ceilings be allowed, unless the Department determines that a change in law or regulation has equal impact on all providers regardless of the ceiling limitation. An example of this would be the minimum wage law.

VIII. IMPLEMENTATION OF NURSING HOME REFORM REQUIREMENTS EFFECTIVE OCTOBER 1, 1990.

As mandated by Section 1919 of the Social Security Act, the following changes are made effective October 1, 1990:

A. Elimination of SNF/ICF Distinction

Effective October 1, 1990, the SNF and ICF distinctions will be eliminated and all participating providers will become NFs. In order to account for the change the following will be implemented:

1. Two levels of NF services will exist.

High NF
Low NF

2. A High NF rate and a Low NF rate will be established for each provider.
3. For existing SNFs, the High NF rate will be the provider's SNF rate in effect on September 30, 1990.
4. For existing ICFs, the Low NF rate will be the provider's ICF rate in effect on September 30, 1990.
5. For existing ICFs with no existing SNF rate, the High NF rate will be the provider's ICF rate in effect on September 30, 1990, plus an amount equal to the statewide mean differential (i.e. the average difference) of the operating component of current SNF/ICF rates.
6. For existing SNFs with no existing ICF rate, the Low NF rate will be the provider's SNF rate in effect on September 30, 1990, minus an amount equal to the statewide mean differential (i.e. the average difference) of the operating component of current SNF/ICF rates.

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B. Cost Increases Related to Nursing Home Reform

To account for cost increases necessary to comply with the Nursing Home Reform provisions, the following amounts will be added to NF rates(see above), effective October 1, 1990:

High NF	\$3.69
Low NF	\$4.96

IX. PAYMENT OF RESERVE BED DAYS

When Medicaid payment is made to reserve a bed while the recipient is absent from the facility, the reserve bed day payment shall be in an amount equal to 50% of the regular payment rate.

X. RECONSIDERATION PROCEDURES FOR LONG TERM CARE DETERMINATIONS

- A. A provider who is dissatisfied with the base year rate determination or the final settlement (in the case of a change in ownership) may request a reconsideration of the determination by addressing a Request for Reconsideration to:

Director
Medical Assistance Division
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

- B. The filing of a Request for Reconsideration will not effect the imposition of the determination.
- C. A request for Reconsideration, to be timely, must be filed with or received by the Medical Assistance Division Director no later than 30 days after the date of the determination notice to the provider.
- D. The written Request for Reconsideration must identify each point on which it takes issue with the Audit Agent and must include all documentation, citation of authority, and argument on which the request is based. Any point not raised in the original filed request may not be raised later.

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- E. The Medical Assistance Division will submit copies of the request and supporting material to the Audit Agent. A copy of the transmittal letter to the Audit Agent will be sent to the provider. A written response from the Audit Agent must be filed with or received by the Medical Assistance Division no later than 30 days after the date of the transmittal letter.
- F. The Medical Assistance Division will submit copies of the Audit Agent's response and supporting material to the provider. A copy of the transmittal letter to the provider will be sent to the Audit Agent. Both parties may then come up with additional submittals on the point(s) at issue. Such follow-up submittals must be filed with or received by the Medical Assistance Division no later than 15 days after the date of the transmittal letter to the provider.
- G. The Request for Reconsideration and supporting materials, the response and supporting materials, and any additional submittal will be delivered by the Medical Assistance Division Director to the Secretary, or his/her designee, within 5 days after the closing date for final submittals.
- H. The Secretary, or his/her designee, may secure all information and call on all expertise he/she believes necessary to decide the issues.
- I. The Secretary, or his/her designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to him. The Secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The Secretary's decision will be final and any changes to the original determination will be implemented pursuant to that decision.

XI. PUBLIC DISCLOSURE OF COST REPORTS

- A. Providers' cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the Medical Assistance Division. Information thus disclosed is limited to cost report documents required by Social Security Administration regulations and, in the case of a settled cost report, the notice of program settlement.

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- B. The request must identify the provider and the specific report(s) requested.
- C. The provider whose report has been requested will be notified by the Medical Assistance Division that its cost report has been requested, and by whom. The provider shall have 10 days in which to comment to the requester before the cost report is released.
- D. The cost for copying will be charged to the requester.

XII. SEVERABILITY

If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.

COMPARISON IN CERTIFICATION REQUIREMENTS

<u>Requirement</u>	<u>Cost Effect</u>	<u>Comments</u>
1. Nurse aide continuing education/in-service	\$0.11	
2. Supplies	\$0.04	for continuing education and in-service
3. RN-8hr.*	\$0.39	
4. 24 hour nursing*	\$0.18	
5. Physician Involvement*	\$0.06	
6. Social services and elimination of ICP/SNP distinction*	\$0.64	
7. Wage adjustment for trained aides	\$0.90	
8. Overtime staff costs due to aide training	\$0.23	
9. PASAAR screen	\$0.01	
10. Pharmacy & dietary consulting	\$0.15	
11. Resident rights	\$0.01	
12. Interest bearing accounts/surety bonds	\$0.10	
13. Increased aide staffing for restraints and individualized needs	\$1.11	

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SUPERSEDES: TN- *94-06*

14. Increased social services/activities staff for individual resident needs \$0.72

15. Resident assessment \$0.31

TOTAL COST PER PATIENT DAY \$4.96

* Increases do not apply to existing SNFs as these requirements already built into SNF cost report.

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SUPERSEDES: TN.

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EXHIBIT D
ESTIMATION OF COSTS COSTA '00 L'0
NEW MEXICO

COST
PER
PT. DAY JUSTIFICATION

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CATEGORY

NURSE AIDE CONTINUING
EDUCATION/INSERVICE

SUPERSEDES: TN - *94-06*

9.11 ASSUME A STANDARD OF 24 HOURS OF IN-SERVICE TRAINING PER AIDE
THIS CATEGORY HAS TWO COMPONENTS: 1) THE COST OF MAINTAINING
STAFFING LEVEL WHILE THE AIDES ARE RECEIVING IN-SERVICE TRAINING AND THE
COST OF THE IN-SERVICE INSTRUCTOR. THE FIRST COMPONENT IS CALCULATED
AS FOLLOWS: ADDITIONAL COSTS OF PROVIDING IN-SERVICE TRAINING TO AIDES
NOT AT THE 24 HOUR LEVEL DIVIDED BY THE NUMBER OF PATIENT DAYS
IN THOSE FACILITIES $1077151.25/67096 = .067$ THE COST FOR THE IN-SERVICE
INSTRUCTOR IS BASED ON THE SALARY LEVEL OF AN RN AND ON THE
NUMBER OF HOURS NEEDED TO ACHIEVE THE STANDARD DIVIDED BY THE NUMBER OF
PATIENT DAYS IN THE AFFECTED FACILITIES $102016.31/67096 = .027$

SUPPLIES

9.04 THIS COST IS BASED ON THE PROVISION OF INSTRUCTOR MANUALS AT AN AVERAGE COST OF
\$22.13, VIDEO AT AN AVERAGE COST OF \$50.00 PER FACILITY AND STUDENT
STUDENT MANUALS AT AN AVERAGE COST OF \$4.22.25 PER FACILITY. MISCELLANEOUS COSTS SUCH AS
PAPER, PENS, ETC. ARE ALSO INCLUDED. A TURNOVER RATE IS CALCULATED FOR EACH
FACILITY USING TOTAL 0-24 HOURS CURRENT AIDE LEVEL. $101073/1375735$
THE DIVISOR IS EQUAL TO RELEVANT PATIENT DAYS.

8 HRS PER DAY SN COVERAGE

9.09 THIS ADJUSTMENT ONLY APPLIES TO ICFs AND REPRESENTS
THE COST OF OBTAINING THE REQUIRED COVERAGE.
 $6536386/1375735$, THE DIVISOR IS EQUAL TO THE TOTAL PATIENT DAYS

24 HOUR NURSING COVERAGE

9.10 THIS IS ADJUSTMENT TO ASSURE LICENSED NURSE COVERAGE AROUND THE CLOCK.
 $6249590/1375735$

PHYSICIAN INVOLVEMENT

9.06 THIS ADJUSTMENT ONLY APPLIES TO ICFs AND REPRESENTS
THE COST OF OBTAINING THE REQUIRED SERVICE.
 $997507/1375735$, THE DIVISOR IS EQUAL TO THE TOTAL PATIENT DAYS

SOCIAL SERVICES &
ICF/SNF DISTINCTION

9.04 ADDITIONAL COSTS NECESSARY TO MEET NF STANDARDS, TO ADDRESS NEW QUALIFICATIONS
FOR SOCIAL WORKERS, ACTIVITIES DIRECTORS, MEDICAL RECORDS
TECHNICIANS AND THE ADDITION OF A DENTAL ADVISOR.
 $882068/1375735$, THE DIVISOR IS EQUAL TO THE TOTAL PATIENT DAYS

NURSE ADJUSTMENT FOR
TRAINED AIDES

9.90 THIS REPRESENT A DIFFERENTIAL BETWEEN NEW UNTRAINED NURSES AND
TRAINED AIDES. $61241839/1375735$

OVERTIME STAFF COSTS DUE TO
AIDE TRAINING

9.23 THIS REPRESENTS THE COSTS ON ENSURING ADEQUATE STAFFING WHILE AIDES
ARE IN TRAINING. $9316963/1375735$

PASAPR SCREENING

9.01 THIS COVERS THE COST OF NEW AND ON-GOING LEVEL 1 SCREENS.
 $94127.21/1375735$

RESIDENT ASSESSMENT AND CARE
PLANNING/SERVICE

9.31 CALCULATED BASED ON FOUR ASSESSMENTS PER BED USING AN AVERAGE
FACILITY SIZE OF 85 BEDS; AVERAGE OF 2.75 AS PER ASSESSMENT;
AT A RATE OF \$14.00 PER HOUR OF ASSESSMENT.

PHARMACY & DIETARY
CONSULTANT

0.15 BASED ON 4 HOURS PER MONTH PER CONSULTANT AT \$50
PER HOUR PER 80 RESIDENTS.
2/11/92/32120

RESIDENT RIGHTS
REQUIREMENTS

0.01 BASED ON \$1.00 PER ADMISSION FACTOR AT 15%
TURNOVER RATE OF AVERAGE OF 80 RESIDENTS PER YEAR. INCLUDES
COST OF FORMS, TALES, TRANSLATION, ETC.
0132/32120

INTEREST BEARING ACCOUNTS
SURETY BONDS

0.10 BASED ON THE NUMBER OF RESIDENTS REQUIRING THAT SERVICE.
THIS ASSUMES 80 PERCENT OF THE RESIDENTS IN AN 80 BED
FACILITY WILL NEED THE SERVICE; THE COST FOR THE ACCOUNTS IS
ONE HOUR AT A COST OF \$11 PER HOUR FOR 80 RESIDENTS; AND AN
ADDITION OF \$500 PER FACILITY FOR THE SURETY BONDS.

ACTIVITIES/SOCIAL SERVICES
INCREASED STAFF FOR INDIVIDUALIZED
SERVICES

0.72 ADDITIONAL STAFF TO ADDRESS RESIDENT NEEDS. BASED ON
30 HOURS OF SOCIAL SERVICES AND 10 HOURS OF
ACTIVITIES WITH ASSOCIATED TOTAL COSTS OF \$17,500 AND \$5,000 RESPECTIVELY
PER 80 RESIDENTS.

INCREASED AIDE STAFFING FOR
INDIVIDUALIZED SERVICES

01.11 BASED ON 2 FTE AIDES WITH BENEFITS PER DAY. ASSUME AIDE COST OF
\$6.12 PER HOUR WITH BENEFITS AT 16 HOURS PER DAY PER 80 RESIDENTS.

TOTAL OBRA '87 LTC COST
PER PATIENT DAY

34.96

NOTE:

ESTIMATES FOR THE FIRST NINE ITEMS IN THIS DOCUMENT WERE DERIVED FROM
FACILITY SPECIFIC INFORMATION COLLECTED VIA A COMPUTERIZED TOOL DEVELOPED
BY THE NEW MEXICO HEALTH CARE ASSOCIATION, PETERSON HALL
& DOWN & BOC SEIDMAN. THE REMAINING ITEMS WERE DEVELOPED BY THE
BY A REASSESSMENT COMMITTEE OF THE NMHCA.
THE NMHCA THEN PRESENTED A PACKAGE TO THE MEDICAL ASSISTANCE DIVISION
THE DIVISION REVIEWED THE SUBMISSION THEN RECOMMENDED ADDITIONAL CHANGES.
THESE FINAL FIGURES REPRESENT THE FINAL NEGOTIATIONS WITH THE
EXECUTIVE DIRECTOR AND PRESIDENT OF THE ASSOCIATION.

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SUPERSEDES: TN. 94-06

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Supersales - 85-4

COST RELATED REIMBURSEMENT OF ICF/MR FACILITIES

The New Mexico Title XIX Program makes reimbursement for appropriately licensed and certified Intermediate Care Facilities for the Mentally Retarded as outlined in this material.

I. GENERAL REIMBURSEMENT POLICY

The Human Services Department will reimbursement ICF/MR facilities the lower of the following, effective for services rendered on or after September 1, 1990:

- A. Billed charges;
- B. The prospective per diem rate as constrained by the ceilings (Section V) established by the Department as described in this plan.

II. DEFINITIONS

Accrual Basis of Accounting --Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected. The expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

Cash Basis of Accounting --Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

Governmental Institution --A provider of services owned and operated by a federal, state or local governmental agency.

Allocable Costs --An item or group of items of cost chargeable to one or more objects, precesses, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

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Applicable Credits --Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. If amounts are received from the Federal Government to finance hospital activities or service operations that are covered by the Medicaid program, then these amounts must be treated as applicable credits.

Charges --The regular rates established by the provider for services rendered to both Medicaid recipients and to other paying patients whether inpatient or outpatient. The rate billed to the Department shall be the usual and customary rate charged to all patients.

Cost Finding --A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.

Cost Center --A division, department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

General Service Cost Centers --Those cost centers which are operated for the benefit of other general service areas as well as special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost center are allocated to other cost centers on the basis of services rendered.

Special Service Cost Centers --Commonly referred to as Ancillary Cost Center. Such centers usually provide direct identifiable services to individual patients, and include departments such as the physical therapy and supply departments.

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Inpatient Cost Centers --Cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

RCC --This is the ratio of charges to charges. The bases or charges used in the RCC formula vary as to the costs to be allocated. The ratios may be expressed as follows:

1. ratio of recipient charges to total charges on a departmental basis.
2. ratio of recipient charges for ancillary services to total charges for ancillary services.
3. ratio of total patient charges by patient care center to the total charges of all patient care centers.

Provider --The entity responsible for the provision of services. The provider must have entered into a valid agreement with the Medicaid program for the provision of such services.

Facility --The actual physical structure in which services are provided.

Owner --The entity holding legal title to the facility.

III. DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS

A. Adequate Cost Data

1. Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.
2. Cost finding-- the cost finding method to be used by ICF/MR providers will be the step-down method. This method recognizes that services rendered by certain non-revenue producing

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departments or centers are utilized by certain other non-revenue producing centers. All cost of non-revenue producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the non-revenue producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greater amount of expense will be allocated first.

- B. Reporting Year -- For the purpose of determining a prospective per diem rate related to cost for ICF/MR services, the reporting year is the provider's fiscal year. The provider will submit a cost report each year.
- C. Cost Reporting -- At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable cost (financial and statistical report) on the N.M. Title XIX cost reporting form. This itemized list must be submitted within 90 days after the close of the provider's cost reporting year. Failure to file a report within the 90 day limit, unless an extension is granted prior to the due date, will result in suspension of Title XIX payments. Extensions must be requested in writing from the Medical Assistance Division prior to the due date of the cost report.

In the case of a change of ownership, the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The Department will withhold the last month's payment to the previous provider as security against any outstanding obligations to the Department. The provider must notify the Department 60 days prior to any change of ownership.

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D. Retention of Records

1. Each ICF/MR provider shall maintain financial and statistical records of the period covered by such cost report for a period of not less than four years following the date of submittal of the N.M. Title XIX Cost Report to the state agency. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider shall make such records available upon demand to representatives of the State Agency, the State Audit Agent, or the Department of Health and Human Services.
2. The State Agency or its audit agent will retain all cost reports submitted by providers for a period of not less than three years following the date of final settlement of such report.

E. Audits

Audits will be performed in accordance with 42 CFR 447.202.

Desk Audit Each cost report submitted will be subjected to a comprehensive desk audit by the state audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the State Agency.

Field Audit Field audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost and to determine whether the expenses attributable to such proper items of cost were accurately determined and reasonable.

After each field audit is performed, the audit agent will submit a complete report of the audit to the

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State Agency. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate and reasonable in accordance with the State Plan. These audit reports will be retained by the State Agency for a period of not less than three years from the date of final settlement of such reports.

- F. Overpayments All overpayments found in audits will be accounted for on the HCFA 64 report to HHS no later than 60 days following the discovery.
- G. Allowable Costs The following identifies costs that are allowable in the determination of a provider's actual, allowable and reasonable costs. All costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.
1. Cost of meeting certification standards These will include all items of expense that the provider must incur under:
 - a. 42 CFR 442
 - b. Sections 1861(j) and 1902(a)(28) of the Social Security Act;
 - c. Standards included in 42 CFR 431.610;
 - d. Cost incurred to meet requirements for licensing under state law which are necessary to provide ICF/MR service.
 2. Costs of Routine Services Allowable costs shall include all items of expense that providers incur to provide routine services, known as operating costs.
 - a. Operating costs include such things as:
 - (1) Regular room
 - (2) Dietary and nursing services
 - (3) Medical and surgical supplies (including but not limited to

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syringes, catheters, ileostomy, and colostomy supplies).

- (4) Use of equipment and facilities
- (5) General services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas.
- (6) Items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans.
- (7) Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, bandaids, laxatives and fecal softeners, aspirin, antacids, OTC ointments, and tongue depressors.
- (8) Items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen administration equipment, and other durable equipment.
- (9) Special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician.
- (10) Laundry services other than for personal clothing.
- (11) Oxygen for emergency use--The Department will allow two options for the purchase of oxygen for patients for whom the attending physician prescribes oxygen administration on a regular or on-going basis:

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- a) The provider may purchase the oxygen and include it as a reimbursable cost in its cost report. This is the same as the method of reimbursement for oxygen administration equipment; or
 - b) The Department will make payment directly to the medical equipment provider in accordance with procedures outlined in Medical Assistance Manual Section 310.08, Medical Supplies, and subject to the limitations on rental payments contained in that section.
- (12) All services delivered in relation to active treatment, such as physical therapy, occupational therapy, speech therapy, psychology services, recreational therapy, etc.
- (13) Managerial, administrative, professional and other services related to the providers operation and rendered in connection with patient care.
- b. Facility cost, for the purpose of specific limitations included in this plan, include only depreciation, lease costs, and long term interest.
- (1) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated life of the assets.
- a) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.
 - b) Historical cost is the actual

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cost incurred in acquiring and preparing an asset for use.

- c) Fair market value is the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American Institute of Real Estate Appraisers (MAI) and who is acceptable to the Department.
 - d) In determining the historical cost of assets where an on-going facility is purchased, the provisions of Medicare Provider Reimbursement Manual (HIM-15) will apply.
 - e) Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American Hospital Association Chart of Accounts for Hospitals.
- (2) Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.
 - (3) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

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c. Gains and Losses on Disposition

Gains or losses on the disposition of depreciable assets used in the program are calculated in accordance with the HIM-15. Disposition of a provider's depreciable assets which effectively terminates its participation in the program shall include the sale, lease, or other disposition of a facility to another entity whether or not that entity becomes a participant in the program. The amount of gain on the disposition of depreciable assets will be subject to recapture as allowed by HIM-15.

- d. Depreciation, interest, lease cost, or other costs are subject to limitations stated in the HIM-15.
- e. Facility costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.

H. Non-Allowable Costs

1. Bad debts, charity, and courtesy allowances: bad debts on non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs.
2. Purchases from related organizations: cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall identify such related organizations and costs in the States's cost reports.
3. Return on equity capital.
4. Other cost and expense items identified as unallowable in HIM-15.

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5. Interest paid on overpayments as per Medical Assistance Manual Section 307.
6. Any civil monetary penalties levied in connection with licensure, certification, or fraud regulations.

IV. ESTABLISHMENT OF PROSPECTIVE PER DIEM RATES

Prospective per diem rates will be established as follows and will be the lower of the amount calculated using the following formulas, or any applicable ceiling:

A. Base Year

For implementation Year 1 (effective September 1, 1990), the providers base year will be for cost reports filed for base year periods ending no later than June 30, 1990. Since these cost reports will not be audited at the time of implementation, an interim rate will be calculated and once the audited cost report is settled, a final prospective rate will be determined. Retrospective settlements of over or under payments resulting from the use of the interim rate will be made.

Rebasing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as Year 1, Year 2, and Year 3. Since rebasing is done every three years, operating year 4 will again become Year 1, etc.

Costs incurred, reported, audited and/or desk reviewed for the provider's last fiscal year which ends in the calendar year prior to year 1 will be used to re-base the prospective per diem rate. Rebasing costs in excess of 110% of the previous year's reported cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.

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- B. Inflation factor to recognize economic conditions and trends during the time period covered by the facility's prospective per diem rate.

The index used to determine the inflation factor will be the Health Care Financing Administration Nursing Home Market Basket Index (MBI)- Without Capital and Medical Fees.

Each provider's operating costs will be indexed to a mid-year point of February 28 for operating Year 1.

The inflation factor will be the percentage change in the most current available actual or forecast MBI for the previous calendar year.

- C. Incentive to Reduce Increases in Cost

As an incentive to reduce the increases in the Administrative and General (A&G) and Room and Board (R&B) cost center, the Department will share with the provider the savings below the A&G/R&B ceiling in accordance with the formula described below:

$$A = [1/2 (B-C)] \leq \$1.00$$

Where:

A = Allowable Incentive per diem

B = A&G/R&B ceiling per diem

C = Allowable A&G/R&B per diem from the base year's cost report

- D. Cost Centers for Rate Calculation

For the purpose of rate calculation, costs will be grouped into four major cost centers. These are:

1. Direct Patient Care (DPC)
2. Administration and General (A&G)
3. Room and Board (R&B)
4. Facility costs (FC)

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E. Case-Mix Adjustment

In assuring the prospective reimbursement system addresses the needs of residents of ICF/MR facilities, a case mix adjustment factor will be incorporated into the reimbursement system. The case-mix index will be used to adjust the reimbursement levels in the Direct Patient Care cost center. The key objective of the case-mix adjustment is to link reimbursement to the acuity level of residents in a facility. To accomplish this objective, the Department utilizes level of care criteria which classify ICF/MR residents into one of three levels, with Level I representing the highest level of need. Corresponding to each level of care, the relative values are as follows:

Level I	1.077
Level II	0.953
Level III	0.768

Using these level specific relative values, a provider specific base year case-mix index (CMI) will be derived. The CMI represents the weighted average of the residents' level of care divided by the total number of residents in the facility. The CMI is calculated as follows:

$$[(A \times 1.077) + (B \times .953) + (C \times .768)] / N = \text{CMI}$$

WHERE: A = Number of Level I residents
B = Number of Level II residents
C = Number of Level III residents
N = Total number of provider's residents

F. Calculation of the Prospective Per Diem Rate

A prospective per diem rate for each of the three levels of ICF/MR classification will be determined for each provider. Payment will be made based on the rate for the level of classification of the recipient.

The provider's Direct Patient Care (DPC) allowable cost per diem will be divided by the provider's case-mix index to determine the cost at a value of 1.00 for the base year. The adjusted DPC is then multiplied by the relative value of the level of

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classification to determine the DPC component of the rate. To this, will be added the allowable cost per diem A & G and R & B amount (as constrained by the ceiling described in Section V.,B.) and the allowable facility cost per diem. The formula for the rates will be as follows:

The formula for Year 1 is:

$$(A1 \times RV) + C1 + D + E = PR \text{ (Year 1)}$$

The formula for Year 2 is:

$$[(A1 \times RV) + C1] \times (1 + MBI) + D + E = PR \text{ (Year 2)}$$

The formula for Year 3 is:

$$[(A2 \times RV) + C2] \times (1 + MBI) + D + E = PR \text{ (Year 3)}$$

Where:

- A = Allowable DPC per diem adjusted to a value of 1.00
- B = The relative value of the level of classification.
- C = Allowable A&G and R&B per diem
- D = Allowable incentive per diem
- E = Allowable facility cost per diem
- MBI = Market Basket Index
- PR = prospective rate
- RV = the relative value for the level
- "1" = The numerical subscript means the date of the data used in the formula. For example, "A1" means the base direct patient care costs established in the base year, while "A2" would refer to the base direct patient care costs adjusted by the MBI

Each provider will have three prospective rates, one for each of the three levels of care(I, II, and III.)

G. Effective dates of prospective rates

Rates will be effective September 1 of each year for each facility. In addition, the case mix index for

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each facility will be reviewed at the mid point of each year. At that time, the rate will be readjusted to reflect the current case mix index.

H. Calculation of rates for existing providers that do not have actuals as of June 30, 1990, and for new providers entering the program after September 1, 1990

For existing and for new providers entering the program that do not have actuals, the provider's interim prospective per diem rate will become the sum of:

1. The state wide average patient care cost per diem for each level plus;
2. The A&G and R&B ceiling (as described in Section V.B.) per diem plus;
3. Facility cost per diem as determined by using the Medicare principles of reimbursement.

After six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report. This cost report must be submitted no later than 90 days after the completion of the six month period or the fiscal year end, whichever comes later. This will be audited to determine the actual allowable and reasonable cost for the provider. A final prospective rate will be established at that time, and retroactive settlement will take place.

I. Changes of provider by sale of an existing facility

When a change of ownership occurs, the provider's prospective rate per diem will become the sum of:

1. The patient care cost per diem for each level, established for the previous owner plus;
2. The A&G and R&B per diem established for the previous owner; plus
3. Allowable facility costs determined by using the Medicare principles of reimbursement.

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J. Changes of ownership by lease of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

1. The patient care cost per diem for each level established for the previous owner; plus
2. The A&G and R&B per diem established for the previous owner; plus
3. The lower of allowable facility cost or the ceiling on lease cost as described by this plan.

K. Sale/Leaseback of and exiting facility

When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

V. ESTABLISHMENT OF CEILINGS

Ceilings on the four major cost centers will be established as follow:

A. Direct Patient Care

No ceiling will be imposed on this cost center.

B. A&G and R&B

The per diem costs for administration and general and for room and board will be grouped together for the establishment of a ceiling. This ceiling will be calculated at 110% of the median of allowable costs for the base year, indexed (using the index described in Section IV.B.) to 12/31 of the base year. The ceiling will then be indexed (using the index described in Section IV.B.) to the mid-point of year 1 and set. For years 2 and 3, the ceiling will not be recalculated, but rather will be indexed forward using the appropriate inflation factor described earlier in these regulations.

C. Facility Cost

No ceiling will be imposed on this cost center, except in relation to leases.

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Effective for leases executed and binding on both parties on or after September 1, 1990, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor and annual rate of return on the fair market value of the facility equal to one times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for the twelve months prior to the date the facility became a provider in the New Mexico Medicaid program. The rates of interest for this fund are published in both the Federal Register and the Commerce Clearing House (CCH).

The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective and the reasonableness of such clauses will be determined by the inflation factor described in Section IV, B of these regulations.

Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider and is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the Department the name of the appraiser, a copy of his/her certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the Department.

VI. ADJUSTMENTS TO BASE YEAR COSTS

Since rebasing of the prospective per diem rate will take place every three years, the Department recognizes that certain circumstances may warrant an adjustment to the base rate. Therefor, the provider may request such an adjustment for the following reasons:

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- A. Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, minimum wage change, property tax increases, etc.)
- B. Additional costs incurred as a result of uninsurable losses from catastrophic occurrences.
- C. Additional costs of approved expansion, remodeling or purchase of equipment.

Such additional costs must reach minimum of \$5,000 for facilities with 16 or more beds and \$1000 for facilities with 15 or less beds, of incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The provider is encouraged to submit such rebasing requests before the cost is actually incurred if possible. The Department will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect: 1) beginning with the month the cost was actually incurred if prior approval was obtained, or 2) no later than 30 days from the date of receipt of the request if retroactive approval was obtained. At no time will rebasing in excess of any applicable ceilings be allowed.

VII. RESERVE BED DAYS

Reserve bed days will be paid using the provider's Level III rate.

VIII. RECONSIDERATION PROCEDURES FOR BASE YEAR DETERMINATIONS

- A. A provider who is dissatisfied with the base year rate determination or the final settlement(in the case of a change of ownership) may request a reconsideration of the determination by addressing a Request for Reconsideration to:

Director
Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504

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- B. The filing of a Request for Reconsideration will not effect the imposition of the determination.
- C. A Request for Reconsideration, to be timely, must be filed with or received by the Medical Assistance Division no later than 30 days after the date of the determination notice to the provider.
- D. The written Request for Reconsideration must identify each point on which it takes issue with the audit agent and must include all documentation, citation of authority, and argument on which the request is based. Any point not raised in the original filed request may not be raised later.
- E. The Medical Assistance Division will submit copies of the request and supporting material to the audit agent. A copy of the transmittal letter to the audit agent will be sent to the provider. A written response from the audit agent must be filed with or received by the Medical Assistance Division no later than 30 days after the date of the transmittal letter.
- F. The Medical Assistance Division will submit copies of the audit agent's response and supporting material to the provider. A copy of the transmittal letter to the provider will be sent to the audit agent. Both parties may then come up with additional submittals on the point(s) at issue. Such follow-up submittals must be filed with or received by the Medical Assistance Division no later than 15 days after the date of the transmittal letter to the provider.
- G. The Request for Reconsideration and supporting materials, the response and supporting materials, and any additional submittal will be delivered by the Medical Assistance Division Director to the Secretary, or his/her designee, within 5 days after the closing date for final submittals.
- H. The Secretary, or his/her designee, may secure all information and call on all expertise he/she believes necessary to decide the issues.

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- I. The Secretary, or his/her designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to him. The Secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The Secretary's decision will be final and any changes to the original determination will be implemented pursuant to that decision.

IX. PUBLIC DISCLOSURE OF COST REPORTS

- A. Provider's cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the Medical Assistance Division. Information thus disclosed is limited to cost report documents required by Social Security Administration regulations and, in the case of a settled cost report, the notice of program settlement.
- B. The request must identify the provider and the specific report(s) requested.
- C. The cost for copying will be charged to the requestor.

X. SEVERABILITY

If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.

Amendment 79-12
T.L. 79-12
September 27, 1979

State Plan for Medical Assistance
Under Title XIX SSA
New Mexico

Attachment 4.19E

Definition of timely payment re-
quirement for the State of New
Mexico

The New Mexico State Plan will define a claim as all services
for one recipient within a bill.

APPROVED by DHEW/HCTA/MS
DATE: OCT 26 1979
TRANSMITTAL NO: 79-12

Attachment 4.19 E
pg 1

STATE <i>New Mexico</i>	A
DATE REC'D <i>4-1-91</i>	
DATE APPV'D <i>4-19-91</i>	
DATE EFF <i>1-1-91</i>	
HCFA 179 <i>91-08</i>	

Amendment 91-08
T.L. 91-08
January 1, 1991

Supersedes: 79-12

The New Mexico Medicaid Program uses 23 claim types. For each claim type, the definition of a claim is the entire document. Each claim type includes the services as identified below:

- 01 Inpatient Hospital: UB82 claim form, inpatient services
- 02 Outpatient Hospital: UB82 claim form, outpatient services
- 03 Home Health: UB82 claim form, home health services
- 04 Dialysis: UB82 claim form, dialysis services
- 05 Rural Health: UB82 claim form, rural health clinic services
- 06 Hospice: UB82 claim form, hospice services
- 07 Federal Qualified Health Center: UB82 claim form, FQHC services
- 08 Physician & related: HCFA 1500 claim form, physician, free-standing clinic, podiatry, and anesthesia services
- 09 Laboratory and X ray: HCFA 1500 claim form, free standing laboratories and X-ray facilities
- 10 Psychology: HCFA 1500 claim form, psychology services
- 11 Vision and Hearing: HCFA 1500 claim form, vision and hearing services
- 12 Midwife: HCFA 1500 claim form, midwife services
- 13 Rehabilitation & misc: HCFA form for rehabilitation services, therapies, case management services, and expanded EPSDT services
- 14 Ambulatory Surgical Centers: HCFA 1500 form, free-standing ambulatory surgical center services
- 15 DME: HCFA 1500 form, durable medical equipment and supplies
- 16 Transportation: HCFA 1500 form for transportation services
- 17 Drug: Pharmacy claim form for pharmacy services

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Amendment 91-08
T.L. 91-08
January 1, 1991

- 18 Dental: Dental claim form, dental services
- 19 EPSDT: EPSDT claim form, EPSDT screening services
- 20 Long Term Care: Turnaround document for long term care
- 21 (not assigned)
- 22 Institutional Cross Over: institutional cross over coinsurance and deductible
- 23 Professional Cross Over: professional cross over coinsurance and deductible
- 24 System Generated Claim: a system generated payment, primary care network administrative fee

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Superseles: 79-12

SUPPLEMENT TO ATTACHMENT 4.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW MEXICO

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(A)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

TN No. 08-06 Approval Date 9-2-08

Effective Date 7-1-08

SUPERSEDES: NONE - NEW PAGE

STATE <u>New Mexico</u>	A
DATE REC'D <u>6-27-08</u>	
DATE APPROV'D <u>9-2-08</u>	
DATE EFF <u>7-1-08</u>	
HCFA 179 <u>08-06</u>	

Amendment 81-11
T.L. 81-11
December 18, 1981

STATE PLAN UNDER TITLE XIX
NEW MEXICO
ATTACHMENT 4.22 - A

This attachment specifies guidelines which the Department applies in determining whether to seek reimbursement from liable third parties.

For cases in which a third party has already been identified, all claims pertinent to the type of coverage will be routinely returned to the provider for filing with the third party. For cases in which a liable third party is newly identified, the Human Services Department will not seek reimbursement for claims already filed with the Department when the amount to be recovered from the third party would be less than \$50. The Department has determined that recovery of payments made for less than this amount would not be cost effective because of the staff time, reproducing and mail costs involved. If, after a claim has been paid, the Department learns of the existence of a liable third party, it will seek reimbursement from the third party within 30 days after the end of the month in which it learned of the existence of the liable third party. Claims accumulated for a particular provider up to this point will be applied in establishing whether such collection is cost effective.

In cases of potential liability, such as an accident or work-related injury, the Human Services Department may choose not to pursue tort liability when the amount to be recovered would be less than \$200.

For claims in which a liable third party has been identified, the Department will pay the amount remaining, under the Title XIX payment schedule, after the amount of the third party's liability has been established. Payment will not be withheld if third party liability or the amount of liability cannot be currently established or is not currently available. For claims involving tort liability, the Department will pay the full amount allowed under the Title XIX payment schedule and seek reimbursement from any liable third party to the limit of legal liability.

APPROVED BY DHHS/HCFA/EPD
DATE: MAR 3 1982
TRANSMITTAL NO: 81-11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

Requirements for Third Party Liability
Identifying Liable Resources

This attachment describes the measures taken by the New Mexico Human Services Department to determine the liability of third parties to pay for all or part of the cost of services furnished under the New Mexico Medicaid state plan.

1. Obtaining Health Insurance Information

A. Medicaid eligibility for all individuals other than those individuals eligible for the Supplemental Security Income Program, Foster Care and Adoptions is determined by the New Mexico Human Services Income Support Division (IV-A Agency)

(1) At the time of application and at each redetermination of eligibility for AFDC or any other program that would include Medicaid eligibility, the eligibility worker obtains information from the applicant or recipient as to whether he/she has other health insurance or is covered by a health insurance policy owned by someone else.

(2) If the applicant/recipient is covered by another health insurance policy the eligibility worker obtains:

- (a) name and address of insurance company,
- (b) name, social security number, and dates of birth of covered recipients,
- (c) type of coverage,
- (d) the policy number and/or group number,
- (e) name and address of policy holder's employer,
- (f) policy holder's name and social security number,
- (g) dates of coverage.

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David M. Price
5-14-90
9-5-90
5-20-90
9-10-90

TN No. _____
Supersedes _____

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HCFA ID: 1076P/0019P

B. Medicaid eligibility because of eligibility for SSI is determined by the Social Security District Offices.

- (1) The New Mexico Human Services Department has an agreement with the Social Security Administration to determine whether the applicant/recipient has other health insurance at the time of initial application or redetermination.
- (2) If other insurance exists the Social Security office obtains the;
 - (a) name and address of the insurance company,
 - (b) policy holder's name and Social Security number,
 - (c) policy numbers and/or group numbers.
- (3) The agreement with SSA also includes a provision for SSA to obtain the appropriate assignment of medical support rights and payments.

C. Transmittal of Information

- (1) For AFDC and all other Medicaid categories other than SSI, the other insurance information is transmitted to the Medicaid TPL unit VIA computer.
- (2) TPL information form Social Security District Offices is transmitted to the Medicaid TPL Unit via form SSA-8019U2 through the U.S. Mail Service.
- (3) If the SSN of an absent parent is available at the time of application for AFDC the name and SSN of the absent parent is maintained in the state's ISD2 eligibility system and can be readily accessed by the Medicaid TPLU. The names and SSN's of absent parents that are maintained in the Child Support Enforcement Data System (COLTS) are available to the MAD-TPLU and if the case has been investigated by the IV-D agency, the information can be utilized to identify whether or not the absent parent is employed and if so, the name and address of the employer can also be obtained.

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- (4) Names and SSN's of custodial parents are maintained in the ISD-2 system or in the Social Services ADAPT system. The Social Services "ADAPT" system includes only the names of the parents of children eligible for Medicaid benefits by virtue of placement in a foster home and having met AFDC income and resource standards. AT such time as Social Security number for both absent and custodial parents are obtained, these numbers will be available to the Third Party Liability Unit of the Medical Assistance Division.

D. Use of Data by Medicaid Agency

- (1) When information is received by the Title XIX TPL Unit either via computer system or mail, the following takes place,
- (a) information verified
 - (b) action taken to include other insurance information in files of Medicaid fiscal agent (name and address of insurance company, policy holder's name and social security number, coverage codes, dates of coverage, policy numbers),
 - (c) updates to the fiscal agent's files will be accomplished within 60 days of receipt of the information.
- (2) After fiscal agent incorporates information into their files all claims for payment of medical services are passed against these files,
- (a) if a claim come in for a recipient who's file indicates other insurance coverage, the following occurs:
 - (1) system compares date of service to coverage date,
 - (2) checks type of service to coverage,
 - (3) if date of service is within coverage dates and service is included in the insurance coverage, the claim is denied and a facsimile claim is produced that

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- includes all of the information that was on the original claim plus the name and address of the etc. This claim is returned to the provider and can then be filed by the provider of service with the appropriate insurance company for payment.
- (4) the amount that would have been paid by medicaid is then stored for future retrieval as a cost avoidance.

2. Exchange of Data

A. State wage information collection agency (SWICA)

- (1) The Data Exchange with the State Labor Department (SWICA) is carried out by way of the HSD eligibility computer system ISD-2 having direct access to the data included in the State Labor Department's computer files.
- (a) at the time of application or redetermination for any program that carries Medicaid eligibility other than SSI, Foster Care or Adoptions, the parents, (either absent or custodial) SSN's are passed against the Labor Department files. If a match occurs, the information is utilized in the eligibility determination and included in the case and system file for future use by both the IV-A agency and the Medical Assistance Division TPL Unit. A positive match would require the eligibility worker to again inquire about the existence of a health insurance policy.
- (b) the MAD-TPLU will perform a data match of Medicaid eligibles and absent parents of Medicaid eligible children with the state WDX information on a quarterly basis. A positive match will result in a follow-up to the employer to determine if health insurance exists, if children are covered and the source and amount of the coverage. If coverage is found to exist, the TPL data is input into the Medicaid fiscal agents eligibility files within

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60 days to accomplish cost avoidance.

B. State Workers Compensation

- (1) The new Mexico Medical Assistance Division has attempted to secure an agreement with the New Mexico Workers Compensation Commission to match Medicaid Eligibility files (name and SSN) with theirs to identify potential medical resources resulting from employment related accidents. Because the workers compensation agency does not have the resources to perform the data matches, they agreed to provide information to the Department so the Department could perform the matches. The Department is currently exploring ways to perform these matches.
- (2) These data matches would take place at least two times a year.
- (3) A positive match would result in the MAD/TPL Unit forwarding an inquiry to the recipient to determine the nature of the injury, the dates, employer, attorney, insurance company, and other related information that could be used to identify funds that could be recouped or cost avoided.
- (4) All communications will be maintained to document failure to reach agreement.

C. State Motor Vehicle Accident Report Files

- (1) The New Mexico Medical Assistance Division TPL Unit will attempt to secure an agreement with the New Mexico Highway and Transportation Department to match the New Mexico Medicaid eligibility file (including all individuals either currently eligible or those that were eligible within the last year) against their files of individuals that were involved in accidents.
- (2) The agreement would provide for carrying out data matches twice a year.

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(3) A positive match would result in the MAD/TPL Unit following up with an inquiry to obtain the specifics of the accident, (date, other parties, insurance coverage who caused accident, attorneys involved, etc). This information would then be used to determine if funds could be recouped.

(4) All correspondence and communication will be maintained to document failure to reach an agreement.

D. Data Exchange with Private Insurance Carriers

(1) The New Mexico Medical Assistance Division TPL Unit will attempt to secure agreements with the larger insurance carriers to perform computer matches of states Medicaid eligibility files with their subscriber files.

(2) All communication and correspondence will be maintained.

E. MAD TPL Unit on yearly basis Accomplishes a Data Exchange with CHAMPUS

3. Diagnosis and Trauma Code Edits

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A. The New Mexico Medicaid program currently subjects all claims with a dollar amount over \$100 to an edit that compares the diagnosis and procedure codes on the claim with identified trauma diagnoses and procedure codes (ICD-9-CM codes 800 thou 999 and selected procedure codes).

B. A positive hit from this edit results in the production and forwarding of an inquiry letter to the recipient identified on the claim to ascertain the specifics of the accident.

- (1) dates, names, insurance
- (2) who was at fault
- (3) type of accident, attorneys involved
- (4) other party insurance.

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- C. Failure to respond to the inquiry within 30 days results in a follow-up inquiry. Failure to respond after 90 days results in termination of Medicaid benefits.
- D. This edit is on-going in the claims processing system and inquiry letters are produced and mailed once a month.
- E. MAD/TPL Unit will work with Medicaid fiscal agent to identify those codes that yield the highest third party collection.

4. Frequency of Data Exchange and Trauma Code Edits

- A. The comparing of AFDC, etc., applicants SSN against the SWICA (State Labor Department) file occurs at the time the applicant applies for assistance (a positive match of this information results in the caseworker making further inquiry as to the existence of other insurance. The existence of other health insurance is then reported via the ISD-2 system to the MAD/TPL Unit.
- B. Other data exchange programs, such as Highway and Transportation Department, Workers Comp, and private insurance will take place at least two times a year, but not more often than every quarter.

5. Follow-ups Procedures for Identifying Legally Liable Third Party Resources

- A. The MAD/TPL Unit immediately verifies information received concerning the existence of potential third party resources.

- (1) Follow-ups on positive hits from Workers Comp or Highway and Transportation Department files would occur in the form of an inquiry letter within 2 weeks of receipt of information.
- (2) If inquiry results in the identification of a resource action is taken to prepare a file for interim follow-up (tort) or update fiscal agent files with appropriate information for cost avoidance.

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(3) If a positive match occurs in the data exchange with private insurance carriers, action is taken within 10 working days to verify the insurance coverage and update the Medicaid fiscal agent files.

B. Inquiry letters that are generated as a result of a positive hit in the trauma code edit are mailed once a month. Follow-up inquiries are mailed every 30 days thereafter. Inquiry letters that are returned that indicate potential tort liability result in the creation of a case file and the forwarding of communication to attorney and/or insurance company of the state's subrogation right. Recipient histories are ordered to determine the amount paid by the Medicaid program as a result of the accident. Information in the recipient history is shared with the attorney involved if a proper release of medical information is executed by the recipient. Subsequent follow-ups are directed to the involved parties as required.

6. Safeguarding Information

- A. All information received by the MAD/TPL Unit is held in strict confidence.
- B. Provisions for confidentiality are included in all data exchange agreements.

C. Specific information is not divulged unless a properly executed release is provided.

7. Use of TPL Information

A. If information received and verified indicates the existence of a health insurance policy, specific information is incorporated into the Medicaid fiscal agents files to prevent the payment of a claim that could be paid by the other insurance except as follows:

- (1) prenatal or preventative services
- (2) services provided to an individual on whose behalf child support enforcement is being carried out by the title IV-D agency and communicated to the Medicaid agency.

A	
STATE	DATE REC'D
DATE REC'D	DATE APP'D
DATE APP'D	DATE EFF
DATE EFF	HCFA 179

TN No. _____
Supersedes _____

Approval Date _____

Effective Date _____

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HCFA ID: 1076P/0019P

- B. If information received reveals potential tort liability, files are prepared and maintained, attorneys and insurance companies are informed of subrogation rights and communication maintained until case is settled.

8. Cooperative Agreements with Other Agencies

- A. The New Mexico MAD/TPL Unit is in the process of entering into agreements with the New Mexico Income Support Division to carry out the required TPL activities related to obtaining TPL information and Child Support Enforcement.
- B. The New Mexico MAD/TPL Unit is in the process of preparing and entering into an agreement with the Social Services Division to obtain TPL information and assignments of medical Support and payment rights for individuals that are eligible for Medicaid by virtue of foster care or adoptions.

9. Reports

- A. In addition to reports routinely produced to document TPL activities, the Medical Assistance Division will Produce Reports that the Secretary deems necessary to determine compliance with the regulation.

STATE <u>New Mexico</u>	A
DATE REC'D <u>5-14-90</u>	
DATE APPV'D <u>9-5-90</u>	
DATE EFF <u>5-20-90</u>	
HCFA 179 <u>70-10</u>	

TN No. _____
Supersedes _____ Approval Date _____ Effective Date _____

TN No. _____

HCFA ID: 1076P/0019P

1. THE NEW MEXICO MEDICAID PROGRAM WILL "PAY & CHASE" IN SITUATIONS AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (42 U.S.C. 1396a(a)(25))

A. Claims for prenatal or preventive pediatric care (including early and periodic screening and diagnosis & treatment services), based on diagnosis codes provided by HCFA.

(1) Inpatient and outpatient hospital claims and pharmacy claims are excluded from this provision and will continue to be "cost avoided".

A		B.	
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NEW MEX	3-14-90	9-5-90	5-20-90
			9010
			HCFA 179

Services provided to individuals on whose behalf Child Support Enforcement is being carried out by the N.M. IV-D agency, if payment for these services is not made by the third party within 30 days after the services are furnished;

(1) Failure of the third party to pay for the services within 30 days must be certified in writing with each claim submitted by the provider seeking medicaid payment.

(2) The provider must certify in writing with each claim submitted that if payment for the services being billed to Medicaid are subsequently paid by the third party, the lower of the third party payment or the Medicaid payment will be immediately refunded to the New Mexico Human Services Department.

2. METHOD USED BY THE NEW MEXICO MEDICAID PROGRAM TO DETERMINE PROVIDER COMPLIANCE WITH THE THIRD PARTY BILLING REQUIREMENTS

A. Individuals on whose behalf medical support is being enforced by Child Support Enforcement are identified to the Medicaid fiscal agent.

B. Based on information referred to in 2.A., the Medicaid fiscal agent adds a child support indicator in the recipients eligibility file. Claims filed are edited against the eligibility file. The presence of the child support indicator causes the claims to suspend for manual review for the following:

TN No. _____
Supersedes _____
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Approval Date _____

Effective Date _____
HCFA ID: 1076P/0019P

- (1) Is the certification form attached to the claim? If not, the claim is denied (cost avoided).
- (2) If certification form is attached it is checked to see if the 30 day requirement has been met.
- (3) If the 30 day requirement has been met and the certification is otherwise in order the claim is paid. A facsimile claim is produced for the Medicaid program to use in billing the recipients Health Insurance carrier.

3. THRESHOLDS

A	
STATE	DATE REC'D
DATE REC'D	DATE APP'D
DATE APP'D	DATE EFF
DATE EFF	HCFA 179

For cases in which a third party has already been identified, all claims pertinent to the type of coverage will be routinely returned to the provider for filing with the third party. For cases in which a liable third party is newly identified, the Human Services Department will not seek reimbursement for claims already filed with the Department when the amount to be recovered from the third party would be less than \$50. The Department has determined that recovery of payments made for less than this amount would not be cost effective because of the staff time, reproducing and mail costs involved. If, after a claim has been paid, the Department learns of the existence of a liable third party, it will seek reimbursement from the third party within 30 days after the end of the month in which it learned of the existence of the liable third party. Claims accumulated for a particular provider up to this point will be applied in establishing whether such collection is cost effective. Pursuant to section 3904.5 of the State Medicaid Manual, thresholds under \$100 do not require justification.

- B. In cases of potential liability, such as an accident or work-related injury, the Human Services Department may choose not to pursue tort liability when the amount to be recovered would be less than \$200. Pursuant to section 3904.5 of the State Medicaid Manual, thresholds under \$250 do not require justification.

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Supersedes _____
TN No. _____

Approval Date _____

Effective Date _____
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C. For claims in which a liable third party has been identified, the Department will pay the amount remaining, under the Title XIX payment schedule, after the amount of the third party's liability has been established. Payment will not be withheld if third party liability or the amount of liability, the Department will pay the full amount allowed under the Title XIX payment schedule and seek reimbursement from any liable third party to limit of legal liability. In personal injury cases where liability has been established, claims related to the injury will be cost-avoided.

4. ASSURANCE THAT MEDICAID PROVIDERS FOLLOW RESTRICTIONS SPECIFIED IN 42 CFR 447.20

A. Sanction of providers who seek payment from Medicaid recipients for balances due after payment from an insurance company when the insurance payment was at least equal to what Medicaid would have paid for the same service.

(1) Upon determination by the Director of the Medical Assistance Division that a provider has sought payment for a service from a Medicaid recipient after receiving payment for that service from that recipient's health insurance company or other third party in an amount at least equal to the amount that Medicaid would have allowed for that same service, an amount equal to three times the amount sought from the recipient will be deducted from the provider's next Medicaid payment. This provision is included in Section 1902 of the Social Security Act (42 U.S.C. 1396a).

B. Providers refusing to furnish services covered under the plan on account of a third party's potential liability for the service(s) are subject to termination of their provider agreement.

STATE	<i>New Mexico</i>	A
DATE REC'D	<i>5-14-90</i>	
DATE APP'D	<i>7-5-90</i>	
DATE OF	<i>5-20-90</i>	
HCFA 179	<i>90-10</i>	

TN No. _____
Supersedes _____
TN No. _____

Approval Date _____

Effective Date _____
HCFA ID: 1076P/0019P

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 4.22-C
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

TN No. 91-19
Supersedes

Approval Date JAN 15 1992

Effective Date OCT 1 1991

TN No. New Page

HCFA ID: 7985E

STATE	<u>New Mexico</u>
DATE REC'D	<u>DEC 17 1991</u>
DATE APP'D	<u>JAN 15 1992</u>
DATE Ltr	<u>OCT 01 1991</u>
HCFA 179	<u>91-19</u>

State: New Mexico

Citation

Sanctions for MCOs and PCCMs

1932(e)
42 CFR 428.726

- (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:
- (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:
- (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE	<u>New Mexico</u>
CAW REF	<u>9-30-03</u>
DATE	<u>12-18-03</u>
DATE EFF	<u>7-1-03</u>
MOCA 175	<u>03-03</u>

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

The New Mexico Medicaid Agency receives information from the Wage Data Exchange tape and the Unemployment Compensation Benefit tape from the State Employment Security Department.

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other states. The information that is requested will be exchanged with states and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

SUPERSEDES: TN- 86-11

STATE	<u>New Mexico</u>
DATE REC'D	<u>8-9-10</u>
DATE APP'D	<u>9-27-10</u>
DATE EFF	<u>7-1-10</u>
HCFA 179	<u>10-10</u>

A

TN No. 10-10
Supersedes
TN No. 86-11

Approval Date 9-27-10

Effective Date 7-1-10

HCFA ID: 0123P/0002P

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

ATTACHMENT 4.33-A
Page 1
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

The Department makes every effort to assure that eligible homeless individuals receive their cards. Arrangements are made on a case by case basis, and would include arrangements such as sending the card to the home of a friend, relative, or public or private shelter.

STATE	<u>NM</u>	A
DATE REC'D	<u>7-2-87</u>	
DATE APPV'D	<u>8-14-87</u>	
DATE EFF	<u>5-5-87</u>	
HCFA 179	<u>87-12</u>	

TN No. 87-12
Supersedes
TN No. new

Approval Date 8-14-87

Effective Date 5-5-87
HCFA ID: 1080P/0010P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

DATE REC'D	DEC 2 1991
DATE APPV'D	JAN 16 1992
DATE EFF	DEC - 1 1991
HCFA 179	91-23

A

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State of New Mexico concerning advance directives. The state statutes are silent on the question of whether a health care provider may object, on the basis of conscience, to the implementation of advance directives.

A. Living will

New Mexico Statutory Act 24-7-1 through 24-7-11 is cited as the "Right to Die Act" and defines a living will as a document, executed by an individual of sound mind and having reached the age of majority, directing that if he is ever certified as suffering from a terminal illness or being in an irreversible coma, maintenance medical treatment shall not be utilized for the prolongation of his life.

The same statute discusses a variety of limitations of living will declaration. They are valid documents only if executed in the same process as a valid will under provisions of the Probate Code. Certification of terminal illness or irreversible coma must be done in writing by two physicians presumed to be acting in good faith. Revocation of the living will can be accomplished by destroying the document or by contrary indication expressed to any one witness over the age of majority.

The statute also defines proxy designation for the benefit of minors who are terminally ill or in irreversible coma. Substituted consent may also be given by all family members who can be contacted through reasonable diligence and who choose to forego treatment for their member.

Attachment 4.34-A (1) contains the "New Mexico Living Will and Declaration Under the Right to Die Act".

B. Durable Power of Attorney

New Mexico Statutory Act 45-5-501 through 45-5-502 defines durable power of attorney as a written document in which a principal designates another person as his attorney-in-fact or agent by a power of attorney containing the words, "This power of attorney shall not be affected by the incapacity of the principal",

Revision: HCFA-PM-91-9
NOVEMBER 1991

(MB)

ATTACHMENT 4.34-A
PAGE 2
OMB NO.:

or "This power of attorney shall become effective upon the incapacity of the principal" or similar language showing the principal's intent that the authority conferred shall be exercised notwithstanding his capacity.

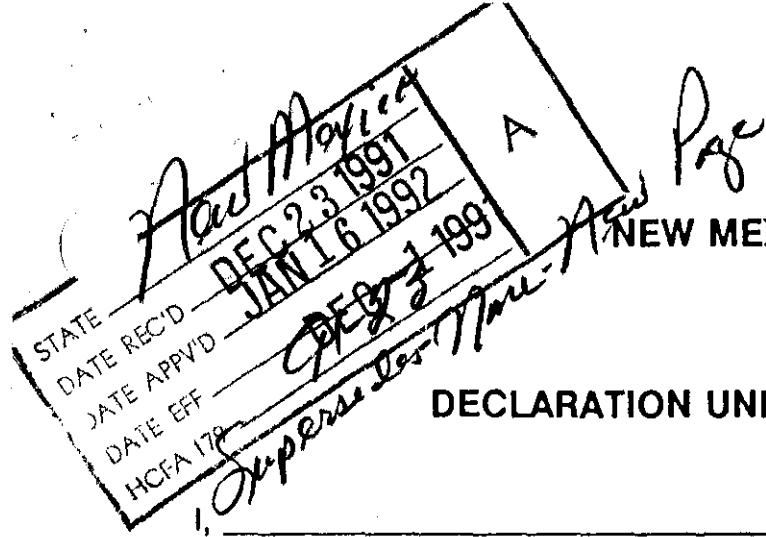
The second section of this statute explains that other powers of attorney are not revoked or terminated if the attorney in-fact, agent or other person acts in good faith without actual knowledge of the death or disability of the principle.

Attachment 4.34-A (2) contains the "New Mexico Durable Power of Attorney for Health Care Decisions" prepared in accordance with NMSA 1978 § 45-5-502.

STATE	<i>New Mexico</i>	A
DATE REC'D	<i>DEC 23 1991</i>	
DATE APPV'D	<i>JAN 16 1992</i>	
DATE EFF	<i>DEC - 1 1991</i>	
HCFA 179	<i>91-23</i>	

TN NO. *91-23*
Supersedes Approval Date *JAN 16 1992* Effective Date *DEC - 1 1991*
TN NO. *New Page*

HCFA ID: 7982E



NEW MEXICO LIVING WILL

AND

DECLARATION UNDER THE RIGHT TO DIE ACT

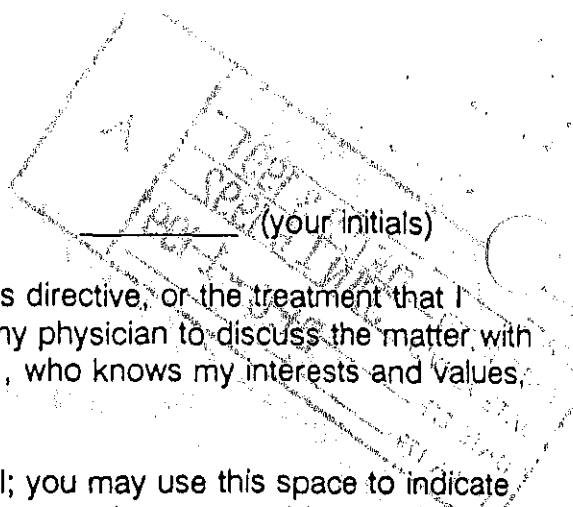
I, _____, being of sound mind and age 18 or older, willfully and voluntarily make known my will and directive that my life shall not be prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time I should be certified in writing by two physicians, one of whom is in charge of my care, to have a terminal illness or be in an irreversible coma, I direct that maintenance medical treatment be withheld or withdrawn, and that I be permitted to die.
2. By maintenance medical treatment, I mean any medical treatment that is designed solely to sustain the life process, but I do not mean medication administered for the purpose of easing pain and discomfort.
3. In the absence of my ability to give directions regarding the use of maintenance medical treatment, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical treatment, and I accept the consequences of such refusal.
4. If my attending physician declines to participate in the withholding or withdrawal of maintenance medical treatment, she/he must take steps to transfer me to another physician who will honor my wishes.
5. I understand the full import of this directive, and I am emotionally and mentally competent to make this directive.
6. I understand that I may revoke this directive at any time by destroying it or saying so in the presence of someone over age 18.
7. I will keep the original of this document at:

(name the place or person who will have the original document)

I will give copies of this document to:

(name the place or person who will have copies of the document)



_____(your initials)

8. If there are any uncertainties or ambiguities about this directive, or the treatment that I should be given if I become incompetent, I request my physician to discuss the matter with _____, who knows my interests and values, and with whom I have discussed my wishes.

9. I offer this further expression of my wishes: (optional; you may use this space to indicate the kind of care you would want, or any medical treatments that you would or would not want)

Date _____	Signature _____
	Address _____

This form must be witnessed below.

WITNESSES

We believe the person who signed this document to be of sound mind and under no constraint or undue influence.

On this _____ day of _____, 19____, the person who signed this document, _____, of _____ (street address), _____ (city), New Mexico, signed the foregoing document, consisting of two typewritten pages, in our sight and presence and declared the same to be his/her document under the Right to Die Act, and at his/her request and in his/her sight and presence and in the sight and presence of each other, we signed our names as witnesses.

Witness _____	Address _____
---------------	---------------

Witness _____	Address _____
---------------	---------------

STATE New Mexico
DATE REC'D DEC 23 1991
DATE APP'D JAN 16 1992
DATE EFF DEC 23 1991
HCFA 172
Supersede 97me New Logo

NEW MEXICO DURABLE POWER OF ATTORNEY
FOR
HEALTH CARE DECISIONS

The powers granted by this document are broad and sweeping. The document is prepared in accordance with NMSA 1978, §45-5-502, and should be interpreted consistently with that statute.

I, _____, reside in _____ County,
New Mexico. I appoint _____ to
serve as my legally-authorized decision maker(s).
Name(s)

If any decision maker appointed above is unable to serve, then I appoint
_____ to serve as my decision maker in place of the person who is
unable to serve.

Check and initial the following paragraph only if more than one person is appointed to act on your behalf and you want any one of them to have the power to act alone without the signature of the other(s). If you do not check and initial the following paragraph and more than one person is named to act on your behalf, then they must act jointly.

() _____ If more than one person is appointed to serve as my decision maker, then each may act alone and independently of each other.

My decision maker shall have the power to act in my name, place and stead in any way which I myself could do with respect to the following matters to the extent permitted by law:

Initial the box opposite each authorization which you desire to give to your decision maker. Your decision maker shall be authorized to engage only in those activities which are initialed. Cross out those authorizations you do not desire to give to your decision maker.

1. Decisions regarding lifesaving and life prolonging medical treatment ()
2. Decisions relating to medical treatment, surgical treatment,
nursing care, medication, and hospitalization ()

3. Decisions relating to residence in a nursing home or other facility and home health care

4. Transfer of property or income as a gift to my spouse for the purpose of qualifying me for governmental medical assistance (i.e., giving my property to my spouse so I will qualify for Medicaid).

5. List others related to health care

()

()

()

()

()

()

In making health care decisions for me, my decision maker should be guided by the following expression of my wishes: (optional)

This power of attorney shall become effective only if I become incapacitated and shall terminate upon my death unless I have revoked it prior to my death. By incapacity, I mean that, among other things, I am unable effectively to make or communicate health or personal care decisions.

(Signature)

Dated: _____, 19 ____

This form must be notarized below.

ACKNOWLEDGEMENT

STATE OF NEW MEXICO)
) ss
COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 19 ____, by _____.

Notary Public

My commission expires: _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

NA

STATE <u>New Mexico</u>	A
DATE REC'D <u>SEP 28 1995</u>	
DATE APPV'D <u>OCT 27 1995</u>	
DATE EFF <u>JUL 01 1995</u>	
HCFA 179 <u>95-13</u>	

TN No. 95-13
Supersedes
TN No. _____
Approval Date: OCT 27 1995 Effective Date: JUL 01 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and
notice requirements specified
in the regulation.)

STATE <u>New Mexico</u>	A
DATE REC'D <u>SEP 26 1995</u>	
DATE APP'D <u>OCT 27 1995</u>	
DATE EFF <u>JUL 01 1995</u>	
HCFA 179 <u>95-13</u>	

TN No. 95-13
Supersedes
TN No. _____

Approval Date: OCT 27 1995

Effective Date: JUL 01 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE <u>New Mexico</u>	A
DATE REC'D <u>SEP 26 1995</u>	
DATE APP'D <u>OCT 27 1995</u>	
DATE EFF <u>JUL 01 1995</u>	
HCFA 179 <u>95-13</u>	

TN No. 95-13
Supersedes
TN No. _____

Approval Date: OCT 27 1995

Effective Date: NOV 01 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

 Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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DATE REC'D <u>SEP 26 1998</u>	
DATE APP'D <u>OCT 27 1998</u>	
DATE EFF <u>JUL 01 1995</u>	
HCFA 179 <u>95-13</u>	

TN No. 95-13
Supersedes
TN No. _____

Approval Date: OCT 27 1995

Effective Date: JUL 01 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

 Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE <u>New Mexico</u>		A
DATE REC'D	<u>SEP 26 1995</u>	
DATE APP'D	<u>OCT 27 1995</u>	
DATE EFF	<u>JUL 01 1995</u>	
HCFA 179	<u>95-13</u>	

TN No. 95-13
Supersedes
TN No. _____

Approval Date: OCT 27 1995

Effective Date: JUL 01 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

 Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE <u>New Mexico</u>	A
DATE REC'D <u>SEP 26 1995</u>	
DATE APPL'D <u>OCT 27 1995</u>	
DATE EFF <u>JUL 01 1995</u>	
HCFA 179 <u>95-13</u>	

TN No. 95-13
Supersedes
TN No. _____

Approval Date: OCT 27 1995

Effective Date: JUL 01 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

 Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE <u>New Mexico</u>	A
DATE REC'D <u>SEP 26 1995</u>	
DATE APP'D <u>OCT 27 1995</u>	
DATE EFF <u>JUL 01 1995</u>	
HCFA 179 <u>95-13</u>	

TN No. 95-13
Supersedes
TN No. _____

Approval Date: OCT 27 1995

Effective Date: JUL 01 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

NA

STATE <u>New Mexico</u>	A
DATE REC'D <u>SEP 28 1995</u>	
DATE APPL'D <u>OCT 27 1995</u>	
DATE EFF <u>JUL 01 1995</u>	
HCFA 179 <u>95-13</u>	

TN No. 95-13 Approval Date: OCT 27 1995 Effective Date: JUL 01 1995
Supersedes
TN No. _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

STATE	<i>New Mexico</i>	A
DATE REC'D	<i>AUG 18 1992</i>	
DATE APPV'D	<i>SEP 15 1992</i>	
DATE EFF	<i>JUL 01 1992</i>	
HCFA 179	<i>92-12</i>	

TN No. *92-12*
Supersedes *None-New Page*
TN No. *None-New Page*

Approval Date *SEP 15 1992* Effective Date *JUL 01 1992*

HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

483.156 (C) REQUIREMENTS

Above and beyond the registry requirements in 42 CFR 483.156(C), The New Mexico Nurse Aide Registry for Long Term Care includes current employer, Medicaid provider number, date of hire, date of decertification, certification number, and recertification date.

STATE	<i>New Mexico</i>	A
DATE REC'D	<i>AUG 18 1992</i>	
DATE APPV'D	<i>SEP 15 1992</i>	
DATE EFF	<i>JUL 01 1992</i>	
HCFA 179	<i>92-12</i>	

TN No. *92-12* Approval Date *SEP 15 1992* Effective Date *JUL 01 1992*
Superseded
TN No. *92-12* HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

DEFINITION OF SPECIALIZED SERVICES

Specialized Services, Definitions

(1) For mental illness, specialized services means the services specified by the State which, combined with the services provided by the NF, results in the continuous and aggressive implementation of an individualized plan of care.

(2) For mental retardation, specialized services means the services specified by the State which, combined with the services provided by the NF or other service providers, results in treatment which meets the requirements of 483.440(a)(1).

STATE <u>New Mexico</u>	A
DATE REC'D <u>AUG 19 1993</u>	
DATE APPV'D <u>SEP 20 1993</u>	
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HCFA 179 <u>93-17</u>	

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

CATEGORICAL DETERMINATIONS

STATE <u>New Mexico</u>	A
DATE REC'D <u>AUG 19 1993</u>	
DATE APPV'D <u>SEP 20 1993</u>	
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STATE <u>New Mexico</u>	A
DATE REC'D <u>2-22-07</u>	
DATE APPV'D <u>5-11-07</u>	
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HCFA 179 <u>07-03</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Mexico

Citation
1902(a)(68) of
the Act,
P.L. 109-171
(section 6032)

4.42 Employee Education About False Claims Recoveries.

- (a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax Identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

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STATE <u>New Mexico</u>	A
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State: New Mexico

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the \$5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

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(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

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Attachment 4.42-A
page 1

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

EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis

1. Entities who meet the \$5,000,000 annual payment threshold as of September 30th of each year will be deemed to be "qualifying entities."

By January 1st of each year, the Department will issue a notification to each qualifying entity reminding the entity of their responsibilities regarding Employee Education About False Claims Recoveries. The initial letter informing qualifying entities of their responsibilities regarding Employee Education About False Claims Recoveries was sent on December 26, 2006, and will occur annually prior to January 1st of each year.

By July 1st of each year, the Department will provide each qualifying entity with a certification document on which the entity must certify they understand and are meeting their responsibilities regarding Employee Education About False Claims Recoveries.

By September 1, 2007, regarding compliance for calendar year 2007, and by October 1, 2007 and each October 1st thereafter, regarding compliance for calendar year 2008 and each year thereafter, the entity must complete the certification document and return it to the Department. In addition to certifying they understand and are meeting their responsibilities regarding Employee Education About False Claims Recoveries, the certification document will require the entity to state if they have written policies, educational programs, handbooks, or other documentation used by the entity to meet the requirements regarding Employee Education About False Claims Recovery.

A response will be deemed inadequate if the entity does not certify they understand and are meeting their responsibilities regarding Employee Education About False Claims Recoveries; if they fail to identify any forms of documentation used by the entity; or, if they fail to respond to a second follow-up request from the Department after not responding to the initial request.

An inadequate response will be followed by an audit of the entity's compliance by the Department. Any time a qualifying entity is subject to an onsite review for any other reason, their compliance will be verified not to exceed once annually. Additionally, qualifying entities may be selected randomly for audit.

2. No later than December 31, 2007, the requirements of this law will be incorporated into the agreements entities sign to participate in the Medicaid Program.
3. No later than July 1, 2007, the requirements of this law will be incorporated into entity contracts including managed care organization contracts and audited annually in an onsite visit conducted by the Department.

SUPERSEDES: NONE - NEW PAGE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Mexico

Citation

1902(a)(69) of
the Act,
P.L. 109-171
(section 6034)

4.43 Cooperation with Medicaid Integrity Program Efforts.

The Medicaid agency assures it complies with such requirements
determined by the Secretary to be necessary for carrying out the
Medicaid Integrity Program established under section 1936 of the
Act.

STATE <u>New Mexico</u>	A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: NEW MEXICO

Attachment 4.46
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Provider Screening and Enrollment

Citation 1902(a)(77) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L. 111-152	4.46 Provider Screening and Enrollment The State Medicaid agency gives the following assurances:
42 CFR 455 Subpart E	PROVIDER SCREENING <u> X </u> Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS <u> X </u> Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. <u> X </u> Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES <u> X </u> Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT <u> X </u> Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT <u> X </u> Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT <u> X </u> Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.
42 CFR 455.422	APPEAL RIGHTS <u> X </u> Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Provider Screening and Enrollment

- 42 CFR 455.432 SITE VISITS
 X Assures that pre-enrollment and post-enrollment site visits of providers who are in “moderate” or “high” risk categories will occur, as required by § 455.432 .
- 42 CFR 455.434 CRIMINAL BACKGROUND CHECKS
 X Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.
- 42 CFR 455.436 FEDERAL DATABASE CHECKS
 X Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.
- 42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER
 X Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.
- 42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS
 X Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.
- 42 CFR 455.460 APPLICATION FEE
 Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.
- 42 CFR 455.470 TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS
 X Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries’ access to medical assistance.

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**ATTACHMENT 5.1-A
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
CITATIONS OF STATE LAWS, RULES, REGULATIONS AND POLICY
STATEMENTS PROVIDING ASSURANCE OF CONFORMITY TO FEDERAL
MERIT SYSTEM STANDARDS**

**ARTICLE 9
PERSONNEL ACT**

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STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY ACT

STATE OF NEW MEXICO

Citations of State Laws, Rules, Regulations and Policy Statements
Providing Assurance of Conformity to Federal Merit System Standards

Article 9 of New Mexico Statutes Annotated 1978 Comp. contains this State's Personnel Act. As assurance of New Mexico's conformity to Federal merit system standards, Article 9 is reproduced here in its entirety as Attachment 5.1-A to the New Mexico State Plan for Medical Assistance under Title XIX.

ARTICLE 9
Personnel Act

APPROVED BY DHEW/ECOA/MS
JAN 3 1980
BUREAU OF HEALTH NO: 79-15

- Sec.
- 10-9-1. Short title.
- 10-9-2. Purpose of act; enactment under constitution.
- 10-9-3. Definitions.
- 10-9-4. Coverage of service.
- 10-9-5. Public officers and public employees; executive branch; annual exempt-salaries plan.
- 10-9-6. Certified school instructors previously employed under the provisions of the Personnel Act.
- 10-9-7. Payment by covered agencies to the personnel board for services of state personnel office.
- 10-9-8. Personnel board; appointment.
- 10-9-9. Board members; pay; meetings.
- 10-9-10. Board duties.
- 10-9-11. Board and office administratively attached to department of finance and administration.

- Sec.
- 10-9-12. Director duties.
- 10-9-13. Rules; adoption; coverage.
- 10-9-14. Blind not barred from competitive examination; method of testing.
- 10-9-15. Duties of state officers and employers.
- 10-9-16. Status of present employees.
- 10-9-17. Certification of payroll.
- 10-9-18. Appeals by employees to the board.
- 10-9-19. Reduction in force.
- 10-9-20. Oaths; testimony; records; refusal.
- 10-9-21. Prohibited acts.
- 10-9-22. Unlawful acts prohibited.
- 10-9-23. Penalties.
- 10-9-24. Existing rules.
- 10-9-25. Federal funds and assistance.



10-9-1. Short title.

This act may be cited as the "Personnel Act."

History: 1953 Comp., § 5-4-28, enacted by Laws 1951, ch. 240, § 1.

Appropriation. — Laws 1971, ch. 319, § 1, appropriates \$230,500 from the general fund to the department of finance and administration for use during the sixtieth fiscal year for the purpose of raising salaries of all employees in the classified service to a minimum of \$330 a month.

Medical center covered by act. — The Los Lunas state hospital and training school (now the Los Lunas medical center) is a state institution and it falls within the category of departments covered by the Personnel Act. 1961-62 Op. Att'y Gen. No. 61-80.

Meaning of "this act". — The term "this act" refers to Laws 1961, ch. 240, the provisions of which are pres-

ently compiled as 10-9-1 to 10-9-4, 10-9-8 to 10-9-10, 10-9-12, 10-9-13 and 10-9-15 to 10-9-25 NMSA 1978.

So in state land office. — The state land office is presently subject to the Personnel Act. 1969 Op. Att'y Gen. No. 69-99.

And agencies already with merit systems. — Nothing in the Personnel Act indicates that agencies that

have adopted merit systems are thereby exempted from the operation of the Personnel Act (decided under former law). 1959-60 Op. Att'y Gen. No. 60-229.

Law review. — For note, "Public Labor Disputes — A Suggested Approach for New Mexico," see 1 N.M. L. Rev. 281 (1971).

10-9-2. Purpose of act; enactment under constitution.

The purpose of the Personnel Act is to establish for New Mexico a system of personnel administration based solely on qualification and ability, which will provide greater economy and efficiency in the management of state affairs. The Personnel Act is enacted under and pursuant to the provisions of Article 7, Section 2 of the constitution of New Mexico, as amended.

History: 1953 Comp., § 5-4-29, enacted by Laws 1961, ch. 240, § 2; 1963, ch. 200, § 1.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

Legislative intent. — In enacting the Personnel Act it was the desire of the legislature to insulate in some manner the paid state employee from the whims and caprice of the political election so as to provide continuity of government in a changing environment. 1963-64 Op. Att'y Gen. No. 64-7.

Ability of government to be enhanced. — The legislature wished to enhance the ability of government by insuring that the "sifting system" of the public election be replaced by objective examinations to assure that competent citizens are initially selected for the "insulated" positions. 1963-64 Op. Att'y Gen. No. 64-7.

Merit system provided. — The Personnel Act provides for a merit system, not a seniority system. 1965 Op. Att'y Gen. No. 65-78A.

C.J.S. reference. — 81A C.J.S. States § 86.

10-9-3. Definitions.

As used in the Personnel Act:

- A. "director" means the personnel director;
- B. "board" means the personnel board;
- C. "service" means the state personnel service created by the Personnel Act, and includes all positions covered by the Personnel Act;
- D. "position" means any state office, job, or position of employment;
- E. "employer" means any authority having power to fill positions, in an agency;
- F. "agency" means any state department, bureau, division, branch or administrative group which is under the same employer;
- G. "class" means a group of positions similar enough in powers and responsibilities that they can be covered by the same qualifications and rate of pay;
- H. "test" means a test of the qualifications, fitness and ability, and includes tests that are written, oral, physical or in the form of a demonstration of skill or any combination thereof;
- I. "employee" means a person in a position in the service who has completed his probationary period; and
- J. "probationer" means a person in a position in the service who is still in the probationary period for that position.

History: 1953 Comp., § 5-4-30, enacted by Laws 1961, ch. 240, § 3.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

Effect on person contemplated by 28-15-1 NMSA 1978. — If a person contemplated by 28-15-1 NMSA 1978 has gained the status of an "employee" as that term is defined by this section and the personnel board rules, he will have additional rights under the state personnel board rules that a "probationer" would not. 1969 Op. Att'y Gen. No. 69-108.

Where employees not entitled to participate. — Since the employees of an intercommunity gas association worked for a corporation controlled by three separate municipalities rather than for the state itself, such employees were not entitled to participate under the provisions of the State Personnel Act. 1966 Op. Att'y Gen. No. 66-7.

C.J.S. reference. — 81A C.J.S. States § 86.

10-9-4. Coverage of service.

The Personnel Act and the service cover all state positions except:

A. officials elected by popular vote or appointed to fill vacancies in elective offices;
B. members of boards and commissions and heads of agencies appointed by the governor;

C. heads of agencies appointed by boards or commissions;

D. directors of department divisions;

E. those in educational institutions and in public schools;

F. those employed by state institutions and by state agencies providing educational programs and who are required to hold valid certificates as certified school instructors as defined in Section 22-1-2 NMSA 1978 issued by the state board of education;

G. those in the governor's office;

H. those in the state militia or state police;

I. those in the judicial branch of government;

J. those in the legislative branch of government;

K. not more than two assistants and one secretary in the office of each official listed in Subsections A, B and C of this section, excluding members of boards and commissions in Subsection B of this section;

L. those of a professional or scientific nature which are temporary in nature;

M. those filled by patients or inmates in charitable, penal or correctional institutions;

N. state employees, if the personnel board, in its discretion, decides that the position is one of policy making; and

O. disadvantaged youth under twenty-two years of age regularly enrolled or to be enrolled in a secondary educational institution approved by the state board of education or in an accredited state institution of advanced learning or vocational training and who are to be employed for not more than seven hundred twenty hours during any calendar year.

(1) The term "disadvantaged youth" shall be defined for purposes of this exemption by regulation duly promulgated by the board.

(2) The board shall:

(a) require that all of the above criteria have been met;

(b) establish employment lists for the certification of the highest standing candidates to the prospective employers; and

(c) establish the pay rates for such employees.

History: 1953 Comp., § 5-4-31, enacted by Laws 1961, ch. 240, § 4; 1963, ch. 200, § 2; 1967, ch. 181, § 1; 1969, ch. 126, § 1; 1975, ch. 182, § 1; 1977, ch. 247, § 45.

The 1977 amendment added present Subsections D and E, redesignated former Subsections D through M as "F" through "O", deleted "New Mexico state personnel" preceding "board" near the end of Subsection O(1) and deleted "state personnel" preceding "board" in the introductory language of Subsection O(2).

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

Due process requirements. — New Mexico has recognized that nonpolicymaking officials are entitled to due process before they may be dismissed, but members of boards and commissions and heads of agencies appointed by the governor are not entitled to the State Personnel Act's notice and hearing requirements preceding dismissal of state employees. *Mitchell v. King*, 537 F.2d 385 (10th Cir. 1976).

Constitutionality of option feature. — The option feature of the Personnel Act, granting to exempt officials the right to place their department or agency under the act, is merely enabling legislation and not an unconstitutional delegation of legislative power. 1961-62 Op. Att'y Gen. No. 62-79.

Purposes underlying exemptions. — The purposes underlying the exemption of certain classes of employees are not to preclude them from benefits such as vacation and sick leave. 1969 Op. Att'y Gen. No. 69-47.

When exempt employees may come under act. —

A state agency not now included under the Personnel Act of 1961 may come under the act at any time that officials exempt from the Personnel Act elect to have their employees covered by the act. 1961-62 Op. Att'y Gen. No. 62-79.

Certain positions exempt. — The following departments, agencies, offices, etc., are exempt from the Personnel Act because they are either (1) not state positions within the meaning of the act or (2) they are not official state agencies within the meaning of the act: district judges, New Mexico historical society and probation officers. 1961-62 Op. Att'y Gen. No. 61-28.

Associate museum directors exempt. — The four associate directors of the museum of New Mexico are exempt from the Personnel Act under Subsection 4C. 1961-62 Op. Att'y Gen. No. 62-19.

Judicial employees are specifically exempt from the Personnel Act. 1969 Op. Att'y Gen. No. 69-47.

Coverage of insurance department personnel. — All insurance department personnel are covered under the Personnel Act except those, if any, who have been properly excluded under the provisions of this section. 1964 Op. Att'y Gen. No. 64-121.

Classification of corrections division teachers. — Teachers employed by the department of corrections (now corrections division) should be classified as state employees under the State Personnel Act. 1974 Op. Att'y Gen. No. 74-2.

C.J.S. reference. — 81A C.J.S. States § 86.

10-9-5. Public officers and public employees; executive branch; annual exempt-salaries plan.

A. The department of finance and administration shall prepare, by May 1 of each odd-numbered year, an exempt-salaries plan for the governor's approval. The plan shall specify salary ranges for the following public-officer and public-employee positions of the executive branch of government:

- (1) members of boards and commissions appointed by the governor;
- (2) heads of agencies appointed by the governor;
- (3) heads of agencies appointed by the respective boards and commissions of the agencies;
- (4) employees in the governor's office;
- (5) positions in the state militia and the state police;
- (6) the assistants and secretaries in the offices of each official covered by Paragraphs (1), (2) and (3) of this section who are excluded from Personnel Act coverage by the provisions of Subsection I [Subsection K] of Section 10-9-4 NMSA 1978;
- (7) positions of a professional or scientific nature which are temporary in nature; and
- (8) state employees whose positions the personnel board has classified as policy-making positions, and exempt employees of elective public officials.

B. Excluded from the provisions of this section are employees of the state board of educational finance and employees of state educational institutions named in Article 12, Section 11 of the constitution of New Mexico.

C. Upon the governor's approval, the plan shall take effect at the beginning of the subsequent fiscal year.

History: 1953 Comp., § 5-4-31.1, enacted by Laws 1971, ch. 283, § 1; 1977, ch. 246, § 42; 1977, ch. 247, § 46; 1977, ch. 365, § 1.

1977 amendments. — Laws 1977, ch. 246, § 42, amending this section by combining Paragraphs (1) and (2) of Subsection B in a single paragraph, was approved April 7, 1977. Laws 1977, ch. 247, § 46, amending this section by inserting a new Paragraph (4) in Subsection A, redesignating Paragraphs (5) through (8) of Subsection A as (6) through (9) and substituting "Subsection K" for "Subsection I" in present Paragraph (6) of Subsection A, was also approved April 7, 1977. However, Laws 1977, ch. 365, § 1, amended this section by adding "the" at the beginning of Paragraph (6) of Subsection A, substituted "who are

excluded from Personnel Act coverage by the provisions of" for "excluding those positions covered by the Personnel Act according to" in Paragraph (6) of Subsection A and incorporated the changes made by the first 1977 amendment but not those of the second, and was approved April 8, 1977. The section is set out as amended by Laws 1977, ch. 365, § 1.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

Board of educational finance administratively attached. — Laws 1977, ch. 246, § 49, administratively attaches the board of educational finance to the educational finance and cultural affairs department. See 21-1-28 NMSA 1978.

C.J.S. reference. — 67 C.J.S. Officers § 93.

10-9-6. Certified school instructors previously employed under the provisions of the Personnel Act.

Certified school instructors who were employed as certified school instructors by state institutions or state agencies under the provisions of the Personnel Act prior to July 1, 1974, may elect to continue to be employed under the Personnel Act. Certified school instructors who elect to continue under the Personnel Act shall file a notice of such election with the personnel director prior to the effective date of this act.

History: 1953 Comp., § 5-4-31.2, enacted by Laws 1975, ch. 182, § 2.

Effective date. — Laws 1975, ch. 182, § 3, makes the act effective on July 1, 1975.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

10-9-7. Payment by covered agencies to the personnel board for services of state personnel office.

Each agency whose personnel are covered by the Personnel Act shall budget for and pay to the personnel board as directed by the department of finance and administration an

10-9-8

10-9-10

assessment for the services furnished to the agency by the state personnel office. The assessment shall be a percentage of the agency's prior year expenditures for personal services and shall be in proportion to the total prior year expenditures for personal services of all covered employment. The state personnel office shall not spend any of such money for the promulgating or filing of rules, policies or plans which have significant financial impact, or which would require significant future appropriations to maintain, without prior, specific legislative approval.

History: 1953 Comp., § 5-4-31.3, enacted by Laws 1976, ch. 11, § 1.

Effective date. — Laws 1976, ch. 11, § 2, makes the act effective on July 1, 1976.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

10-9-8. Personnel board; appointment.

The personnel board is created, and shall be composed of five members appointed by the governor, who shall serve staggered terms of five years each with one board member's term expiring each year. No person shall be a member of the board or eligible for appointment to the board who is an employee in the service, holds political office or is an officer of a political organization.

History: 1953 Comp., § 5-4-32, enacted by Laws 1961, ch. 240, § 5.

Meaning of "political office". — Under the theory advanced by a Kentucky court, any person who is elected by the voters to a public office would be deemed holding a political office within the intent of Laws 1961, ch. 240, §§ 5 and 15. This would be so even if the election were conducted along what is commonly

known as nonpartisan lines rather than political party lines. The term "political office" applies to every elected public office within the state including, but not limited to state elected positions, county elected positions and municipal elected positions, even if conducted along nonpartisan lines. 1961-62 Op. Att'y Gen. No. 61-53.

C.J.S. reference. — 67 C.J.S. Officers § 8.

10-9-9. Board members; pay; meetings.

Each board member shall be paid per diem and mileage according to the Per Diem and Mileage Act [10-8-1 to 10-8-7 NMSA 1978] when traveling on board business. The board shall meet at the call of the chairman but in the absence of such call, at least once every two months.

History: 1953 Comp., § 5-4-33, enacted by Laws 1961, ch. 240, § 6; 1967, ch. 181, § 2.

C.J.S. reference. — 67 C.J.S. Officers §§ 90, 91, 109.

10-9-10. Board duties.

The board shall:

- A. promulgate regulations to effectuate the Personnel Act;
- B. hear appeals and make recommendations to employers;
- C. hire, with the approval of the governor, a director experienced in the field of personnel administration;
- D. review budget requests prepared by the director for the operation of the personnel program and make appropriate recommendations thereon;
- E. make investigations, studies and audits necessary to the proper administration of the Personnel Act;
- F. make an annual report to the governor at the end of each fiscal year;
- G. establish and maintain liaison with the department of finance and administration;
- and
- H. represent the public interest in the improvement of personnel administration in the system.

History: 1953 Comp., § 5-4-34, enacted by Laws 1961, ch. 240, § 7; 1963, ch. 200, § 3; 1967, ch. 181, § 3.

Cross-reference. — For Public Records Act, see 14-3-1 NMSA 1978 et seq.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

Effect of word "shall". — The word "shall" in this section appears to place a mandatory duty upon the board to promulgate rules and regulations to effectuate the Personnel Act. 1963-64 Op. Att'y Gen. No. 64-22.

Classification under rule-making authority. — Under the rule-making authority of this section and

10-9-13 NMSA 1978 the state personnel board has a limited and restricted right to classify as confidential certain portions of an individual's personnel file which would not otherwise be made available to the state unless on a confidential or restricted basis. 1963-64 Op. Att'y Gen. No. 64-19.

C.J.S. reference. — 67 C.J.S. Officers § 110.

10-9-11. Board and office administratively attached to department of finance and administration.

The board and the state personnel office are administratively attached, as defined in the Executive Reorganization Act [9-1-1 to 9-1-10 NMSA 1978], to the department of finance and administration.

History: 1953 Comp., § 5-4-34.1, enacted by Laws 1977, ch. 247, § 47.

Cross-reference. — See 9-6-6 B NMSA 1978.

10-9-12. Director duties.

The director shall:

- A. supervise all administrative and technical personnel activities of the state;
- B. act as secretary to the board;
- C. establish, maintain and publish annually a roster of all employees of the state, showing for each employee his division, title, pay rate and other pertinent data;
- D. make annual reports to the board;
- E. recommend to the board rules he considers necessary or desirable to effectuate the Personnel Act; and
- F. supervise all tests and prepare lists of persons passing them to submit to prospective employers.

History: 1953 Comp., § 5-4-35, enacted by Laws 1961, ch. 240, § 8; 1967, ch. 181, § 4.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

C.J.S. reference. — 67 C.J.S. Officers § 110.

10-9-13. Rules; adoption; coverage.

Rules promulgated by the board shall be effective when filed as required by law. The rules shall provide, among other things, for:

- A. a classification plan for all positions in the service;
- B. a pay plan for all positions in the service;
- C. competitive entrance and promotion tests to determine the qualifications, fitness and ability of applicants to perform the duties of the position for which they apply, and such rules shall also provide for the awarding to those applicants having a passing grade of one preference point for each year of consecutive residency in New Mexico, immediately prior to taking the test, not to exceed a total of five preference points;
- D. exemption from competitive entrance tests for those professional persons applying for classified positions in the service who possess recognized registration or certification by another state agency;
- E. a period of probation of one year during which a probationer may be discharged or demoted or returned to the eligible list without benefit of hearing;
- F. the establishment of employment lists for the certification of the highest standing candidates to the prospective employers, and procedure to be followed in hiring from the lists;
- G. hours of work, holidays and leave;

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H. dismissal or demotion procedure for employees in the service, including presentation of written notice stating specific reasons and time for the employees to reply thereto, in writing, and appeals to the board;

I. the rejection of applicants who fail to meet reasonable requirements as to age, physical condition, training, experience or moral conduct; and

J. employment of any apparently qualified applicant for a period of not more than ninety days when an emergency condition exists and there are no applicants available on an appropriate employment list as provided in Subsection F of this section. The applicant, if employed shall be paid at the same rate as a comparable position covered by the Personnel Act.

History: 1953 Comp., § 5-4-36, enacted by Laws 1961, ch. 240, § 9; 1963, ch. 200, § 4; 1967, ch. 181, § 5; 1975, ch. 26, § 1.

Emergency clause. — Laws 1975, ch. 26, § 2, makes the act effective immediately. Approved March 17, 1975.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

Generally, as to employment termination and pay. — Terminal leave pay is available to involuntarily terminated employees at the discretion of the appointing authority. Terminal leave pay is available to voluntarily resigning employees as a matter of right. The only limitations upon the power of the appointing authority to dismiss are that notice must be given in writing to the dismissed employee and an authorized reason for dismissal must be stated therein. The only limitation on the right of the voluntarily resigning employee to terminal pay is the requirement that he must give 14 days' notice to the appointing authority. 1959-60 Op. Att'y Gen. No. 60-213.

Physician dismissal by miners' hospital board. — The miners' hospital board may dismiss a physician in their employment for not abiding by the rules and regulations of the hospital board, but the physician has the right to appeal the dismissal to the personnel board. 1964 Op. Att'y Gen. No. 64-130.

Dismissal of employees. — The miners' hospital board has power to remove or discharge any employee, but it must exercise this power in accordance with the rules promulgated by the personnel board. 1964 Op. Att'y Gen. No. 64-130.

Right to board hearing. — An employee covered by Personnel Act has a right to a personnel board hearing on his dismissal when the reason given for the dismissal is administrative change and a reduction in personnel. 1961-62 Op. Att'y Gen. No. 62-138.

Requiring physical examination. — The state personnel board has the authority to require a physical examination of all applicants for employment. 1963-64 Op. Att'y Gen. No. 64-22.

Harmonization with other act. — The Personnel Act can be harmonized with the provision in the General Appropriation Act that "insurance department

personnel shall have qualifications as established by the superintendent of insurance." 1964 Op. Att'y Gen. No. 64-121.

Granting of overtime pay or time-off. — There is no prohibition against the cattle sanitary board (now N.M. livestock board) paying its employees engaged in inspecting meat overtime pay or granting compensatory time-off for the extra hours worked. 1967 Op. Att'y Gen. No. 67-20.

Generally, as to specific work hours. — There is no requirement contained in the New Mexico constitution or statutes that work be done at any specific hours of the day. 1967 Op. Att'y Gen. No. 67-89.

And eight-hour days. — There is no specific requirement, either constitutional or statutory, requiring that employees of the state work an eight-hour day. 1967 Op. Att'y Gen. No. 67-89.

Classification under rule-making authority. — Under the rule-making authority of this section and 10-9-10 NMSA 1978, the state personnel board has a limited and restricted right to classify as confidential certain portions of an individual's personnel file which would not otherwise be made available to the state unless on a confidential or restricted basis. 1963-64 Op. Att'y Gen. No. 64-19.

Salary matter of public record. — An employee's salary, kept and published under this section, is a matter of public record under 14-2-1 NMSA 1978. 1968 Op. Att'y Gen. No. 68-110.

So is test score and position. — A job applicant's test score and position on an eligibility list under this section, possessed by the state personnel office, is a public record under 14-2-1 NMSA 1978. 1968 Op. Att'y Gen. No. 68-110.

But not medical and employment histories. — The medical history and employment history solicited from an applicant's previous employer, under this section, are not public records under 14-2-1 NMSA 1978. 1968 Op. Att'y Gen. No. 68-110.

Law review. — For note, "Public Labor Disputes — A Suggested Approach for New Mexico," see 1 N.M. L. Rev. 281 (1971).

C.J.S. reference. — 67 C.J.S. Officers § 110.

10-9-14. Blind not barred from competitive examination; method of testing.

A. No agency or officer of the state or any of its political subdivisions shall prohibit, prevent, disqualify or discriminate against any blind person, otherwise qualified, from registering, taking or competing in a competitive entrance or promotion test for any position for which the blind person makes application.

B. The state personnel board and all political subdivisions of the state which require competitive or promotion tests for any position shall provide an adequate and equal test by an appropriate method for any blind person requesting such a test at the time of submitting his application.

History: 1953 Comp., § 5-4-36.1, enacted by Laws 1967, ch. 71, § 1.

Cross-references. — For agency, defined, see 10-9-3 NMSA 1978. For Handicapped Employment Act, see 28-10-9 NMSA 1978 et seq.

C.J.S. references. — 67 C.J.S. Officers §§ 11, 34; 81A C.J.S. States § 86.

10-9-15. Duties of state officers and employers.

All officers and employers of the state shall comply with the Personnel Act. All employers shall hire employees only from employment lists of applicants who meet prescribed minimum requirements and have passed the prescribed tests, provided by the director. All officers and employers shall furnish any records or information which the director or the board requests.

History: 1953 Comp., § 5-4-37, enacted by Laws 1961, ch. 240, § 10.

Cross-reference. — For definition of employer, see 10-9-3 NMSA 1978.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

C.J.S. reference. — 67 C.J.S. Officers § 110.

10-9-16. Status of present employees.

All employees of the state holding positions brought into the classified service by the Personnel Act shall be continued in their positions and become regular employees without original examinations, if they have held the position for at least one year immediately prior to the effective date of the Personnel Act. All other employees of the state holding positions brought into the service by the Personnel Act shall be continued in their positions as probationers until they have, not later than one year from the effective date of the Personnel Act, taken and passed a qualifying test prescribed by the director for the position held. An employee who fails to qualify shall be dismissed within thirty days after the establishment of an employment or promotion list for his position. Nothing in the Personnel Act shall preclude the reclassification or reallocation of any position held by an incumbent.

This section shall not apply to employees of the grant-in-aid agencies whose status as employees or probationers shall be recognized under rules to be promulgated by the board.

History: 1953 Comp., § 5-4-38, enacted by Laws 1961, ch. 240, § 11.

Effective date. — Laws 1961, ch. 240, contains no effective date provision, but was enacted at a session which adjourned on March 11, 1961. See N.M. Const., art. XV, § 23.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

C.J.S. reference. — 67 C.J.S. Officers § 34.

10-9-17. Certification of payroll.

No person shall make or approve payment for personnel services to any person in the service, unless the payroll voucher or account of the pay is certified by the director that the person being paid was employed in accordance with the Personnel Act.

History: 1953 Comp., § 5-4-39, enacted by Laws 1961, ch. 240, § 12.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

C.J.S. references. — 67 C.J.S. Officers § 99; 81A C.J.S. States § 86.

10-9-18. Appeals by employees to the board.

Any employee who is dismissed or demoted, or who is suspended, may, within thirty days after the dismissal, demotion or suspension, appeal to the board. The appealing employee and the appointing authority whose action is reviewed have the right to be heard publicly and to present facts pertinent to the appeal. Any applicant denied permission to take an examination, or who is disqualified, may appeal to the board. Technical rules of evidence shall not apply. If the board finds the ground for the action is not substantiated, then it shall make written findings and recommendations to the employer, who shall reinstate,

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within thirty days after notice, the employee, with pay, from the date of suspension, demotion or discharge. Any decision made by the board is final. The board may designate a hearing officer who may be a member of the board or any qualified state employee to preside over and take evidence at any hearing held pursuant to this section.

History: 1953 Comp., § 5-4-40, enacted by Laws 1961, ch. 240, § 13; 1963, ch. 200, § 5; 1973, ch. 66, § 1; 1975, ch. 5, § 1.

C.J.S. reference. — 67 C.J.S. Officers §§ 58-72.

10-9-19. Reduction in force.

Whenever an employee is terminated by an employer in a reduction in force by the employer, the terminated employee shall be rehired by that employer if the same or a comparable position becomes available in an increase of force within six months after the termination.

History: 1953 Comp., § 5-4-40.1, enacted by Laws 1963, ch. 200, § 7.

C.J.S. reference. — 67 C.J.S. Officers §§ 49, 62.

Emergency clause. — Laws 1963, ch. 200, § 8, makes the act effective immediately. Approved March 19, 1963.

10-9-20. Oaths; testimony; records; refusal.

The board has the power to administer oaths, subpoena witnesses and compel the production of books and papers pertinent to any investigation or hearing authorized by the Personnel Act. Refusal to testify before the board on matters pertaining to personnel is grounds for dismissal from the service.

History: 1953 Comp., § 5-4-41, enacted by Laws 1961, ch. 240, § 14.

C.J.S. reference. — 67 C.J.S. Officers § 107.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

10-9-21. Prohibited acts.

A. No employer shall dismiss an employee for failure or refusal to pay or promise to pay any assessment, subscription or contribution to any political organization or candidate; however, nothing herein contained shall prevent voluntary contributions to political organizations.

B. No person in the personnel office, or employee in the service, shall hold political office or be an officer of a political organization during his employment. For the purposes of the Personnel Act, being a member of a local school board shall not be construed to be holding political office, and being an election official shall not be construed to be either holding political office, or being an officer of a political organization. Nothing in the Personnel Act shall deny employees the right to vote as they choose or to express their opinions on political subjects and candidates.

C. Any employee who becomes a candidate for public office must, upon filing or accepting the nomination and during the campaign, take a leave of absence. This subsection does not apply to those employees of a grant-in-aid agency, whose political activities are governed by federal statute.

D. The director shall investigate any written charge by any person, that this section has been violated and take whatever steps deemed necessary.

E. No person shall be refused the right of taking an examination, or from appointment to a position, from promotion or from holding a position, because of political or religious opinions or affiliation, or because of race or color.

F. No employee or probationer shall engage in partisan political activity while on duty.

G. With respect to employees of federal grant-in-aid agencies, the applicable personnel standards, regulations and federal laws limiting activities shall apply and shall be set forth in rules promulgated by the board.

History: 1953 Comp., § 5-4-42, enacted by Laws 1961, ch. 240, § 15; 1963, ch. 200, § 6; 1967, ch. 181, § 6.

Cross-reference. — For definition of incompatible office, see 10-6-5 NMSA 1978.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

Constitutionality. — Subsection B does not violate the first amendment guarantee of freedom of speech in requiring that certain state employees not hold public office, nor does it deny equal protection by exempting some state employees from its provisions. State ex rel. Gonzales v. Manzagol, 87 N.M. 230, 531 P.2d 1203 (1975).

Legislative power. — The legislature had the constitutional power under N.M. Const., art. VII, § 2B, to enact this section and to thereby provide, as a qualification or standard for continued employment by the state in a position covered by the State Personnel Act, that the employee not hold "political office." State ex rel. Gonzales v. Manzagol, 87 N.M. 230, 531 P.2d 1203 (1975).

Phrase "while on duty" as used in the Personnel Act means to be actually on the job. 1961-62 Op. Att'y Gen. No. 62-116.

Scope of prohibition in Subsection B. — The words "be an officer of a political organization" are relatively clear. The prohibition (in Subsection B) is without restriction and the legislative intent of these words applies with equal force to the highest and lowest office in a political party or organization. Since there is no restriction, all officers of the party or organization are included within the prohibition, from the state chairman to membership in the central committee or executive committee on down the line to precinct officers and division officers. 1961-62 Op. Att'y Gen. No. 61-53.

Effect of election to public office. — Under the theory advanced by a Kentucky court, any person who is elected by the voters to a public office would be deemed holding a political office within the intent of Laws 1961, ch. 240, §§ 5 and 15. This would be so even

if the election were conducted along what is commonly known as nonpartisan lines rather than political party lines. The term "political office" applies to every elected public office within the state including, but not limited to state elected positions, county elected positions and municipal elected positions, even if conducted along nonpartisan lines (decided prior to 1963 amendment). 1961-62 Op. Att'y Gen. No. 61-53.

Example of political office. — The office of city councilman clearly falls within the definition of a "political office" and petitioner who held such office could properly be discharged from his classified state job under this section. State ex rel. Gonzales v. Manzagol, 87 N.M. 230, 531 P.2d 1203 (1975).

When political activity permissible. — A state employee covered by the Personnel Act may engage in political activity while on annual leave, on week-ends and after working hours during the work week. 1961-62 Op. Att'y Gen. No. 62-116.

Effect of section on municipal election judges or clerks. — Municipal election judges or clerks are not holders of public office under the prohibition of the Personnel Act. 1961-62 Op. Att'y Gen. No. 62-37.

On candidate for delegate to constitutional convention. — A candidate for the position of delegate to the constitutional convention, which is both a temporary and occasional position, is not a candidate for "public office" and need not take a leave of absence. 1969 Op. Att'y Gen. No. 69-28.

On the delegate. — The position of delegate to a constitutional convention is not a "political office" within the meaning of Subsections B or C of this section. 1969 Op. Att'y Gen. No. 69-28.

Generally, as to delegates. — There is no fundamental inconsistency between the positions of public employee covered by the State Personnel Act and that of delegate to the constitutional convention. 1969 Op. Att'y Gen. No. 69-28.

C.J.S. reference. — 67 C.J.S. Officers §§ 54(1), 60, 62, 66.

10-9-22. Unlawful acts prohibited.

It is unlawful to:

A. make any false statement, certificate, mark or rating with regard to any test, certification or appointment made under the Personnel Act;

B. directly or indirectly give, pay, offer, solicit or accept any money or other valuable consideration or secure or furnish any special or secret information for the purpose of affecting the rights or prospects of any person with respect to employment in the service.

History: 1953 Comp., § 5-4-43, enacted by Laws 1961, ch. 240, § 16.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

C.J.S. reference. — 67 C.J.S. Officers §§ 60, 62.

10-9-23. Penalties.

Any person willfully violating any provision of the Personnel Act or the rules of the board is guilty of a misdemeanor. In addition to the criminal penalties, a person found guilty of a misdemeanor under the Personnel Act is ineligible for appointment to or employment in a position in the service, and forfeits his office or position.

History: 1953 Comp., § 5-4-44, enacted by Laws 1961, ch. 240, § 17.

C.J.S. reference. — 67 C.J.S. Officers §§ 125 to 134.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

10-9-24. Existing rules.

Existing personnel rules, policies and pay plans for employees of the state shall govern until new rules, policies and pay plans are established under the Personnel Act.

History: 1953 Comp., § 5-4-45, enacted by Laws 1961, ch. 240, § 18.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

10-9-25. Federal funds and assistance.

When the provisions of any laws of the United States, or any rule, order, or regulation of any federal agency or authority providing federal funds for use in New Mexico, either directly or indirectly or as a grant-in-aid, to be matched or otherwise, impose as a condition for the receipt of such funds, other or higher personnel standards or different classifications than are provided for by the Personnel Act, the board has the authority and is directed to adopt rules and regulations to meet the requirements of such law, rule, order or regulation.

History: 1953 Comp., § 5-4-46, enacted by Laws 1961, ch. 240, § 19.

Separability clause. — Laws 1961, ch. 240, § 20, provides for the severability of the act if any part or application thereof is held invalid.

Repealing clause. — Laws 1961, ch. 240, § 21, repeals 5-4-2, 5-4-18 to 5-4-27, and 42-1-63 to 42-1-73, 1953 Comp.

Personnel Act. — See 10-9-1 NMSA 1978 and notes thereto.

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DATE: JAN 3 1980
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF NEW MEXICO

NONDISCRIMINATION

This Division has received assurance from the Licensure Division of the State Health Agency that currently approved methods of administration under the civil rights requirements are on file in the Regional Office.

ATTACHMENT 7.2-A
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
NONDISCRIMINATION

MAGI ELIGIBILITY

State: New Mexico
Date Received: 1/14/14
Date Approved: 1/17/14
Effective Date: 1/1/14
Transmittal Number: NM 13-22 MM1

SUPERSEDING PAGES OF STATE PLAN MATERIAL		
TRANSMITTAL NUMBER: 13-0022-MM1		STATE: New Mexico
Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, S57,S59 and S14 and related pages or sections of pages being deleted as obsolete		
State Plan Section	Complete Pages Removed	Partial Pages Removed
Attachment 2.2-A	Page 1 Page 3 Page 3a Page 4 Page 4a Page 12 Page 13 Page 13a Page 14 Page 14a Page 17a Page 23 Page 23b Page 23f Page 23G Page 23H	Page 2, A.2.b Page 2, A.2.c Page 2a, A.3 Page 5, A.10 Page 9c, B.1 for "Caretaker relatives" and "Pregnant women" Page 17b (1 st paragraph Page 17c, #15 Page 20, B.14 Page 23c, B.20 Page 23c, B.22 Page 25, C.4
Supplement 1 to Attachment 2.2-A	Page 1	
Attachment 2.6-A	Page 3b Page 11a Page 19 Page 19a Page 19b Page 21	Page 1, A.2.a(i) and (iii) Page 6 related to AFDC recipients, pregnant women, infants, and children Page 7, 1.a(1) and (2) Page 12, C.1.e(2) Page 18, C.5.e Page 21a, C.6.e Page 25, C.11.a(3)
Supplement 1 to Attachment 2.6-A	Pages 1, 1a, 2, and 3	
Supplement 2 to Attachment 2.6-A	Pages 1-5	

Supplement 8a to Attachment 2.6-A	Page 3	Page 3a, #4,7, 8, 9 Page 3b for pregnant women and children
Supplement 8b to Attachment 2.6-A		Page 1 for children only. Page 2 for pregnant women and children only.
Supplement 12 to Attachment 2.6-A	Pages 1, 2, 2a, 3	

State: New Mexico
 Date Received: 1/14/14
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MAGI ELIGIBILITY

- S10: MAGI-Based Income Methodologies
- S14: AFDC Income Standards
- S21: Presumptive Eligibility by Hospitals
- S25: Eligibility Groups (Mandatory) – Parents and other Caretakers
- S28: Eligibility Groups (Mandatory) – Pregnant Women
- S30: Eligibility Groups (Mandatory) – Infants and Children Under Age 19
- S32: Eligibility Groups (Mandatory) – Individuals Below 133% of the FPL
- ~~S33~~: Eligibility Groups (Mandatory) – Former Foster Care Children up to age 26
(MACPro submission 19-0001)
- S50: Eligibility Groups (Optional) – Individuals Above 133% of the FPL
- S51: Eligibility Groups (Optional) – Optional Coverage of Parents and Caretakers
- S52: Eligibility Groups (Optional) – Reasonable Classification of Individuals
- S53: Eligibility Groups (Optional) – Non IV-E Adoption Assistance
- S54: Eligibility Groups (Optional) – Optional Targeted Low Income Children
- S55: Eligibility Groups (Optional) – Tuberculosis
- S57: Eligibility Groups (Optional) – Foster Care Adolescents
- S59: Eligibility Groups (Optional) – Family Planning
- S88: Non-Financial Eligibility State Residency
- S89: Non-Financial Eligibility Citizenship and Non-Citizen Eligibility
- S94: General Eligibility Requirements Eligibility Process

- List of traditional state plan pages superseded by MAGI SPAs



Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

MAGI-Based Income Methodologies

S10

1902(e)(14)
42 CFR 435.603

- ☒ The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ☐ The pregnant woman is counted just as herself.
- ☐ The pregnant woman is counted as herself, plus one.
- ☒ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ☒ Current monthly household income and family size
- ☐ Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☒ Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- ☒ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

☐ Yes ☒ No



Medicaid Eligibility

☐ The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

☒ Age 19

☐ Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: New Mexico
Date Received: 1/13/14
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Date Effective: 1/1/14
Transmittal Number: 13-23



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

AFDC Income Standards

S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- ☒ Statewide standard
- ☐ Standard varies by region
- ☐ Standard varies by living arrangement
- ☐ Standard varies in some other way

Enter the statewide standard

	Household size	Standard (\$)	
+	1	345.08	X
+	2	463.43	X
+	3	581.82	X
+	4	701.2	X
+	5	819.59	X
+	6	937.98	X
+	7	1,056.36	X

Additional incremental amount

☒ Yes ☐ No

Increment amount \$ 118

State: New Mexico
Date Received: 1/13/14
Date Approved: 4/11/14
Date Effective: 1/1/14
Transmittal Number: NM 13-22 MM1

The dollar amounts increase automatically each year

☐ Yes ☒ No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

TN: NM 13-22 MM1

Date Approved: 17 April, 2014

Date Effective: 1 Jan, 2014

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Medicaid Eligibility

The standard is as follows:

- ☒ Statewide standard
- ☐ Standard varies by region
- ☐ Standard varies by living arrangement
- ☐ Standard varies in some other way

Enter the statewide standard

	Household size	Standard (\$)	
+	1	231	X
+	2	310	X
+	3	389	X
+	4	469	X
+	5	548	X
+	6	627	X
+	7	706	X

Additional incremental amount

☒ Yes ☐ No

Increment amount \$

State: New Mexico
Date Received: 1/13/14
Date Approved: 4/11/14
Date Effective: 1/1/14
Transmittal Number: NM 13-22 MM1

The dollar amounts increase automatically each year

☐ Yes ☒ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- ☒ Statewide standard
- ☐ Standard varies by region
- ☐ Standard varies by living arrangement
- ☐ Standard varies in some other way

Enter the statewide standard

TN: NM 13-22 MM1

Date Approved: 17 April, 2014

Date Effective: 1 Jan, 2014



Medicaid Eligibility

	Household size	Standard (\$)	
+	1	345.08	X
+	2	463.43	X
+	3	581.82	X
+	4	701.2	X
+	5	819.59	X
+	6	937.98	X
+	7	1,056.36	X

Additional incremental amount

☒ Yes ☐ No

Increment amount \$

State: New Mexico

Date Received: 1/13/14

Date Approved: 4/11/14

Date Effective: 1/1/14

Transmittal Number: NM 13-22 MM1

The dollar amounts increase automatically each year

☐ Yes ☒ No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ☐ Statewide standard
- ☐ Standard varies by region
- ☐ Standard varies by living arrangement
- ☐ Standard varies in some other way

The dollar amounts increase automatically each year

☐ Yes ☐ No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ☐ Statewide standard
- ☐ Standard varies by region

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TN: NM 13-22 MM1	Date Approved: 17 April, 2014	Date Effective: 1 Jan, 2014
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Medicaid Eligibility

- ☐ Standard varies by living arrangement
☐ Standard varies in some other way

The dollar amounts increase automatically each year

☐ Yes ☐ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- ☐ Statewide standard
☐ Standard varies by region
☐ Standard varies by living arrangement
☐ Standard varies in some other way

The dollar amounts increase automatically each year

☐ Yes ☐ No

State: New Mexico

Date Received: 1/13/14

Date Approved: 4/11/14

Date Effective: 1/1/14

Transmittal Number: NM 13-22 MM1

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- ☒ Statewide standard
☐ Standard varies by region
☐ Standard varies by living arrangement
☐ Standard varies in some other way

Enter the statewide standard

TN: NM 13-22 MM1

Date Approved: 17 April, 2014

Date Effective: 1 Jan, 2014



Medicaid Eligibility

	Household size	Standard (\$)	
+	1	266	X
+	2	357	X
+	3	447	X
+	4	539	X
+	5	630	X
+	6	721	X
+	7	812	X
+	8	922	X

Additional incremental amount

☒ Yes ☐ No

Increment amount \$

State: New Mexico

Date Received: 1/13/14

Date Approved: 4/11/14

Date Effective: 1/1/14

Transmittal Number: NM 13-22 MM1

The dollar amounts increase automatically each year

☐ Yes ☒ No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- ☒ Statewide standard
- ☐ Standard varies by region
- ☐ Standard varies by living arrangement
- ☐ Standard varies in some other way

TN: NM 13-22 MM1

Date Approved: 17 April, 2014

Date Effective: 1 Jan, 2014



Medicaid Eligibility

	Household size	Standard (\$)	
+	1	451	X
+	2	608	X
+	3	765	X
+	4	923	X
+	5	1,080	X
+	6	1,238	X
+	7	1,395	X
+	8	1,553	X

Additional incremental amount

☒ Yes ☐ No

Increment amount \$

The dollar amounts increase automatically each year

☐ Yes ☒ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: New Mexico

Date Received: 1/13/14

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Date Effective: 1/1/14

Transmittal Number: NM 13-22 MM1

TN: NM 13-22 MM1

Date Approved: 17 April, 2014

Date Effective: 1 Jan, 2014



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals

S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

☒ Yes ☐ No

☒ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

☒ A qualified hospital is a hospital that:

☒ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

☒ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

☒ Yes ☐ No

☒ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

☒ Pregnant Women

☒ Infants and Children under Age 19

☒ Parents and Other Caretaker Relatives

☒ Adult Group, if covered by the state

☒ Individuals above 133% FPL under Age 65, if covered by the state

☒ Individuals Eligible for Family Planning Services, if covered by the state

☒ Former Foster Care Children

☒ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

☐ Other Family/Adult groups:

☐ Eligibility groups for individuals age 65 and over

☐ Eligibility groups for individuals who are blind

☐ Eligibility groups for individuals with disabilities

☐ Other Medicaid state plan eligibility groups

☐ Demonstration populations covered under section 1115

State: New Mexico
Date Received: 3/26/14
Date Approved: 6/13/14
Effective Date: 1/1/14
Transmittal Number: NM 13-26

The state establishes standards for qualified hospitals making presumptive eligibility determinations.



Medicaid Eligibility

☒ Yes ☐ No

Select one or both:

- ☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards: 90% of PE should result in a submission of a Medicaid application.

- ☒ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards: 90% of Medicaid applications that are submitted with a PE determination should result in Medicaid eligibility.

- ☒ The presumptive period begins on the date the determination is made.

- ☒ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

- ☒ Periods of presumptive eligibility are limited as follows:

☐ No more than one period within a calendar year.

☐ No more than one period within two calendar years.

☒ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

☐ Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

☒ Yes ☐ No

☒ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

☐ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

State: New Mexico
Date Received: 3/26/14
Date Approved: 6/13/14
Effective Date: 1/1/14
Transmittal Number: NM 13-26



Medicaid Eligibility

☐ The presumptive eligibility determination is based on the following factors:

The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is

☐ being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

☐ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☒ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: New Mexico

Date Received: 3/26/14

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Transmittal Number: NM 13-26



Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Parents and Other Caretaker Relatives	State: New Mexico Date Received: 1/13/14 Date Approved: 4/11/14 Date Effective: 1/1/14 Transmittal Number: NM 13-22 MM1	S25
42 CFR 435.110 1902(a)(10)(A)(i)(I) 1931(b) and (d)		
<p><input checked="" type="checkbox"/> Parents and Other Caretaker Relatives - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.</p> <p><input checked="" type="checkbox"/> The state attests that it operates this eligibility group in accordance with the following provisions:</p> <p><input checked="" type="checkbox"/> Individuals qualifying under this eligibility group must meet the following criteria:</p> <p><input checked="" type="checkbox"/> Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.</p> <p>The state elects the following options:</p> <p>This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old,</p> <p><input checked="" type="checkbox"/> provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.</p> <p><input checked="" type="checkbox"/> Options relating to the definition of caretaker relative (select any that apply):</p> <p><input type="checkbox"/> The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.</p> <p>Definition of domestic partner: <input type="text"/></p> <p><input checked="" type="checkbox"/> The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.</p> <p>Description of other relatives: <input type="text" value="Relatives within the fifth degree of relationship to the dependent child."/></p> <p><input type="checkbox"/> The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.</p> <p><input checked="" type="checkbox"/> Options relating to the definition of dependent child (select the one that applies):</p> <p>The state elects to eliminate the requirement that a dependent child must be deprived of parental support or</p> <p><input checked="" type="radio"/> care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.</p> <p><input type="radio"/> The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):</p>		

TN: NM 13-22 MM1

Approved: 4/11/14

Date Effective: 1 Jan, 2014

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Medicaid Eligibility

☐ Have household income at or below the standard established by the state.

☐ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☐ Income standard used for this group

☐ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☒ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

☐ Maximum income standard

☒ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

☒ The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☐ The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☐ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☐ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

TN: NM 13-22 MM1

Approved: 4/11/14

Date Effective: 1 Jan, 2014

State: New Mexico

Date Received: 1/13/14

Date Approved: 4/11/14

Date Effective: 1/1/14

Transmittal Number: NM 13-22 MM1



Medicaid Eligibility

- ☐ A percentage of the federal poverty level: %
- ☐ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- ☐ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- ☒ The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- ☐ Other dollar amount

☒ Income standard chosen:

Indicate the state's income standard used for this eligibility group

- ☐ The minimum income standard
- ☒ The maximum income standard

- ☐ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.
- ☐ Another income standard in-between the minimum and maximum standards allowed

☒ There is no resource test for this eligibility group.

☒ Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

☒ Yes ☐ No

- ☒ The presumptive period begins on the date the determination is made.
- ☒ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☒ Periods of presumptive eligibility are limited as follows:

- ☐ No more than one period within a calendar year.
- ☐ No more than one period within two calendar years.
- ☒ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

State: New Mexico
Date Received: 1/13/14
Date Approved: 4/11/14
Date Effective: 1/1/14
Transmittal Number: NM 13-22 MM1

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Date Effective: 1 Jan, 2014

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State: New Mexico
Date Received: 1/13/14
Date Approved: 4/11/14
Date Effective: 1/1/14
Transmittal Number: NM 13-22 MM1



Medicaid Eligibility

☐ Other reasonable limitation:

The state requires that a written application be signed by the applicant or representative.

☒ Yes ☐ No

☒ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

☐ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☒ The presumptive eligibility determination is based on the following factors:

☒ The individual must be a caretaker relative, as described at 42 CFR 435.110.

☒ Household income must not exceed the applicable income standard described at 42 CFR 435.110.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☒ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities

S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

☐ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966

☐ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act

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Medicaid Eligibility

☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act

☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

☒ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	Correctional facilities (state prisons/county jails)	Trained correctional staff will make PE determinations for inmates upon release.	X

The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and ☒ has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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State: New Mexico

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Transmittal Number: NM 13-22 MM1



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Pregnant Women

S28

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

State: New Mexico
Date Received: 1/13/14
Date Approved: 4/11/14
Date Effective: 1/1/14
Transmittal Number: NM13-22 MM1

☒ **Pregnant Women** - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☒ The state attests that it operates this eligibility group in accordance with the following provisions:

☒ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

☒ Yes ☐ No

☒ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☒ Income standard used for this group

☒ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

☐ Yes ☒ No

The minimum income standard for this eligibility group is 133% FPL.

☒ Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant

☒ women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

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Approved: 4/11/14

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Medicaid Eligibility

- ☐ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ☐ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ 185% FPL

The amount of the maximum income standard is: % FPL

☒ Income standard chosen

Indicate the state's income standard used for this eligibility group:

- ☐ The minimum income standard
- ☒ The maximum income standard
- ☐ Another income standard in-between the minimum and maximum standards allowed.

☒ There is no resource test for this eligibility group.

☒ Benefits for individuals in this eligibility group consist of the following:

- ☐ All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- ☒ Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

Pregnancy-related services, as defined at 42 CFR 440.210 (a)(2), include prenatal, delivery, postpartum and family planning services, as well as services related to conditions which may complicate pregnancy.

Full Medicaid coverage is provided only for pregnant women with income at or below the income limit described below:

☒ Minimum income limit for full Medicaid coverage

The minimum income standard used for full coverage under this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

- ☒ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

☒ Maximum income limit for full Medicaid coverage

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Medicaid Eligibility

☐ The highest effective income level for coverage under section 1902(a)(10)(A)(i)(III) (qualified pregnant women) or section 1931(b) and (d) (low-income families) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent standard.

☐ The highest effective income level for coverage under section 1902(a)(10)(A)(i)(III) (qualified pregnant women) or section 1931(b) and (d) (low-income families) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent standard.

☐ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

☐ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The amount of the maximum income limit for full Medicaid coverage is:

☐ A percentage of the federal poverty level: %

☒ A dollar amount

Income Standard Entry - Dollar Amount - Automatic Increase Option

\$13a

The standard is as follows:

- ☒ Statewide standard
☐ Standard varies by region
☐ Standard varies by living arrangement
☐ Standard varies in some other way

Enter the statewide standard

	Household size	Standard (\$)	
+	1	451	X
+	2	608	X
+	3	765	X
+	4	923	X
+	5	1,080	X
+	6	1,238	X
+	7	1,395	X
+	8	1,553	X

Additional incremental amount

☒ Yes ☐ No

Increment amount \$

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Medicaid Eligibility

The dollar amounts increase automatically each year

☐ Yes ☒ No

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☒ Income limit chosen for full Medicaid coverage:

- ☐ The minimum income limit
- ☒ The maximum income limit
- ☐ Another income limit in-between the minimum and maximum standards allowed.

☒ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

☒ Yes ☐ No

- ☒ The presumptive period begins on the date the determination is made.
- ☒ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

- ☒ There may be no more than one period of presumptive eligibility per pregnancy.

A written application must be signed by the applicant or representative.

☒ Yes ☐ No

☒ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

☐ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☒ The presumptive eligibility determination is based on the following factors:

- ☒ The woman must be pregnant
- ☒ Household income must not exceed the applicable income standard at 42 CFR 435.116.
- ☒ State residency
- ☒ Citizenship, status as a national, or satisfactory immigration status

- ☒ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities

S17

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Medicaid Eligibility

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

- ☒ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan
- ☒ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act
- ☒ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- ☒ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☒ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☒ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☒ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☒ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☒ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☒ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☒ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☒ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	Correctional facilities (state prisons/county jails)	Trained correctional staff will make PE determinations for inmates upon release.	X

- The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, ☒ and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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Medicaid Eligibility

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Infants and Children under Age 19	State: New Mexico Date Received: 1/13/14 Date Approved: 4/11/14 Date Effective: 1/1/14 Transmittal Number: NM 13-22 MM1	S30
42 CFR 435.118 1902(a)(10)(A)(i)(III), (IV), (VI) and (VII) 1902(a)(10)(A)(ii)(IV) and (IX) 1931(b) and (d)		

- ☒ **Infants and Children under Age 19** - Infants and children under age 19 with household income at or below standards established by the state based on age group.

- ☒ The state attests that it operates this eligibility group in accordance with the following provisions:

- ☒ Children qualifying under this eligibility group must meet the following criteria:

- ☒ Are under age 19
- ☒ Have household income at or below the standard established by the state.

- ☒ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

- ☒ Income standard used for infants under age one

- ☒ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

☐ Yes ☒ No

The minimum income standard for infants under age one is 133% FPL.

- ☒ Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

- The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

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Medicaid Eligibility

- The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ☐ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ 185% FPL.

Enter the amount of the maximum income standard: % FPL.

☒ Income standard chosen

The state's income standard used for infants under age one is:

☒ The maximum income standard

- If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ☐ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- ☐ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- ☐ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- ☐ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

☒ Income standard for children age one through age five, inclusive

☒ Minimum income standard

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Medicaid Eligibility

The minimum income standard used for this age group is 133% FPL.

☒ Maximum income standard

- The state certifies that it has submitted and received approval for its converted income standard(s) for children
- ☒ age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

- ☒ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ☐ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ☐ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: % FPL.

☒ Income standard chosen

The state's income standard used for children age one through five is:

☒ The maximum income standard

- If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- ☐ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

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Medicaid Eligibility

☐ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

☐ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

☐ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

☒ Income standard for children age six through age eighteen, inclusive

☒ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

☒ Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

☒ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

☐ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

☐ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

☐ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

☐ 133% FPL

Enter the amount of the maximum income standard: % FPL

☒ Income standard chosen

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Medicaid Eligibility

The state's income standard used for children age six through eighteen is:

☒ The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

☐ There is no resource test for this eligibility group.

☐ Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

☒ Yes ☐ No

Presumptive Eligibility for Children

S16

1902(a)(47)
1920A
42 CFR 435.1101
42 CFR 435.1102

☐ The state provides Medicaid coverage to children when determined presumptively eligible by a qualified entity under the following provisions:

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Medicaid Eligibility

If the state has elected to cover Optional Targeted Low-Income Children (42 CFR 435.229), the income standard for presumptive eligibility is the higher of the standard used for Optional Targeted Low-Income Children or the standard used for Infants and Children under 19 (42 CFR 435.118), for that child's age.

If the state has not elected to cover Optional Targeted Low Income Children (42 CFR 435.229), the income standard for presumptive eligibility is the standard used under the Infants and Children under Age 19 eligibility group (42 CFR 435.118), for that child's age.

- ☒ Children under the following age may be determined presumptively eligible:

Under age

- ☒ The presumptive period begins on the date the determination is made.

- ☒ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made;
or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

- ☒ Periods of presumptive eligibility are limited as follows:

- ☐ No more than one period within a calendar year.
☐ No more than one period within two calendar years.
☒ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
☐ Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

- ☒ Yes ☐ No

- ☒ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.
☐ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

- ☒ The presumptive eligibility determination is based on the following factors:

- ☒ Household income must not exceed the applicable income standard described above, for the child's age.
☒ State residency
☒ Citizenship, status as a national, or satisfactory immigration status

- ☒ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

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Medicaid Eligibility

List of Qualified Entities

S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

- ☒ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan
- ☒ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act
- ☒ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- ☒ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☒ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☒ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☒ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☒ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☒ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☒ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☒ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☒ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	Correctional facilities (state prisons/county jails)	Trained correctional staff will make PE determinations for inmates upon release.	X

- The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and provided adequate training to the entities and organizations involved. A copy of the training materials has been included.
- ☒

An attachment is submitted.

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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Eligibility Groups - Mandatory Coverage Adult Group

S32

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

☒ Yes ☐ No

☒ **Adult Group** - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

☒ The state attests that it operates this eligibility group in accordance with the following provisions:

☒ Individuals qualifying under this eligibility group must meet the following criteria:

☒ Have attained age 19 but not age 65.

☒ Are not pregnant.

☒ Are not entitled to or enrolled for Part A or B Medicare benefits.

☒ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

☒ Have household income at or below 133% FPL.

☒ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☒ There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is

☒ receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

☒ Under age 19, or

☐ A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

☒ **Presumptive Eligibility**

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

☒ Yes ☐ No

☒ The presumptive period begins on the date the determination is made.

TN: NM 13-22 MM1

Approved: 4/11/14

Date Effective: 1 Jan, 2014

State: New Mexico
Date Received: 1/13/14
Date Approved: 4/11/14
Date Effective: 1/1/14
Transmittal Number: NM 13-22 MM1



Medicaid Eligibility

- ☒ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

- ☒ Periods of presumptive eligibility are limited as follows:

- ☐ No more than one period within a calendar year.
☐ No more than one period within two calendar years.
☒ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
☐ Other reasonable limitation:

The state requires that a written application be signed by the applicant or representative.

- ☒ Yes ☐ No

- ☒ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.
☐ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

- ☒ The presumptive eligibility determination is based on the following factors:

- ☒ The individual must meet the categorical requirements of 42 CFR 435.119.
☒ Household income must not exceed the applicable income standard described at 42 CFR 435.119.
☒ State residency.
☒ Citizenship, status as a national, or satisfactory immigration status.

- ☒ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities

S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

- ☐ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan
☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

TN: NM 13-22 MM1

Approved: 4/11/14

Date Effective: 1 Jan, 2014

Page 2 of 3

State: New Mexico
Date Received: 1/13/14
Date Approved: 4/11/14
Date Effective: 1/1/14
Transmittal Number: NM 13-22 MM1



Medicaid Eligibility

- ☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- ☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☐ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☒ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	Correctional facilities (state prisons/county jails)	Trained correctional staff will make PE determinations for inmates upon release.	X

- The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, ☒ and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN: NM 13-22 MM1

Approved: 4/11/14

Date Effective: 1 Jan, 2014

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

Package Header

Package ID NM2019MS00030
Submission Type Official
Approval Date 2/28/2019
Superseded SPA ID N/A

SPA ID NM-19-0001
Initial Submission Date 1/18/2019
Effective Date N/A

State Information

State/Territory Name: New Mexico

Medicaid Agency Name: NM Human Services
Department, Medical
Assistance Division

Submission Component

☒ State Plan Amendment

☒ Medicaid

☐ CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

Package Header**Package ID** NM2019MS00030**SPA ID** NM-19-0001**Submission Type** Official**Initial Submission Date** 1/18/2019**Approval Date** 2/28/2019**Effective Date** N/A**Superseded SPA ID** N/A**SPA ID and Effective Date****SPA ID** NM-19-0001

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Eligibility Determinations of Individuals Age 65 or Older or Who Have Blindness or a Disability	1/1/2019	new
Mandatory Eligibility Groups	1/1/2019	NM-13-0022
Optional Eligibility Groups	1/1/2019	NM-13-0022
Individuals above 133% FPL under Age 65	1/1/2019	new

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

Package Header

Package ID	NM2019MS00030	SPA ID	NM-19-0001
Submission Type	Official	Initial Submission Date	1/18/2019
Approval Date	2/28/2019	Effective Date	N/A
Superseded SPA ID	N/A		

Executive Summary

Summary Description Including Goals and Objectives New Mexico currently covers the mandatory former foster care individuals up to age 26 and on Medicaid and in foster care in New Mexico at the time they turned 18 or age out of the foster care system. While New Mexico formerly had State Plan authority to cover former foster care individuals up to age 26 who are former residents of other states, CMS finalized a regulation retracting states' authority to receive federal Medicaid matching funds to cover this population without a waiver. New Mexico would like to continue to cover the former foster care out of state individuals and has requested to do so through our 1115 Waiver request. Concurrent with the waiver request the state is required to also submit State Plan Amendment (SPA) S50 to cover these individuals.

New Mexico is required to cover these individuals under state law. Our goal is to cover these out of state individuals as we had done before we were required to rescind this option in our State Plan. New Mexico considers this a vulnerable population that should be covered regardless of whether aging out of foster care in New Mexico or from another state. There is also a parity issue as dependents are allowed to be covered under their parents health insurance coverage up to age 26 through private insurance.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	\$56700
Second	2020	\$75600

Federal Statute / Regulation Citation

42 CFR 435.150
1902(a)(10)(A)(i)(IX)
42 CFR 435.218
1902(a)(10)(ii)(XX)

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created
No Items available	

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

Package Header**Package ID** NM2019MS00030**SPA ID** NM-19-0001**Submission Type** Official**Initial Submission Date** 1/18/2019**Approval Date** 2/28/2019**Effective Date** N/A**Superseded SPA ID** N/A**Governor's Office Review**

- ☐ No comment
- ☐ Comments received
- ☒ No response within 45 days
- ☐ Other

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

CMS-10434 OMB 0938-1188

The submission includes the following:

☐ Administration

☒ Eligibility

☒ Income/Resource Methodologies

☐ MAGI-Based Methodologies

☒ Financial Eligibility Requirements for Non-MAGI Groups

Reviewable Unit Name	Source Type
Included in Another Submission Package	

Financial Eligibility Requirements for Non-MAGI Groups

 APPROVED

☐ Income/Resource Standards

☒ Mandatory Eligibility Groups

Reviewable Unit Name	Source Type
Included in Another Submission Package	

APPROVED

Reviewable Unit Name	Included in Analysis
1. Introduction	Yes
2. Literature Review	Yes
3. Methodology	Yes
4. Results	Yes
5. Discussion	Yes
6. Conclusion	Yes
7. References	Yes
8. Appendix	No
9. Glossary	No
10. Acknowledgments	No
11. Abstract	Yes
12. Executive Summary	No
13. Table of Contents	No
14. List of Figures	No
15. List of Tables	No
16. Bibliography	Yes
17. Index	No
18. Footnotes	No
19. Endnotes	No
20. Appendix A	No
21. Appendix B	No
22. Appendix C	No
23. Appendix D	No
24. Appendix E	No
25. Appendix F	No
26. Appendix G	No
27. Appendix H	No
28. Appendix I	No
29. Appendix J	No
30. Appendix K	No
31. Appendix L	No
32. Appendix M	No
33. Appendix N	No
34. Appendix O	No
35. Appendix P	No
36. Appendix Q	No
37. Appendix R	No
38. Appendix S	No
39. Appendix T	No
40. Appendix U	No
41. Appendix V	No
42. Appendix W	No
43. Appendix X	No
44. Appendix Y	No
45. Appendix Z	No

Source
Type

Optional Eligibility Groups

APPROVED

Eligibility and Enrollment Processes

☐ **Benefits and Payments**

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

Package Header

Package ID	NM2019MS00030	SPA ID	NM-19-0001
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Superseded SPA ID	N/A		

Indicate whether public comment was solicited with respect to this submission.

- ☐ Public notice was not federally required and comment was not solicited
- ☐ Public notice was not federally required, but comment was solicited
- ☒ Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- ☒ Newspaper Announcement

Name of Paper:	Date of Publication:	Locations covered:
Las Cruces Sun News	10/31/2018	Southern New Mexico
Albuquerque Journal	10/31/2018	Northern and Central New Mexico

☐ Publication in state's administrative record, in accordance with the administrative procedures requirements

☐ Email to Electronic Mailing List or Similar Mechanism

☒ Website Notice

Select the type of website

☒ Website of the State Medicaid Agency or Responsible Agency

Date of Posting: Oct 29, 2018

Website URL: <http://www.hsd.state.nm.us/2017-comment-period-open.aspx>

☐ Website for State Regulations

☐ Other

☐ Public Hearing or Meeting

☐ Other method

Upload copies of public notices and other documents used

Name	Date Created
18-003 Individuals above 133% Former Foster Care Albuquerque Journal	12/10/2018 4:15 PM EST
18-003 Individuals above 133% Former Foster Care Las Cruces Sun-News	12/10/2018 4:18 PM EST
18-003 Individuals above 133% Former Foster Care NEWSPAPER	12/10/2018 4:25 PM EST

Upload with this application a written summary of public comments received (optional)

Name	Date Created
------	--------------

No items available

Name

Date Created

Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

Package Header

Package ID NM2019MS00030
Submission Type Official
Approval Date 2/28/2019
Superseded SPA ID N/A

SPA ID NM-19-0001
Initial Submission Date 1/18/2019
Effective Date N/A

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

☒ Yes
☐ No

This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

☒ Yes
☐ No

☒ The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, prior to submission of this SPA

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

☒ All Indian Health Programs

Date of solicitation/consultation:

10/29/2018

Method of solicitation/consultation:

Letter to all Native American Tribes in New Mexico

☒ All Urban Indian Organizations

Date of solicitation/consultation:

10/29/2018

Method of solicitation/consultation:

Letter to all Native American Tribes in New Mexico

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

☒ All Indian Tribes

Date of consultation:

10/29/2018

Method of consultation:

Letter to all Native American Tribes in New Mexico

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name

Date Created

18-003 Individuals above 133% Former Foster Care TN 102918

12/3/2018 5:58 PM EST



Indicate the key issues raised (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

Medicaid State Plan Eligibility

Financial Eligibility Requirements for Non-MAGI Groups

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

Package Header

Package ID	NM2019MS00030	SPA ID	NM-19-0001
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Superseded SPA ID	new		
	User-Entered		

The state applies the following financial methodologies for all eligibility groups whose eligibility is not based on modified adjusted gross income (MAGI) rules (described in 42 C.F.R. §435.603):

A. Financial Eligibility Methodologies

- ☒ The state determines financial eligibility consistent with the methodologies described in 42 C.F.R. §435.601.

B. Eligibility Determinations of Aged, Blind and Disabled Individuals

Eligibility is determined for aged, blind and disabled individuals based on one of the following:

- ☒ SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.

- ☐ State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.

- ☐ State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

C. Financial Responsibility of Relatives

- ☒ The state determines the financial responsibility of relatives consistent with the requirements and methodologies described in 42 C.F.R. §435.602.

D. Additional Information (optional)

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001









Package Header

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Submission Type Official	Initial Submission Date 1/18/2019
Approval Date 2/28/2019	Effective Date 1/1/2019
Superseded SPA ID NM-13-0022	
System-Derived	





Mandatory Coverage







A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
Infants and Children under Age 19		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Parents and Other Caretaker Relatives		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Pregnant Women		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Deemed Newborns		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Former Foster Care Children		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Transitional Medical Assistance		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Extended Medicaid due to Spousal Support Collections		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package ?	Included in Another Submission Package	Source Type ?
SSI Beneficiaries		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Closed Eligibility Groups		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Deemed To Be Receiving SSI		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package 	Included in Another Submission Package	Source Type 
Working Individuals under 1619(b)					
Qualified Medicare Beneficiaries		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Qualified Disabled and Working Individuals		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Specified Low Income Medicare Beneficiaries		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Qualifying Individuals		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW




Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

Package Header**Package ID** NM2019MS00030**SPA ID** NM-19-0001**Submission Type** Official**Initial Submission Date** 1/18/2019**Approval Date** 2/28/2019**Effective Date** 1/1/2019**Superseded SPA ID** NM-13-0022

System-Derived

B. The state elects the Adult Group, described at 42 CFR 435.119.☒ Yes ☐ No**Families and Adults**

Eligibility Group Name	Covered In State Plan	Include RU in Package 	Included in Another Submission Package	Source Type 
Adult Group 	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED

C. Additional Information (optional)**Eligibility Groups Deselected from Coverage**

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

Package Header

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System-Derived	

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals. *

☒ Yes ☐ No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Reasonable Classifications of Individuals under Age 21		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Children with Non-IV-E Adoption Assistance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Independent Foster Care Adolescents		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Optional Targeted Low Income Children		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Individuals above 133% FPL under Age 65		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="radio"/>	APPROVED
Individuals Needing Treatment for Breast or Cervical Cancer		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Eligible for Family Planning Services		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	CONVERTED
Individuals with Tuberculosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW
Individuals Electing COBRA Continuation Coverage		<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for but Not Receiving Cash Assistance		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Individuals Eligible for Cash Except for Institutionalization		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Individuals Receiving Home and Community- Based Waiver Services under Institutional Rules		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Optional State Supplement Beneficiaries		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Individuals in Institutions Eligible under a Special Income Level		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
PACE Participants		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Individuals Receiving Hospice		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Children under Age 19 with a Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Age and Disability-Related Poverty Level		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Work Incentives		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Ticket to Work Basic		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Ticket to Work Medical Improvements		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Family Opportunity Act Children with a Disability		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Individuals Receiving State Plan Home and Community-Based Services		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS0003O | NM-19-0001

Package Header**Package ID** NM2019MS0003O**SPA ID** NM-19-0001**Submission Type** Official**Initial Submission Date** 1/18/2019**Approval Date** 2/28/2019**Effective Date** 1/1/2019**Superseded SPA ID** NM-13-0022

System-Derived

B. Medically Needy Options for Coverage**The state provides Medicaid to specified groups of individuals who are medically needy.***☐ Yes ☒ No

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

Package Header

Package ID NM2019MS00030

SPA ID NM-19-0001

Submission Type Official

Initial Submission Date 1/18/2019

Approval Date 2/28/2019

Effective Date 1/1/2019

Superseded SPA ID NM-13-0022

System-Derived

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals above 133% FPL under Age 65

MEDICAID | Medicaid State Plan | Eligibility | NM2019MS00030 | NM-19-0001

Individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state.

Package Header

Package ID NM2019MS00030
Submission Type Official
Approval Date 2/28/2019
Superseded SPA ID new
User-Entered

SPA ID NM-19-0001
Initial Submission Date 1/18/2019
Effective Date 1/1/2019

The state covers the optional individuals above 133% FPL group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 65
2. Are not otherwise eligible for and enrolled in mandatory coverage under the state plan
3. Are not otherwise eligible for and enrolled in optional full Medicaid coverage under the state plan
4. Have household income that exceeds 133% FPL but is at or below the standard set by the state

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

C. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

☒ Yes ☐ No

D. Income Standard Used

1. The state uses the same income standard for all individuals covered.

☒ Yes ☐ No

2. The income standard for this eligibility group is:

- ☐ a. Percentage of the federal poverty level.
- ☒ b. No income test (the income standard is infinite).

E. Coverage of Dependent Children

Parents or caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

- ☒ 1. Under age 19, or
- ☐ 2. A higher age of children, if any covered under the Reasonable Classifications of Children eligibility group (42 CFR 435.222) on March 23, 2010:

F. Phase-In

The state elects to phase-in coverage to individuals in this group.

☐ Yes ☒ No

G. Additional Information (optional)

This coverage is to further the out-of-state former foster care youth demonstration project authorized under section 1115 of the Act Project No.11-W-00285/6 and will begin when the demonstration authority is approved and end when the demonstration authority expires.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals above 133% FPL

S50

1902(a)(10)(A)(ii)(XX)
1902(hh)
42 CFR 435.218

Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

☐ Yes ☒ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage

Optional Coverage of Parents and Other Caretaker Relatives

851

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

☐ Yes ☒ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage

Reasonable Classification of Individuals under Age 21

SS2

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

☒ Yes ☐ No

☒ The state attests that it operates this eligibility group in accordance with the following provisions:

- ☒ Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:
 - ☒ Be under age 21, or a lower age, as defined within the reasonable classification.
 - ☒ Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.
 - ☒ Not be eligible and enrolled for mandatory coverage under the state plan.
- ☒ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

☒ Yes ☐ No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

☒ Yes ☐ No

Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

- ☒ The state attaches the approved pages from the Medicaid state plan as of March 23, 2010 to indicate the age groups, reasonable classifications, and income standards used at that time for this eligibility group.

An attachment is submitted.

Current Coverage of All Children under a Specified Age

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Medicaid Eligibility

The state covers all children under a specified age limit, equal to or higher than the age limit and/or income standard used in the Medicaid state plan as of March 23, 2010, provided the income standard is higher than the current mandatory income standard for the individual's age. The age limit and/or income standard used must be no higher than any age limit and/or income standard covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

☒ Yes ☐ No

Indicate below the age under which all children are covered under this eligibility group, based on a specific age group used previously in the Medicaid state plan or under a Demonstration, which is equal to or higher than the age group for coverage of all children in the Medicaid state plan as of March 23, 2010.

☐ Under age 21 ☐ Under age 20 ☒ Under age 19 ☐ Under age 18

Enter the income standard used for this age group. The standard must be higher than the mandatory income standard for the individual's age, not more restrictive than that used in the Medicaid state plan as of March 23, 2010 and not less restrictive than that used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

☒ Income standard used

☒ Minimum income standard

The minimum income standard for this classification of children must exceed the lowest income standard chosen for children under this age under the Infants and Children under Age 19 eligibility group.

☒ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

☐ Yes ☒ No

The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

☐ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

☒ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

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Medicaid Eligibility

- The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

- The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

- ☒ A percentage of the federal poverty level: %

- The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

- The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

- ☐ Other dollar amount

☒ Income standard chosen

Individuals qualify under this classification under the following income standard:

- ☒ The maximum income standard.

- If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

- If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

- If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

- If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

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Medicaid Eligibility

The state covers reasonable classifications of children previously covered in the Medicaid state plan as of March 23, 2010, with income standards higher than the current mandatory income standard for the age group. Age limits and income standards are equal to or higher than the Medicaid state plan as of March 23, 2010, but no higher than any age limit and/or income standard for this classification covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

☐ Yes ☒ No

Other Reasonable Classifications Previously Covered

The state covers reasonable classifications of children not covered in the Medicaid state plan as of March 23, 2010, but covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

☐ Yes ☒ No

Additional new age groups or reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

☐ Yes ☒ No

☒ There is no resource test for this eligibility group.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage	853
Children with Non IV-E Adoption Assistance	
42 CFR 435.227 1902(a)(10)(A)(ii)(VIII)	
Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.	
<input type="radio"/> Yes <input checked="" type="radio"/> No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148

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Eligibility Groups - Options for Coverage Optional Targeted Low Income Children

SS4

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

☒ Yes ☐ No

☒ The state attests that it operates this eligibility group in accordance with the following provisions:

☒ Individuals qualifying under this eligibility group must not be eligible for Medicaid under any mandatory eligibility group.

☒ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

☒ Yes ☐ No

The state also covered this eligibility group in the state plan as of March 23, 2010.

☒ Yes ☐ No

☒ Until October 1, 2019, states must include at least those individuals covered as of March 23, 2010, but may cover additional individuals. Effective October 1, 2019, states may reduce or eliminate coverage for this group.

☒ Individuals are covered under this eligibility group, as follows:

☐ All children under age 18 or 19 are covered:

☒ The reasonable classification of children covered is:

☐ Under age 1

☐ Age 1 through age 5, inclusive

☐ Age 6 through age 18, inclusive

☒ Under age

☐ Age through age

☒ Income standard used for this classification

☒ Minimum income standard

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Medicaid Eligibility

The income standard for this classification of children must exceed the lowest income standard chosen for children in the age group selected above, under the mandatory Infants and Children under Age 19 eligibility group.

☒ Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for this ☒ classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

- ☒ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ☐ The state's effective income level for this classification of children under the Medicaid State Plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ☐ The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ 200% FPL.
- ☐ A percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.
- ☒ The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

% FPL

☒ Income standard chosen, which must exceed the minimum income standard

Individuals qualify under the following income standard:

- ☒ The maximum income standard.
- ☐ The state's effective income level for this eligibility group under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective ☐ income level for this eligibility group under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective ☐ income level for this eligibility group under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

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Medicaid Eligibility

- ☐ If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ☐ If higher than the effective income level used under the state plan as of March 23, 2010, 200% FPL.
- ☐ If higher than the effective income level used under the state plan as of March 23, 2010, a percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.
- ☐ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this eligibility group in the state plan as of March 23, 2010.

The income standard for this eligibility group is: % FPL

☒ There is no resource test for this eligibility group.

☒ Presumptive Eligibility

Presumptive eligibility for this group depends upon the selection of presumptive eligibility for the Infants and Children under Age 19 eligibility group. If presumptive eligibility is done for that group, it is done for this group under the same provisions.

PRA Disclosure Statement

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Medicaid Eligibility

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Eligibility Groups - Options for Coverage Individuals with Tuberculosis

S35

1902(a)(10)(A)(ii)(XII)
1902(z)

Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services.

☐ Yes ☒ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
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Eligibility Groups - Options for Coverage Independent Foster Care Adolescents

SS7

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

☒ Yes ☐ No

☒ The state attests that it operates this eligibility group in accordance with the following provisions:

☒ Individuals qualifying under this eligibility group must meet the following criteria:

☒ Are under the following age

☒ Under age 21

☐ Under age 20

☐ Under age 19

☒ Were in foster care under the responsibility of a state on their 18th birthday.

☒ Are not eligible and enrolled for mandatory coverage under the Medicaid state plan.

☒ Have household income at or below a standard established by the state.

☒ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

☒ Yes ☐ No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

☒ Yes ☐ No

The state covers children under this eligibility group, as follows (selection may not be more restrictive than the coverage in the Medicaid state plan as of March 23, 2010 until October 1, 2019, nor more liberal than the most liberal coverage in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013):

☒ All children under the age selected

☐ A reasonable classification of children under the age selected:

☒ Income standard used for this eligibility group

☒ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

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Medicaid Eligibility

☒ Maximum income standard

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

☒ Yes ☐ No

☒ No income test was used (all income was disregarded) for this eligibility group under (check all that apply):

- ☒ The Medicaid state plan as of March 23, 2010.
- ☒ The Medicaid state plan as of December 31, 2013.
- ☐ A Medicaid 1115 demonstration as of March 23, 2010.
- ☐ A Medicaid 1115 demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

☒ Income standard chosen

Individuals qualify under this eligibility group under the following income standard:

This eligibility group does not use an income test (all income is disregarded).

☒ There is no resource test for this eligibility group.

PRA Disclosure Statement

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Medicaid Eligibility

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Eligibility Groups - Options for Coverage Individuals Eligible for Family Planning Services

S59

1902(a)(10)(A)(ii)(XXI)
42 CFR 435.214

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

☒ Yes ☐ No

☒ The state attests that it operates this eligibility group in accordance with the following provisions:

☐ The individual may be a male or a female.

☐ Income standard used for this group

☐ Maximum income standard

☒ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is the highest of the following:

- ☒ The state's current effective income level for the Pregnant Women eligibility group (42 CFR 435.116) under the Medicaid state plan.
- ☐ The state's current effective income level for pregnant women under a Medicaid 1115 demonstration.
- ☐ The state's current effective income level for Targeted Low-Income Pregnant Women under the CHIP state plan.
- ☐ The state's current effective income level for pregnant women under a CHIP 1115 demonstration.

The amount of the maximum income standard is: % FPL

☐ Income standard chosen

The state's income standard used for this eligibility group is:

- ☒ The maximum income standard
- ☐ Another income standard less than the maximum standard allowed.

☐ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

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Medicaid Eligibility

☒ In determining eligibility for this group, the state uses the following household size:

- ☒ All of the members of the family are included in the household
- ☐ Only the applicant is included in the household
- ☐ The state increases the household size by one

☒ In determining eligibility for this group, the state uses the following income methodology:

- ☒ The state considers the income of the applicant and all legally responsible household members (using MAGI-based methodology).
- ☐ The state considers only the income of the applicant.

☒ Benefits for this eligibility group are limited to family planning and related services described in the Benefit section.

☒ Presumptive Eligibility

The state makes family planning services and supplies available to individuals covered under this group when determined presumptively eligible by a qualified entity.

☐ Yes ☒ No

PRA Disclosure Statement

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TN: NM 13-22 MM1

Approved: 4/11/14

Date Effective: 1 Jan, 2014

State: New Mexico

Date Received: 1/13/14

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Date Effective: 1/1/14

Transmittal Number: NM 13-22 MM1



Medicaid Eligibility

State: New Mexico
Date Received: 1/13/14
Date Approved: 4/11/14
Date Effective: 1/1/14
Transmittal Number: NM 13-24

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility State Residency

S88

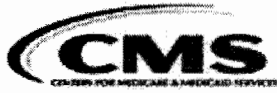
42 CFR 435.403

State Residency

- ☒ The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- ☐ Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
 - ☐ Intends to reside in the state, including without a fixed address, or
 - ☐ Entered the state with a job commitment or seeking employment, whether or not currently employed.
- ☐ Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- ☐ Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
 - ☐ Residing in the state, with or without a fixed address, or
 - ☐ The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- ☐ Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
 - ☐ Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
 - ☐ Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
 - ☐ If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- ☐ Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- ☐ Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- ☐ Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- ☐ IV-E eligible children living in the state, or



Medicaid Eligibility

☐ Otherwise meet the requirements of 42 CFR 435.403.

State: New Mexico
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Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

☒ Yes ☐ No

☒ The state has interstate agreements with the following selected states:

- | | | | |
|--|---|--|--|
| <input checked="" type="checkbox"/> Alabama | <input checked="" type="checkbox"/> Illinois | <input checked="" type="checkbox"/> Montana | <input checked="" type="checkbox"/> Rhode Island |
| <input checked="" type="checkbox"/> Alaska | <input checked="" type="checkbox"/> Indiana | <input checked="" type="checkbox"/> Nebraska | <input checked="" type="checkbox"/> South Carolina |
| <input checked="" type="checkbox"/> Arizona | <input checked="" type="checkbox"/> Iowa | <input checked="" type="checkbox"/> Nevada | <input checked="" type="checkbox"/> South Dakota |
| <input checked="" type="checkbox"/> Arkansas | <input checked="" type="checkbox"/> Kansas | <input checked="" type="checkbox"/> New Hampshire | <input checked="" type="checkbox"/> Tennessee |
| <input checked="" type="checkbox"/> California | <input checked="" type="checkbox"/> Kentucky | <input checked="" type="checkbox"/> New Jersey | <input checked="" type="checkbox"/> Texas |
| <input checked="" type="checkbox"/> Colorado | <input checked="" type="checkbox"/> Louisiana | <input type="checkbox"/> New Mexico | <input checked="" type="checkbox"/> Utah |
| <input checked="" type="checkbox"/> Connecticut | <input checked="" type="checkbox"/> Maine | <input type="checkbox"/> New York | <input checked="" type="checkbox"/> Vermont |
| <input checked="" type="checkbox"/> Delaware | <input checked="" type="checkbox"/> Maryland | <input checked="" type="checkbox"/> North Carolina | <input checked="" type="checkbox"/> Virginia |
| <input checked="" type="checkbox"/> District of Columbia | <input checked="" type="checkbox"/> Massachusetts | <input checked="" type="checkbox"/> North Dakota | <input checked="" type="checkbox"/> Washington |
| <input checked="" type="checkbox"/> Florida | <input checked="" type="checkbox"/> Michigan | <input checked="" type="checkbox"/> Ohio | <input checked="" type="checkbox"/> West Virginia |
| <input checked="" type="checkbox"/> Georgia | <input checked="" type="checkbox"/> Minnesota | <input checked="" type="checkbox"/> Oklahoma | <input checked="" type="checkbox"/> Wisconsin |
| <input checked="" type="checkbox"/> Hawaii | <input checked="" type="checkbox"/> Mississippi | <input checked="" type="checkbox"/> Oregon | <input type="checkbox"/> Wyoming |
| <input checked="" type="checkbox"/> Idaho | <input checked="" type="checkbox"/> Missouri | <input checked="" type="checkbox"/> Pennsylvania | |

☒ The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- ☒ Are IV-E eligible
- ☐ Are in the state only for the purpose of attending school
- ☐ Are out of the state only for the purpose of attending school
- ☐ Retain addresses in both states
- ☐ Other type of individual

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The state has a policy related to individuals in the state only to attend school.

☐ Yes ☒ No

☒ Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

☒ Yes ☐ No



Medicaid Eligibility

Provide a description of the definition:

Residence is not abandoned by temporary absences. Temporary absences occur when recipients leave New Mexico for specific purposes with time-limited goals. An individual may be temporarily absent from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined the individual is a resident there for purposes of Medicaid.

PRA Disclosure Statement

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Transmittal Number: NM 13-24



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Non-Financial Eligibility		S89
Citizenship and Non-Citizen Eligibility	<div>State: New Mexico Date Received: 1/13/14 Date Approved: 3/19/14 Effective Date: 1/1/14 Transmittal Number: 13-25</div>	
<p>1902(a)(46)(B) 8 U.S.C. 1611, 1612, 1613, and 1641 1903(v)(2),(3) and (4) 42 CFR 435.4 42 CFR 435.406 42 CFR 435.956</p>		
Citizenship and Non-Citizen Eligibility <p>The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.</p> <p><input checked="" type="checkbox"/> The state provides Medicaid eligibility to otherwise eligible individuals:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> Who are citizens or nationals of the United States; and<ul style="list-style-type: none">Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and<input checked="" type="checkbox"/> Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956. <p>The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.</p> <p>The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.</p> <p><input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.</p> <p><input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>The date benefits are furnished is:</p> <ul style="list-style-type: none"><input checked="" type="radio"/> The date of application containing the declaration of citizenship or immigration status.<input type="radio"/> The date the reasonable opportunity notice is sent.<input type="radio"/> Other date, as described:		

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STATE: NEW MEXICO

SUPERSEDES: NEW PAGE



Medicaid Eligibility

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

☒ Yes ☐ No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

☒ Yes ☐ No

☒ Pregnant women

☒ Individuals under age 21:

☒ Individuals under age 21

☐ Individuals under age 20

☐ Individuals under age 19

State: New Mexico

Date Received: 1/13/14

Date Approved: 3/19/14

Effective Date: 1/1/4

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☒ An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

☒ An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

☒ Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

☒ Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

☒ Granted employment authorization under 8 CFR 274a.12(c);

☒ Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

☒ Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

☒ Granted Deferred Action status;

☒ Granted an administrative stay of removal under 8 CFR 241;

☒ Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who -

☒ Has been granted employment authorization; or

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STATE: NEW MEXICO ☒ Is under the age of 14 and has had an application pending for at least 180 days;

SUPERSEDES: NEW PAGE



Medicaid Eligibility

6. Has been granted withholding of removal under the Convention Against Torture;
7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);
8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));
10. **Exception:** An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

☐ Other

☒ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

☒ Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;

☒ Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

PRA Disclosure Statement

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State: New Mexico
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TN No: 13-25
STATE: NEW MEXICO

APPROVAL DATE: 3/19/14
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EFFECTIVE DATE: 1/1/14

State: New Mexico
Date Received: 12/13/13
Date Approved: 2/12/14
Date Effective: 10/1/13
Transmittal Number: 13-21



Medicaid Eligibility

OMB Control Number 0938-1148
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General Eligibility Requirements Eligibility Process

S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

- ☒ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

- ☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

- ☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

- ☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

- ☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

- ☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

☐ Yes ☒ No



Medicaid Eligibility

- ☒ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

- ☒ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:
- ☐ Once every 12 months
 - ☐ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency
- If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional
- ☐ information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.
- ☐ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):
- ☒ Once every 12 months
 - ☐ Once every 6 months
 - ☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

- The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between
- ☒ Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

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CHIP

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

- CS3: Eligibility for Medicaid Expansion Program
- CS14: Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Eligibility for Medicaid Expansion Program

CS3

42 CFR 457.320(a)(2) and (3)

Income eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards:

There should be no overlaps or gaps for the ages entered.

Age and Household Income Ranges

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	0	6	200	300	X
+	6	19	138	240	X

PRA Disclosure Statement

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CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Child Health Insurance Program Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards CS14

Section 2101(f) of the ACA and 42 CFR 457.310(d)

☒ Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

- ☐ The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

- ☒ The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

- ☐ The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.
- ☐ The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.
- ☐ The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

% FPL

- ☐ The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.

- ☒ Other.

The state will identify children protected by Section 2101(f) and enroll such children in a separate CHIP based on the following methodology and procedures as approved by CMS.

New Mexico will enroll children whose family income falls above the converted MAGI Medicaid FPL, but below the following percentages of FPL:
Children 0 to 6: 307% FPL
Children 6 to 19: 245% FPL

Describe the benefits provided to this population:



CHIP Eligibility

- ☒ This population will be provided the same benefits as are provided to children in the state's Medicaid program.
- ☐ This population will be provided the same benefits as are provided to children in the state's separate CHIP.
- ☐ Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

- ☒ Cost sharing is the same as for children in the Medicaid program.
- ☐ Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- ☐ No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- ☐ Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

PRA Disclosure Statement

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ABP

ALTERNATIVE BENEFIT PLAN (ABP)

- ABP1: ABP Populations
- ABP2a: Voluntary Benefit Package Selection Assurances
- ABP2c: Enrollment Assurances – Mandatory Participants
- ABP3: Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package
- ABP4: Alternative Benefit Plan Cost-Sharing
- ABP5: Benefits Description
- ABP7: Benefits Assurances
- ABP8: Service Delivery Systems
- ABP9: Employer Sponsored Insurance and Payment of Premiums
- APB10: General Assurances
- APB11: Payment Methodology



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Alternative Benefit Plan Populations

ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name:

New Mexico Expansion Alternative Benefit Plan

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s).

Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory.

Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

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State: New Mexico
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Date Approved: 11-04-19
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TN: NM 19-0003

Date Approved: 11/04/2019

Date Effective: 01/01/2019

Supersedes: NM 13-0030



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

- a) Enrollment in the specified Alternative Benefit Plan is voluntary;
- b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and
- c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

The state/territory assures it will inform the individual of:

- a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and
- b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

Letter

Email

Other

State: New Mexico
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TN: NM 19-0003

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Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Notices of eligibility for the Adult Group will describe Alternative Benefit Plan (ABP) exemption criteria, processes for self-identification, and procedures for choosing to enroll in the Medicaid State Plan benefit package. Individuals who are enrolled in managed care will also receive information about the ABP, the exemption criteria and related processes from their managed care organization (MCO); this information is also contained in each MCO member handbook.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

Individuals in the Adult Group will be automatically enrolled in the ABP when they are determined eligible. Their eligibility notice, referenced and attached above, will describe how they can self-identify as being potentially exempt from the ABP. For managed care recipients, the self-identification process will be facilitated by the member's MCO, which will receive the request for an exemption, evaluate the member based on criteria set forth at 42 CFR 440.315 and further defined by the State, provide benefits counseling to the member (including a description of cost differences between the ABP and the Medicaid State Plan), and facilitate the member's voluntary selection of the ABP that is the Medicaid State Plan, if applicable.

The MCO may also identify members who may be Medically Frail and qualify for an ABP exemption through a mandatory Health Risk Assessment (HRA). The HRA is the first step of care coordination during which the MCO makes contact with their members, asks a series of general health questions, and explains care coordination. The HRA is designed to help the MCO identify members who may be candidates for care coordination due to their medical needs or health status, and is required within the first 30 days of a member's enrollment with the MCO. Members who are identified through the HRA as potentially Medically Frail will receive a Comprehensive Needs Assessment (CNA) to assess the member's physical and behavioral health needs, long-term care needs and disease management needs. The member will also receive a notice from the MCO about the ABP exemption criteria and process. Upon receipt of this notice, the member must initiate the request to be considered for a potential exemption from the ABP through self-identification.

For Native American Medicaid recipients who are exempt from managed care, the state's third-party assessor (TPA) contractor will receive and process the recipient's self-identification and request for an ABP exemption based on criteria set forth at 42 CFR 440.315 and further defined by the State. The TPA contractor will provide benefits counseling and facilitate the recipient's voluntary transition to the ABP that is the Medicaid State Plan, if applicable.

The state/territory assures it will document in the exempt individual's eligibility file that the individual:

- a) Was informed in accordance with this section prior to enrollment;
- b) Was given ample time to arrive at an informed choice; and
- c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

In the eligibility system.

In the hard copy of the case record.

Other

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What documentation will be maintained in the eligibility file? (Check all that apply)



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Copy of correspondence sent to the individual.

Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

Other

The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

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OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Enrollment Assurances - Mandatory Participants

ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

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How will the state/territory identify these individuals? (Check all that apply)

Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Only individuals eligible for the Adult Group will be enrolled in the Alternative Benefit Plan (ABP). Individuals eligible for other Medicaid categories on the basis of their eligibility criteria (including age, disability and pregnancy) will be correctly identified at enrollment and placed in the correct category of eligibility. Adult Group members who become pregnant must report their pregnancy to a State eligibility office to facilitate their transition to the pregnancy category, or they will remain in the Adult Group.

Self-identification

Describe:

Individuals in the Adult Group will be automatically enrolled in the ABP when they are determined eligible. Their eligibility notice will describe how they can self-identify as exempt from the ABP. For managed care recipients, the self-identification process will be facilitated by the member's MCO, which will receive the request for an exemption, evaluate the member based on criteria set forth at 42 CFR 440.315 and further defined by the State, provide benefits counseling to the member (including a description of cost differences between the ABP and Medicaid State Plan), and facilitate the member's voluntary selection of the ABP that is the Medicaid State Plan, if applicable.

For Native American Medicaid recipients who are exempt from managed care, the state's third-party assessor (TPA) contractor will receive and process the recipient's self-identification and request for an ABP exemption based on criteria set forth at 42 CFR 440.315 and further defined by the State. The TPA contractor will provide benefits counseling and facilitate the recipient's voluntary transition to the ABP that is the Medicaid State Plan, if applicable. Because Native American Medicaid recipients are exempt from cost-sharing under both the ABP and the Medicaid State Plan, the TPA contractor is not required to describe the cost differences between the two benefit plans, since the recipient will be exempt from cost-sharing in either instance.

Other

Describe:

For managed care recipients, their managed care organization (MCO) may identify members who may be Medically Frail and qualify for an ABP exemption through a mandatory Health Risk Assessment (HRA). The HRA is the first step of care coordination during which the MCO makes contact with their members, asks a series of general health questions, and explains care coordination. The HRA is designed to help the MCO identify members who may be candidates for care coordination due to their medical needs or health status, and is required within the first 30 days of a member's enrollment with the MCO. Members who are identified through the HRA as potentially Medically Frail will receive a Comprehensive Needs Assessment (CNA) to assess the member's physical and behavioral health needs, long-term care needs and disease management needs. The member will also receive a notice from the MCO about the ABP exemption criteria and process. Upon receipt of this notice, the



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member must initiate the request to be considered for a potential exemption from the ABP through self-identification.

Native American Medicaid recipients who opt-in to managed care will have access to the MCO processes described above, including the HRA, CNA and related care coordination; however, these services are not available to the Native American fee-for-service population.

The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

Review of claims data

Self-identification

Review at the time of eligibility redetermination

Provider identification

Change in eligibility group

Other

Describe:

Managed care members who may be considered Medically Frail may also be identified through the MCO HRA process, described above.

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

Monthly

Quarterly

Annually

Ad hoc basis

Other

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The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.



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Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

For managed care recipients, the self-identification process will be facilitated by the member's MCO, which will receive the request for an exemption, evaluate the member based on criteria set forth at 42 CFR 440.315 and further defined by the State, provide benefits counseling to the member (including a description of cost differences between the ABP and Medicaid State Plan), and facilitate the member's voluntary selection of the ABP that is the Medicaid State Plan, if applicable.

For Native American Medicaid recipients who are exempt from managed care, the state's third-party assessor (TPA) contractor will receive and process the recipient's self-identification and request for an ABP exemption based on criteria set forth at 42 CFR 440.315 and further defined by the State. The TPA contractor will provide benefits counseling and facilitate the recipient's voluntary transition to the ABP that is the Medicaid State Plan, if applicable. Because Native American Medicaid recipients are exempt from cost-sharing under both the ABP and the Medicaid State Plan, the TPA contractor is not required to describe the cost differences between the two benefit plans, since the recipient will be exempt from cost-sharing in either instance.

The MCOs and TPA contractor will conduct the evaluation of ABP exemption criteria, benefits counseling and voluntary transition to the ABP that is the Medicaid State Plan, if applicable, within 10 working days of receipt of the request from the Medicaid recipient. The recipient will remain enrolled in the ABP until a decision has been made about their exemption and the recipient has made a proactive choice to switch to the Medicaid State Plan benefit package. The recipient will receive a notice informing them of the MCO's or TPA contractor's decision. If the recipient qualifies for an exemption from the ABP, they may then choose whether to remain in the ABP or select the Medicaid State Plan as their benefit package. The MCO or TPA contractor will make an indication of this choice using identifiers that are available in the Medicaid Management Information System (MMIS), which will in turn trigger the recipient's appropriate benefit package. Recipients who are determined by the MCO or TPA contractor as not meeting the criteria set forth at 42 CFR 440.315 and as further defined by the State may request a reconsideration or file a fair hearing in accordance with State regulations.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

PRA Disclosure Statement

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State Name:

Attachment 3.1-L-

Transmittal Number: NM - 19 - 0003

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3

Select one of the following:

The state/territory is amending one existing benefit package for the population defined in Section 1.

The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package:

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

Benchmark Benefit Package.

Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).

State employee coverage that is offered and generally available to state employees (State Employee Coverage):

A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):

Secretary-Approved Coverage.

The state/territory offers benefits based on the approved state plan.

The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option.

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

Largest plan by enrollment of the three largest small group insurance products in the state's small group market.



Alternative Benefit Plan

Any of the largest three state employee health benefit plans by enrollment.

Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.

Largest insured commercial non-Medicaid HMO.

Plan name: Presbyterian Health Plan - Individual Silver C HMO

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The Presbyterian Health Plan - Individual Silver C HMO plan was also chosen by the New Mexico Health Insurance Marketplace as its EHB Base Benchmark Plan.

PRA Disclosure Statement

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Attachment 3.1-C- ☐

Alternative Benefit Plan Cost-Sharing

ABP4

Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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State Name:

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Benefits Description

ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

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Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:	Source:	Remove
Cancer Clinical Trials	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Covers routine patient costs associated with Phase I, II, III and IV cancer clinical trials.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Benefit Provided:	Source:	Remove
Dental Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
No	Medicaid State Plan	
Amount Limit:	Duration Limit:	
Annual limits on some services	None	
Scope Limit:		
Refer to State Plan 1905(a)		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Refer to State Plan 1905(a)		

Benefit Provided:	Source:	Remove
Dialysis	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		

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Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Home Health Care & Intravenous Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Limited to 100 four-hour visits per year.

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The recipient must require skilled care and be unable to receive medical care on an ambulatory outpatient basis.

Benefit Provided:

Hospice Care Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

To be eligible for hospice care, a physician must provide a written certification that the recipient has a terminal illness. Certification statements must include information that is based on the recipient's medical prognosis, and that the life expectancy is six months or less if the terminal illness runs its typical course. Recipients must elect to receive hospice care for the duration of the election period. If the recipient receives hospice benefits beyond 210 days, the hospice must obtain a written recertification statement. For the duration of the recipient's election of hospice care, the recipient waives their right to Medicaid payment of concurrent services related to the treatment of the terminal condition or a related condition; or for services equivalent to hospice care.

Benefit Provided:

Outpatient Diagnostic Labs, X-Ray & Pathology

Source:

Base Benchmark Small Group

Remove

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Supersedes: NM 13-0030



Alternative Benefit Plan

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Outpatient Surgery

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Primary Care to Treat Illness/Injury

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

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Benefit Provided:	Source:	Remove
Radiation Therapy and Chemotherapy	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Benefit Provided:	Source:	Remove
Specialist Visits	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Benefit Provided:	Source:	Remove
Treatment of Diabetes	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
This benefit includes medical supplies for the treatment of diabetes.		

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Alternative Benefit Plan

Benefit Provided:	Source:	Remove
Vision Care for Eye Injury or Disease	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Refraction for visual acuity is not covered. Routine vision care is not covered.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Benefit Provided:	Source:	Remove
Vision Hardware	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
One complete set of contact lenses or eyeglasses	None	
Scope Limit:		
Covered only following surgery for the removal of cataracts from one or both eyes. Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery. Materials obtained more than 90 days following surgery are not covered.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Benefit Provided:	Source:	Remove
Podiatry and Routine Foot Care	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	<div>State: New Mexico Date Received: 03-07-19 Date Approved: 11-04-19 Date Effective: 01-01-19 Transmittal Number: 19-0003</div>
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Covered when medically necessary due to malformations, injury, acute trauma or diabetes. Orthopedic shoes, arch supports and foot orthotics are not covered unless they are medically necessary for the treatment of diabetes.		



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Urgent Care Services/Facilities

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Observation Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Observation services for greater than 24 hours will require Prior Authorization.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Defined as outpatient services furnished by a hospital and practitioner/provider on the hospital's premises. Observation services may include the use of a bed and periodic monitoring to evaluate an outpatient's condition.

Benefit Provided:

Source:

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Amount Limit:

Duration Limit:

State: New Mexico
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Alternative Benefit Plan

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

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Alternative Benefit Plan

2. Essential Health Benefit: Emergency services

Collapse All

Benefit Provided: Emergency Ground or Air Ambulance Services	Source: Base Benchmark Small Group	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization required when taking a recipient to a facility over 100 miles from the New Mexico border.		

Benefit Provided: Emergency Department Services/Facilities	Source: Base Benchmark Small Group	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 		

Benefit Provided: Emergency Dental Care	Source: Base Benchmark Small Group	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Covers emergency dental care that is needed because of accidental injury from an outside force to a sound, natural tooth. To be considered sound, the tooth must not have significant decay or prior trauma.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 		

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Emergency treatment of jawbones or surrounding tissues is also covered.

Add

State: New Mexico
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Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided:	Source:	Remove
Bariatric Surgery	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
Limited to one per lifetime	None	
Scope Limit:		
Covered for morbid obesity; or for individuals who have a BMI greater than 35 with at least one co-morbidity related to obesity and who have been previously unsuccessful with medical treatment for obesity.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Benefit Provided:	Source:	Remove
Inpatient Medical and Surgical Care	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Surgeries for cosmetic purposes are not covered.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Prior authorization required for use of a hospital over 100 miles from the New Mexico border, except in an emergency.		

Benefit Provided:	Source:	Remove
Organ and Tissue Transplants	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	State: New Mexico Date Received: 03-07-19 Date Approved: 11-04-19 Date Effective: 01-01-19 Transmittal Number: 19-0003
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Covers medical, surgical and hospital services for the recipient; organ procurement costs; certain travel costs; and immunosuppressive drugs.		



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Reconstructive Surgery

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covers reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders that result from accidental injury, congenital defects or disease.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

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Alternative Benefit Plan

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided:	Source:	Remove
Delivery and Inpatient Maternity Services	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Includes lactation support, supplies and counseling.		

Benefit Provided:	Source:	Remove
Pre- and Post-Natal Care	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Amniocentesis, ultrasound or any other procedures requested solely to determine the sex of the fetus are not covered. An exception is made if it is medically necessary to determine the existence of a sex-linked genetic disorder. Determination of the sex of the fetus is covered as part of a medically necessary procedure, but is not covered as an additional visit when the sex of the fetus cannot be determined during the medically necessary procedure.		

Add

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Alternative Benefit Plan

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All

Benefit Provided:	Source:	Remove
Inpatient Hospital Services	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Refer to State Plan 1905(a)		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Refer to State Plan 1905(a)		

Benefit Provided:	Source:	Remove
Medication-Assisted Therapy for Opioid Addiction	State Plan 1905(a)	
Authorization:	Provider Qualifications:	State: New Mexico Date Received: 03-07-19 Date Approved: 11-04-19 Date Effective: 01-01-19 Transmittal Number: 19-0003
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Refer to State Plan 1905(a)		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Refer to State Plan 1905(a)		

Benefit Provided:	Source:	Remove
Outpatient Behavioral Health Professional Services	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Includes screening, evaluation, testing, assessment, medication management, therapy, and Intensive Outpatient Program (IOP) services.		



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Drug/Alcohol Dependency Treatment Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Refer to State Plan 1905(a)

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Refer to State Plan 1905(a)

Benefit Provided:

Electroconvulsive Therapy (ECT)

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Assertive Community Treatment (ACT)

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

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Alternative Benefit Plan

Scope Limit:

Refer to State Plan 1905(a)

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Refer to State Plan 1905(a)

Benefit Provided:

Psychosocial Rehabilitation (PSR)

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Refer to State Plan 1905(a)

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Refer to State Plan 1905(a)

Add

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Alternative Benefit Plan

6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.): Authorization: Provider Qualifications:

Limit on days supply

No

State licensed

Limit on number of prescriptions

Limit on brand drugs

Other coverage limits

Preferred drug list

Coverage that exceeds the minimum requirements or other:

New Mexico's ABP prescription drug benefit plan is the same as the prescription drug coverage under the Medicaid State Plan.

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Alternative Benefit Plan

7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All

Benefit Provided:

Autism Spectrum Disorder

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covers speech, occupational and physical therapy, and applied behavioral analysis for recipients age 21-22 who are enrolled in high school.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization required after initial evaluation. This is a state-mandated service.

Benefit Provided:

Cardiovascular Rehabilitation

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Short-term therapy (two consecutive months)

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Duration limit is per cardiac event. Exceptions made based on medical necessity. Long-term therapy is not covered.

Benefit Provided:

Durable Medical Equipment & Supplies

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage of medical supplies is limited to diabetic supplies, contraceptive supplies, lactation supplies, cardiac event monitors, and holter monitors.

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Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Requires a physician's prescription and prior authorization.

Benefit Provided:

Inpatient Rehabilitative Facilities

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covers inpatient services at a skilled nursing or acute rehabilitation facility when provided as a step-down level of care following discharge from the hospital prior to discharge to home. Extended care or long-term care not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Orthotic Appliances

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Foot orthotics, including shoes and arch supports, are only covered when an integral part of a leg brace, or are diabetic shoes.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Requires a provider's prescription and prior authorization.

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Benefit Provided:

Prosthetic Devices, Repair and Replacement

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

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Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization required unless the prosthetic device is surgically implanted.

Benefit Provided:

Rehabilitative Services - PT/OT/SLP

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Short-term therapy (two consecutive months)

Scope Limit:

Includes physical and occupational therapy and speech-language pathology.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physical and occupational therapy require prior authorization, but the initial evaluation does not. Speech language pathology requires prior authorization (including evaluations). Duration limit is per condition; concurrent treatment for separate conditions is covered. Exceptions made based on medical necessity. Long-term therapy is not covered.

Benefit Provided:

Habilitative Services - PT/OT/SLP

Source:

Other state-defined

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Short-term therapy (two consecutive months)

Scope Limit:

Includes physical and occupational therapy and speech-language pathology.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physical and occupational therapy require prior authorization, but the initial evaluation does not. Speech language pathology requires prior authorization (including evaluations). Duration limit is per condition; concurrent treatment for separate conditions is covered. Exceptions made based on medical necessity. Long-term therapy is not covered.



Alternative Benefit Plan

Benefit Provided:

Pulmonary Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Short-term therapy (two consecutive months)

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Duration limit is per condition; concurrent treatment for separate conditions is covered. Exceptions made based on medical necessity. Long-term therapy is not covered.

Add

State: New Mexico
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Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:

Diagnostic Imaging

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Lab Tests, X-Ray Services and Pathology

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

State: New Mexico
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Alternative Benefit Plan

9. Essential Health Benefit: Preventive and wellness services and chronic disease management

Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:	Source:	Remove
Allergy Testing and Injections	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Benefit Provided:	Source:	Remove
Annual Physical Exam & Consultation	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Includes a health appraisal exam; laboratory and radiological tests; and early detection procedures. Does not include eye refractions, vision hardware or routine vision services; or hearing aids or hearing aid testing.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		

Benefit Provided:	Source:	Remove
Chronic Disease Management	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	

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Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Diabetes Equipment, Supplies & Education

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Genetic Evaluation & Testing

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Immunizations

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This benefit includes ACIP-recommended vaccines.

Benefit Provided:

Insertion/Removal of Contraceptive Devices

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Osteoporosis Treatment & Management

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

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Benefit Provided:

Periodic Glaucoma Test (Age 35 or older)

Source:

Base Benchmark Small Group

Remove



Alternative Benefit Plan

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage includes testing every one to two years.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Preventive Care and Screenings

Source:

State Plan 1905(a)

Remove

Authorization:

No

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Refer to State Plan 1905(a)

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Refer to State Plan 1905(a)

Benefit Provided:

Voluntary Family Planning Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Sterilization reversal is not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

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Alternative Benefit Plan

Benefit Provided:

Source:

Remove

Authorization:

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

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Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The source plan for this benefit is the New Mexico Medicaid State Plan. Prior authorization required for certain services. Some services subject to a periodicity schedule.

Add

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TN: NM 19-0003

Date Approved: 11/04/2019

Date Effective: 01/01/2019

Supersedes: NM 13-0030



Alternative Benefit Plan

11. Other Covered Benefits from Base Benchmark

Collapse All

State: New Mexico
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Transmittal Number: 19-0003

TN: NM 19-0003
Supersedes: NM 13-0030

Date Approved: 11/04/2019

Date Effective: 01/01/2019



Alternative Benefit Plan

State: New Mexico
Date Received: 03-07-19
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12. Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All

Base Benchmark Benefit that was Substituted:

Acupuncture (20 visits per year)

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substituted with dental services within the Ambulatory Patient Services category.

Base Benchmark Benefit that was Substituted:

Chiropractic Care (20 visits per year)

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substituted with dental services within the Ambulatory Patient Services category.

Base Benchmark Benefit that was Substituted:

CMJ and TMJ Conditions

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substituted with dental services within the Ambulatory Patient Services category.

Base Benchmark Benefit that was Substituted:

Special Medical Foods

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substituted with dental services within the Ambulatory Patient Services category.

Base Benchmark Benefit that was Substituted:

Infertility (Diagnosis, Treatment & Correction)

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substituted with dental services within the Ambulatory Patient Services category. The base benchmark infertility coverage does not include in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or variations of these procedures; surrogate parenting; reversal of sterilization; or any costs associated with the collection, preparation or storage of sperm for artificial insemination, including donor fees, donor egg or sperm retrieval; or infertility medications, including oral infertility drugs.

Add



Alternative Benefit Plan

13. Other Base Benchmark Benefits Not Covered

Collapse All

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Newborn Child Care

Source:

Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Newborns who are born to Medicaid-enrolled mothers are automatically deemed eligible for Medicaid or CHIP, and all newborn services are covered under the Medicaid State Plan.

Add

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TN: NM 19-0003
Supersedes: NM 13-0030

Date Approved: 11/04/2019

Date Effective: 01/01/2019



Alternative Benefit Plan

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided:

Non-Emergency Transportation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covers expenses for transportation, meals and lodging that are determined necessary to secure medical or behavioral health services for an Alternative Benefit Plan recipient.

Other:

There is no authorization requirement for this benefit.

Add

State: New Mexico
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TN: NM 19-0003

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Date Effective: 01/01/2019

Supersedes: NM 13-0030



Alternative Benefit Plan

15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

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Alternative Benefit Plan

State: New Mexico
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Attachment 3.1-C- ☐

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Benefits Assurances

ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. ☐

Prescription Drug Coverage Assurances

The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.



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The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Alternative Benefit Plan

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Attachment 3.1-C- ☐

Service Delivery Systems

ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

☒ Managed Care Organizations (MCO).

☐ Prepaid Inpatient Health Plans (PIHP).

☐ Prepaid Ambulatory Health Plans (PAHP).

☐ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

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Managed Care Options

Managed Care Assurance

☒ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

As part of New Mexico's efforts to roll-out its new Section 1115 waiver for Centennial Care on January 1 (which includes both the Other Adult Group and the ABP), the state held more than 200 public education events in every region of the state, including 52 events that were held in Native American communities. The state began running radio, print and online advertisements about Centennial Care in August 2013.

A tribal consultation was held in August 2013, during which the state discussed the ABP services package, as well as the intended selection of New Mexico's Section 1937 option and base benchmark plan. These topics were also discussed at every quarterly Medicaid Advisory Committee (MAC) meeting throughout 2013 and early 2014 to ensure communication with stakeholders. A meeting with tribal providers was held in November 2013 and a second provider meeting took place in March 2014.

In addition, New Mexico began a year-long comprehensive readiness review of its four Centennial Care managed care organizations (MCOs) in early 2013 to ensure that the MCOs are fully operational and compliant with the standards and conditions outlined in the Centennial Care waiver. Ten workgroups were created to focus on certain areas of implementation, such as reporting, care coordination, IT systems, and other issues pertinent to implementing the waiver and, more specifically, the ABP.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

Yes

The managed care program is operating under (select one):



Alternative Benefit Plan

- ☐ Section 1915(a) voluntary managed care program.
- ☐ Section 1915(b) managed care waiver.
- ☐ Section 1932(a) mandatory managed care state plan amendment.
- ☒ Section 1115 demonstration.
- ☐ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

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Identify the date the managed care program was approved by CMS:

Describe program below:

New Mexico Centennial Care provides managed physical, behavioral health and long-term care services through four managed care organizations (MCOs). New Mexico's vision for Centennial Care is to build a health care system that delivers the right amount of care at the right time and in the right setting. This vision includes educating recipients to become savvy health care consumers, promoting integrated care, delivering proper care coordination for the most at-risk recipients, involving recipients in their own wellness, and paying providers for good health outcomes. More detailed information about New Mexico Centennial Care can be found online at www.state.nm.us/centennialcare.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- ☒ Traditional state-managed fee-for-service
- ☐ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

In New Mexico, most Native American Medicaid recipients maintain a choice to opt-in to the Centennial Care (managed care) program, or to access care through a traditional state-managed fee-for-service delivery system; however, Native American recipients who are dually eligible for Medicare and Medicaid or who have a nursing facility level of care, are required to enroll in Centennial Care. Native American recipients who access care through fee-for-service may opt-in to Centennial Care at any time during their eligibility.

The base services offered in the ABP are the same for both fee-for-service and Centennial Care recipients, and are detailed in Section 5 of this State Plan Amendment; however, Centennial Care recipients may receive additional "value-added services" from their MCOs that are not available to fee-for-service recipients.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

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Alternative Benefit Plan

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Alternative Benefit Plan

Attachment 3.1-C- ☐

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General Assurances

ABP10

Economy and Efficiency of Plans

- ☒ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.

Yes

Compliance with the Law

- ☒ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.
- ☒ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).
- ☒ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

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Attachment 3.1-C- ☐

Payment Methodology

ABP11

Alternative Benefit Plans - Payment Methodologies

The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

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