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# New Mexico Register

The official publication for all official notices of rulemaking and filing of proposed, adopted and emergency rules.

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# The New Mexico Register

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# New Mexico Register

Volume XXXVII, Issue 16
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# Notices of Rulemaking and Proposed Rules

## ENVIRONMENT DEPARTMENT

### NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD NOTICE OF SCHEDULED PUBLIC HEARING TO CONSIDER PROPOSED AMENDMENTS TO 20.3.1 NMAC, 20.3.2 NMAC, 20.3.3 NMAC, 20.3.4 NMAC, 20.3.6 NMAC, and 20.3.20 NMAC OF THE RADIATION PROTECTION REGULATIONS EIB 26-54 (R)

The New Mexico Environmental Improvement Board ("Board") will hold a public hearing beginning at 1 p.m. on November 6, 2026, and continuing at the direction of the Board, to consider the matter of EIB 26-54 (R), proposed revisions to 20.3.1 NMAC, 20.3.2 NMAC, 20.3.3 NMAC, 20.3.4 NMAC, 20.3.6 NMAC, and 20.3.20 NMAC. The hearing will last as long as required to hear all testimony, evidence, and public comment, and is expected to last approximately 4 hours. The Board may make a decision on the proposed amendments at the conclusion of the hearing, or the Board may convene a meeting after the hearing to consider action on the proposal.

The hearing will be conducted in a hybrid format to allow for both in-person and virtual participation. The in-person hearing will be held at the New Mexico State Capitol Building (Roundhouse), 490 Old Santa Fe Trail, Santa Fe, New Mexico 87505. Detailed information concerning the time, location, and instructions on how to join the hearing virtually is available on the New Mexico Environment Department ("NMED") events calendar at https://www.env.nm.gov/events-calendar/, under the calendar entry corresponding to the hearing start date. If you have difficulties joining the meeting, please contact Pamela Jones at (505) 660-4305 or pamela.jones@env.nm.gov.

The proposed amendments and related information, including technical information, may be reviewed online at https://www.env.nm.gov/opf/docketed-matters/; during regular business hours at 525 Camino De Los Marquez, Santa Fe, New Mexico 87505; or by contacting the Radiation Control Bureau's Senior Environmental Scientist, Thomas Collins, at (505) 231-0166 or Thomas.collins@env.nm.gov.

Public comments will be received via SmartComment at https://nmed.commentinput.com?id=bZhgAQ7Ge, via electronic mail to Pamela.Jones@env.nm.gov; or via physical mail to Pamela Jones, P.O. Box 5469, Santa Fe, NM 87502 until the conclusion of the hearing. Comments received after the conclusion of the hearing will not be viewed.

The purpose of the public hearing is for the Board to consider and take possible action on a petition by NMED requesting the Board to adopt proposed regulatory changes to 20.3.1 NMAC, 20.3.2 NMAC, 20.3.3 NMAC, 20.3.4 NMAC, 20.3.6 NMAC, and 20.3.20 NMAC of the Radiation Protection Regulations. The proposed regulatory changes are attached as Attachment 1 to the Petition for Regulatory Change ("Petition"), docket number EIB 26-54 (R), available for viewing online at https://www.env.nm.gov/opf/docketed-matters/. If you need assistance obtaining a copy of the proposed amendments, the Petition, or any other documents related to this matter, then please contact: Pamela Jones, Board Administrator, P.O. Box 5469, 1190 St. Francis Drive, Suite S-2103, Santa Fe, NM, 87502; Pamela.Jones@env.nm.gov; (505) 660-4305. In your correspondence, please reference docket number EIB 26-54 (R).

Technical information that served as a basis for the proposed rule may be viewed online at https://www.env.nm.gov/opf/docketed-matters and may also be obtained from the Petitioners upon request to the Radiation Control Bureau's Senior Environmental Scientist, Thomas Collins, at (505) 231-0166 or Thomas.collins@env.nm.gov.

The proposed regulatory changes requested by the Radiation Control Bureau ("Bureau") of NMED are necessary for the Bureau to effectively operate the Radiation Control Program in the State. To achieve this, the Bureau is proposing to revise the definitions, clarify the scope, update requirements for the application for registration of radiation machines for certain practitioners, revise the requirements for a shielding plan review, reorganizing the appendices in 20.3.2 NMAC and 20.3.6 NMAC, and clarifying certain requirements to align with the Bureau's current business practices. Additionally, the Bureau will incorporate regulatory requirements from the U.S. Food and Drug Administration for fluoroscopic x-ray systems, computed tomography equipment, and cabinet x-ray systems, and update the recognized credentialing organizations for medical imaging and radiation therapy. The Bureau will also use this opportunity to make several minor changes in order to improve the clarity and enforceability of the regulations.

NMED is authorized by NMSA 1978, Section 74-1-7(A)(5)(2024) to revise New Mexico's radiation control regulations. NMED is also authorized by NMSA 1978, Section 61-14E-3 (2009) to administer and enforce provisions of the Medical Imaging and Radiation Therapy Health and Safety Act.

The Board has the authority to amend the Radiation Protection Regulations under NMSA 1978, Section 74-1-8(A)(5)(2024), NMSA 1978, Section 74-1-9 (1985), NMSA 1978, Section 74-3-5(A) (2000), and NMSA 1978, Section 61-14E-5 (2009). The hearing will be conducted in accordance

with the Board's Rulemaking Procedures found at 20.1.1 NMAC, the Environmental Improvement Act, NMSA 1978, Section 74-1-9 (1985), and other applicable procedures.

The Board may make a decision on the proposed rule at the conclusion of the hearing, or the Board may convene a meeting on a later date after the hearing to consider action on the proposed rule. Alternatively, the Board may continue the hearing beyond the expected conclusion date, leaving the hearing record open and continuing to receive comments. Notice of continuation will be posted on the Board's and NMED's websites.

All interested persons will be given reasonable opportunity at the hearing to submit relevant evidence, data, views, and arguments, orally or in writing, to introduce exhibits, and to examine witnesses. Any person who wishes to submit a non-technical written statement for the record in lieu of oral testimony must file such statement prior to the close of the hearing via SmartComment at https://nmed.commentinput.com?id=bZhgAQ7Ge; by electronic mail at pamela.jones@env.nm.gov; or by physical mail to Pamela Jones, P.O. Box 5469, Santa Fe, NM, 87502. Any statements received after the conclusion of the hearing will not be viewed.

Persons wishing to present technical testimony must file with the Board a written notice of intent to do so. The requirements for a notice of intent can be found in 20.1.1.302 NMAC. Technical testimony means scientific, engineering, economic, or other specialized testimony, whether oral or written, but does not include legal argument, general comments, or statements of policy concerning matters at issue in the hearing. Notices of intent for the hearing must be received by the Board no later than 5:00 p.m. MST on October 16, 2026, and should reference the name of the regulations, the date of the hearing, and docket number EIB 26-54 (R). Notices of intent to present technical testimony shall be submitted to Pamela Jones, Board Administrator, P.O. Box 5469, Santa Fe, NM 87502, pamela.jones@env.nm.gov.

Persons requiring language interpretation services or have a disability and need a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing should contact Pamela Jones no later than October 8, 2025, at (505) 660-4305 or pamela.jones@env.nm.gov. TDD or TDY users please dial 7-1-1 or 800-659-8331 to access this number via Relay New Mexico.

**STATEMENT OF NON-DISCRIMINATION**

NMED does not discriminate on the basis of race, color, national origin, disability, age or sex in the administration of its programs or activities, as required by applicable laws and regulations. NMED is responsible for coordination of compliance efforts and receipt of inquiries concerning non-discrimination requirements implemented by 40 C.F.R. Parts 5 and 7, including Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, and Section 13 of the Federal Water Pollution Control Act Amendments of 1972. If you have any questions about this notice or any of NMED's non-discrimination programs, policies or procedures, you may contact: Kate Cardenas, Non-Discrimination Coordinator, New Mexico Environment Department, 1190 St. Francis Dr., Suite N4050, P.O. Box 5469, Santa Fe, NM 87502, (505) 827-2855 nd.coordinator@env.nm.gov.

If you believe that you have been discriminated against with respect to a NMED program or activity, you may contact the Non-Discrimination Coordinator identified above or visit our website at https://www.env.nm.gov/non-employee-discrimination-complaint-page/ to learn how and where to file a complaint of discrimination.

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## ENVIRONMENT DEPARTMENT

### AVISO DE LA JUNTA DE MEJORAMIENTO AMBIENTAL DE NUEVO MÉXICO ACERCA DE LA AUDIENCIA PÚBLICA PROGRAMADA PARA CONSIDERAR LAS ENMIENDAS PROPUESTAS A 20.3.1 NMAC, 20.3.2 NMAC, 20.3.3 NMAC, 20.3.4 NMAC, 20.3.6 NMAC, y 20.3.20 NMAC DE LAS NORMAS DE PROTECCIÓN RADIOLÓGICA EIB 26-54 (R)

La Junta de Mejoramiento Ambiental de Nuevo México ("Junta") llevará a cabo una audiencia pública a partir de la 1 p.m. el 6 de noviembre de 2026, la cual continuará en la dirección de la Junta, con el objetivo de considerar el asunto de EIB 26-54 (R), acerca de las revisiones propuestas a 20.3.1 NMAC, 20.3.2 NMAC, 20.3.3 NMAC, 20.3.4 NMAC, 20.3.6 NMAC y 20.3.20 NMAC. La audiencia durará el tiempo que sea necesario para escuchar todos los testimonios, pruebas y comentarios públicos, y se espera que tenga una duración aproximada de 4 horas. La Junta puede tomar una decisión sobre las enmiendas propuestas al concluir la audiencia, o la Junta puede convocar una reunión después de la audiencia con el fin de considerar una acción sobre la propuesta.

La audiencia se llevará a cabo en un formato híbrido para permitir la participación tanto en persona como virtual. La audiencia presencial se llevará a cabo en el Edificio del Capitolio del Estado de Nuevo México (Rotonda), 490 Old Santa Fe Trail, Santa Fe, Nuevo México 87505. La información detallada acerca de la hora, el lugar y las instrucciones sobre cómo unirse a la audiencia de forma virtual se encuentra disponible en el calendario de eventos del Departamento de Medio Ambiente

de Nuevo México ("NMED") en https://www.env.nm.gov/events-calendar/, en el acceso al calendario correspondiente a la fecha de inicio de la audiencia. Si tiene dificultades para unirse a la reunión, comuníquese con Pamela Jones al (505) 660-4305 o pamela.jones@env.nm.gov.

Las enmiendas propuestas y la información relacionada, incluyendo la información técnica, pueden revisarse en línea en https://www.env.nm.gov/opf/docketed-matters/; durante el horario comercial habitual en 525 Camino De Los Marquez, Santa Fe, Nuevo México 87505; o comunicándose con el Científico Ambiental Senior de la Oficina de Control Radiológico, Thomas Collins, al (505) 231-0166 o Thomas.collins@env.nm.gov.

Los comentarios públicos se recibirán a través de SmartComment en https://nmed.commentinput.com?id=bZhgAQ7Ge, por correo electrónico a Pamela.Jones@env.nm.gov; o por correo físico a Pamela Jones, P.O. Box 5469, Santa Fe, NM 87502 hasta que la audiencia concluya. No se revisarán los comentarios que se reciban después de que la audiencia hay concluido.

El propósito de la audiencia pública es que la Junta considere y tome posibles medidas sobre una petición por parte del NMED solicitando a la Junta que adopte los cambios regulatorios propuestos a 20.3.1 NMAC, 20.3.2 NMAC, 20.3.3 NMAC, 20.3.4 NMAC, 20.3.6 NMAC y 20.3.20 NMAC de las Normas de Protección Radiológica. Los cambios regulatorios propuestos se adjuntan como Anexo 1 a la Petición de Cambio Regulatorio ("Petición"), con número de expediente EIB 26-54 (R), disponible para su consulta en línea en https://www.env.nm.gov/opf/docketed-matters/. Si necesita ayuda para obtener una copia de las enmiendas propuestas, la Petición o cualquier otro documento relacionado con este asunto, comuníquese con: Pamela Jones, Administradora de la Junta, P.O. Box 5469, 1190 St. Francis Drive, Suite S-2103, Santa Fe, NM, 87502; Pamela.Jones@env.nm.gov; (505) 660-4305. En su correspondencia, haga referencia al número de expediente EIB 26-54 (R).

La información técnica que sirvió de base para la norma propuesta se puede ver en línea en https://www.env.nm.gov/opf/docketed-matters y también se puede obtener de los Solictantes previa solicitud al Científico Ambiental Senior de la Oficina de Control Radiológico, Thomas Collins, al (505) 231-0166 o Thomas.collins@env.nm.gov.

Los cambios regulatorios propuestos solicitados por la Oficina de Control Radiológico ("Oficina") del NMED son necesarios para que la Oficina opere de manera efectiva el Programa de Control Radiológico en el Estado. Co neste objetivo en mente, la Oficina propone revisar las definiciones, aclarar el alcance, actualizar los requisitos para la solicitud de registro de máquinas de radiación para ciertos profesionales, revisar los requisitos para una revisión del plan de blindaje, reorganizar los apéndices en 20.3.2 NMAC y 20.3.6 NMAC y aclarar ciertos requisitos con el fin de alinearlos con las prácticas comerciales actuales de la Oficina. Además, la Oficina incorporará requisitos regulatorios de la Administración de Alimentos y Medicamentos de EE.UU. correspondientes a sistemas de rayos X fluoroscópicos, equipos de tomografía computarizada y sistemas de rayos X de gabinete, y actualizará las organizaciones de acreditación reconocidas para imagenología médica y radioterapia. La Oficina también aprovechará esta oportunidad para realizar diversos cambios menores con el fin de mejorar la claridad y la aplicabilidad de las normas.

El NMED cuenta con autorización por parte de NMSA 1978, Sección 74-1-7(A)(5)(2024) de revisar las normas de Control Radiológico de Nuevo México. El NMED también está autorizado por NMSA 1978, Sección 61-14E-3 (2009) para administrar y hacer cumplir las disposiciones de la Ley de Salud y Seguridad de Radioterapia e Imagenología Médica.

La Junta tiene la autoridad para modificar las Normas de Protección Radiológica de conformidad con NMSA 1978, Sección 74-1-8(A)(5) (2024), NMSA 1978, Sección 74-1-9 (1985), NMSA 1978, Sección 74-3-5(A) (2000) y NMSA 1978, Sección 61-14E-5 (2009). La audiencia se llevará a cabo de acuerdo con los Procedimientos de Reglamentación de la Junta que se encuentran en 20.1.1 NMAC, la Ley de Mejoramiento Ambiental, NMSA 1978, Sección 74-1-9 (1985) y otros procedimientos aplicables.

La Junta puede tomar una decisión con respecto a la norma propuesta al concluir la audiencia, o la Junta puede convocar una reunión en una fecha posterior después de la audiencia con el fin de considerar la acción sobre la norma propuesta. De forma alternativa, la Junta puede continuar la audiencia más allá de la fecha de conclusión prevista, dejar abierto el registro de la audiencia y seguir recibiendo comentarios. El aviso de continuación se publicará en los sitios web de la Junta y del NMED.

A todas las personas interesadas se les dará una oportunidad razonable durante la audiencia para presentar pruebas, datos, opiniones y argumentos relevantes, de forma oral o escrita, así como de presentar evidencia e interrogar a los testigos. Cualquier persona que desee presentar una declaración escrita no técnica para su registro en acta en lugar de un testimonio oral debe presentar dicha declaración antes del cierre de la audiencia a través de SmartComment en https://nmed.commentinput.com?id=bZhgAQ7Ge; por correo electrónico a pamela.jones@env.nm.gov; o por correo físico a Pamela Jones, P.O. Box 5469, Santa Fe, NM, 87502. No se revisarán las declaraciones que se reciban después de que la audiencia hay concluido.

Las personas que deseen presentar un testimonio técnico deben presentar ante la Junta una notificación por escrito de su intención de hacerlo. Los requisitos para un aviso de intención se pueden encontrar en 20.1.1.302 NMAC. Un testimonio técnico constituye un testimonio científico, de ingeniería, económico u otro testimonio especializado, ya sea oral o escrito, pero no incluye argumentos legales, comentarios generales o declaraciones de políticas relacionadas con los asuntos en cuestión en la audiencia. La Junta debe recibir las notificaciones de intención para la audiencia a más tardar el 16 de octubre de 2026 a las 5:00 p. m. MST y debe hacer referencia al nombre de las normas, la fecha de la audiencia y el número de expediente EIB 26-54 (R). Las notificaciones de intención de presentar un testimonio técnico se deben enviar a Pamela Jones, Administradora de la Junta, P.O. Box 5469, Santa Fe, NM 87502, pamela.jones@env.nm.gov.

Las personas que requieran servicios de interpretación de idiomas o presenten una discapacidad y necesiten un lector, un amplificador, un intérprete de lenguaje de señas calificado o cualquier otra forma de ayuda o servicio auxiliar para poder asistir o participar en la audiencia deben comunicarse con Pamela Jones a más tardar el 8 de octubre de 2025 al (505) 660-4305 o pamela.jones@env.nm.gov. Los usuarios de TDD o TDY deben marcar 7-1-1 o 800-659-8331 para tener acceso a este número a través de Relay New Mexico.

**DECLARACIÓN DE NO DISCRIMINACIÓN**

El NMED no discrimina por motivos de raza, color, origen nacional, discapacidad, edad o sexo en la administración de sus programas o actividades, de conformidad con las leyes y normas aplicables. El NMED se hace responsable de coordinar los esfuerzos de cumplimiento y recibir consultas relacionadas con los requisitos de no discriminación implementados por 40 C.F.R. Partes 5 y 7, incluido el Título VI de la Ley de Derechos Civiles de 1964, tal como estuvieren modificados; Sección 504 de la Ley de Rehabilitación de 1973; la Ley de Discriminación por Edad de 1975, el Título IX de las Enmiendas a la Educación de 1972 y la Sección 13 de las Enmiendas a la Ley Federal de Control de la Contaminación del Agua de 1972. Si tiene alguna pregunta sobre este aviso o cualquiera de los programas, políticas o procedimientos de no discriminación del NMED, puede comunicarse con: Kate Cardenas, Coordinadora de No Discriminación, Departamento de Medio Ambiente de Nuevo México,1190 St. Francis Dr., Suite N4050, P.O. Box 5469, Santa Fe, NM 87502, (505) 827-2855 nd.coordinator@env.nm.gov.

Si considera que ha sido discriminado con respecto a un programa o actividad del NMED, puede comunicarse con la Coordinadora de No Discriminación identificada con anterioridad o visite nuestro sitio web en https://www.env.nm.gov/non-employee-discrimination-complaint-page/ para saber cómo y dónde presentar una queja por discriminación.

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## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

### NOTICE OF RULEMAKING

The New Mexico Health Care Authority (HCA), through the Medical Assistance Division (MAD), is proposing to amend the New Mexico Administrative Code (NMAC) rule *8.310.3, Health Care Professional Services, Professional Providers, Services and Reimbursement*.

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

Notice Date: August 25, 2026
Hearing Date: September 25, 2026
Adoption Date: Proposed as January 1, 2027

Technical Citations: 2025 Legislative HB 56, 2025 Practitioner Parity, The American Medical Association for coding along with CMS have approved restructure of billing codes unbundling a 30 year guidance for global maternity services. CPT® 2027 Maternity Care Services code changes | American Medical Association

**The HCA is proposing to amend the rule as follows:**
**8.310.3 NMAC**
**Section 8**
The Mission Statement has been updated to include HCA's current mission statement.

**Section 9**
Duplicate language regarding licensed midwives has been corrected as "licensed midwives" is already captured on the next line.

**Section 11**
Language regarding the medical practitioners has been amended to align with CMS and AMA guidelines for unbundling global maternity care to itemized maternity care.

Language regarding the medical practitioners related to the birthing options program has been amended to align with the 2025 Legislative House Bill 56.

Language has been amended to include Doula's, Lactation providers and Chiropractors as new providers.

Throughout the NMAC updates have been made to update HCA to HSD.

**I. RULE**
These proposed rule changes will be contained in 8.310.3 NMAC. This register and the proposed rule are available on the HCA website at: https://www.hca.nm.gov/lookingforinformation/registers/ and https://www.hca.nm.gov/2026-

comment-period-open/. If you do not have internet access, a copy of the proposed register and rule may be requested by contacting MAD at (505) 827-1337.

**II. EFFECTIVE DATE**

HCA proposes implementing this rule effective January 1, 2027.

**III. PUBLIC HEARING**

A public hearing to receive testimony on this proposed rule will be held on September 25, 2026, at 9:00 am. The hearing will be held in the Large Conference Room of the Administrative Services Division (ASD), 1474 Rodeo Rd, Santa Fe, NM 87505 and via Microsoft Teams.

**Join Teams Meeting**
**Join:** https://teams.microsoft.com/meet/296752804748879?p=05F3wf4GlZmapZuMvA
Meeting ID: 296 752 804 748 879
Passcode: cM6S7KU3

**Dial in by phone**
+1 505-312-4308,,2695564# United States, Albuquerque
Phone conference ID: 269 556 4#

If you are a person with a disability and you require this information in an alternative format or require special accommodation to participate in the public hearing, please contact the MAD in Santa Fe at (505) 827-1337. The HCA requests at least ten (10) working days advance notice to provide requested alternative formats and special accommodation.

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

**IV. ADDRESS**

Interested persons may address written comments to:

New Mexico Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Recorded comments may be left at (505) 827-1337. Interested persons may also address comments via electronic mail to: HCA-madrules@hca.nm.gov. Written mail, electronic mail and recorded comments must be received **no later than 5:00 p.m. MDT on September 25, 2026**. Written and recorded comments will be given the same consideration as oral testimony made at the public hearing. All written comments received will be posted as they are received on the HCA website at https://www.hca.nm.gov/lookingforinformation/registers/ and https://www.hca.nm.gov/2026-comment-period-open/ along with the applicable register and rule. The public posting will include the name and any contact information provided by the commenter.

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## HEALTH, DEPARTMENT OF

### NOTICE OF PUBLIC HEARING

The New Mexico Department of Health (Department) will hold a public hearing on the proposed adoption of a new rule, 7.35.3 NMAC, concerning the New Mexico Medical Psilocybin Program ("Program"), and proposed amendments to Program rule sections 7.35.2.7 NMAC, 7.35.2.10, and 7.35.2.24 NMAC. The hearing will be held on Friday, October 2, 2026 at 9:00 a.m. in the Harold Runnels Building auditorium, located at 1190 St. Francis Drive, Santa Fe, New Mexico. The hearing will also be broadcast via a live web-based video conference, and via telephone. Members of the public who wish to submit public comment regarding the proposed rule will be able to do so in person at the hearing, via video conference, or via telephone during the hearing, and by submitting written comment.

The rule 7.35.3 NMAC proposes to adopt standards for patient enrollment in the New Mexico Medical Psilocybin Program, as well as standards concerning certifying clinicians, practitioners, facilitators, healing centers and other approved locations, and educational programs in the NM Medical Psilocybin Program. The rule includes, but is not limited to, the following:

- Application requirements for patients;
- Application requirements, operating requirements, data submittal requirements, and prohibitions for certifying clinicians, practitioners, facilitators, healing centers and other approved locations, and educational programs;
- Curriculum and didactic requirements for educational programs;
- Provisions for Department evaluation and assessment of educational programs, healing centers and other approved locations;
- Requirements for third-party evaluators of educational programs;
- Educational requirements for certifying clinicians, practitioners, and facilitators;
- Practitioner and facilitator practicum requirements;
- Educational program mentoring requirements;
- Provisions for reciprocal enrollment by certifying clinicians, practitioners, and facilitators, and for reciprocal recognition of educational programs;
- Provisions for administrative review of denied initial patient applications;
- Prohibitions and limitations for qualified patients and certificants;
- Emergency planning and adverse health event reporting requirements for healing centers and other approved locations;
- Protocols for storage and handling of psilocybin products; and
- Provisions for the denial, suspension, revocation, or other disciplinary action against, a patient's enrollment or application for enrollment, and against the

certification or application for certification of a certifying clinician, practitioner, facilitator, healing center or other approved location, or educational program; and a hearings process for those persons to appeal the decision or proposed decision of the Department.

The proposed amendment to 7.35.2.7 NMAC would revise definitions used in Medical Psilocybin Program rules.

The proposed amendment to 7.35.2.10(G) NMAC would revise general producer requirements.

The proposed amendment to 7.35.2.24 NMAC would revise requirements concerning the transportation of psilocybin.

The purpose of the proposed rule 7.35.3 NMAC and proposed amendments to 7.35.2.7, 7.35.2.10(G), and 7.35.2.24 NMAC is to implement the Medical Psilocybin Act, sections 26-2D-1 through -11, NMSA 1978.

The legal authority authorizing the adoption of this rule by the Department is the Department of Health Act, Subsection E of section 9-7-6 NMSA 1978, which authorizes the secretary of the department of health 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,"; and the Medical Psilocybin Act, at section 26-2D-7, NMSA 1978, which requires the Department to establish:

- appropriate qualifying conditions for qualified patients;
- necessary initial and ongoing training for producers and clinicians;
- treatment protocols, including patient selection criteria, medical service standards, dosage standards and approved settings for administration of psilocybin to patients;
- safety protocols for transporting, storing and handling psilocybin and treating patients;
- other best practices for producers and clinicians;
- requirements for data collection to evaluate the program and the use of best practices by producers and clinicians; and
- other requirements, restrictions and limitations to ensure an efficacious program.

A free copy of the full text of the proposed rule can be obtained online from the New Mexico Department of Health's website at http://nmhealth.org/about/asd/cmo/rules/ or by contacting the Department using the contact information below.

The public hearing will be conducted to receive public comment on the proposed rule. Any interested member of the public may attend the hearing and may submit data, views, or arguments on the proposed rule either orally or in writing during the hearing.

The hearing will be held on October 2, 2026 at the Harold Runnels Building auditorium, located at 1190 St. Francis Drive, Santa Fe, New Mexico.

To access the hearing via the Internet: please go to https://www.microsoft.com/en-us/microsoft-teams/join-a-meeting and then enter the following meeting i.d. code and passcode where indicated on the screen: meeting i.d. code 283 701 292 311 099 and passcode Cx9ND6Pk and then click the "Join a meeting" button.
To access the hearing by telephone: please call 1-505-312-4308 and enter phone conference i.d. 120 257 56#

Individuals who wish to receive an e-mailed calendar invitation for the hearing may register online at https://events.gcc.teams.microsoft.com/event/6f41bc8d-b848-4eb7-88ec-3f0ca5f9ade6@04aa6bf4-d436-426f-bfa4-04b7a70e60ff

All comments will be recorded.

Written public comment regarding the proposed rule can be submitted either by e-mail to Jacob Clark at jacob.clark@doh.nm.gov, or by U.S. postal mail to the following address:

Jacob Clark
NMDOH OGC
P.O. Box 26110
1190 St. Francis Dr., Suite N-4095
Santa Fe, NM 87502-6110

Written comments must be received by the close of the public rule hearing October 2, 2026. All written comments will be published on the agency website at https://www.nmhealth.org/about/asd/cmo/rules/ within 3 days of receipt, and will be available at the New Mexico Department of Health for public inspection.

If you are an individual with a disability and need special assistance or accommodation to attend or participate in the hearing, please contact Jacob Clark by telephone at (505) 827-2997. The Department requests at least ten (10) days' advance notice to provide special accommodation.

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## PUBLIC EDUCATION DEPARTMENT

### NOTICE OF PROPOSED RULEMAKING

**Public Hearing**

The New Mexico Public Education Department (PED) gives notice on Tuesday, August 25, 2026, that it will conduct a public hearing for the following proposed rulemakings on Thursday, September 24, 2026, from 1:30 p.m. to 2:30 p.m. (MDT) in Mabry Hall, located in the Jerry Apodaca Education Building, 300 Don Gaspar Ave., Santa Fe, New Mexico 87501.

**Repeal and replace of 6.20.2 NMAC, Governing Budgeting and Accounting for New Mexico Public Schools and School Districts**

The PED will give a verbal summary statement, on record, at the hearing.

The purpose of the public hearing is to receive public input on the proposed rulemakings. Attendees who wish to provide public comments on the record will be given three minutes to make a statement concerning the proposed rulemaking. To submit written comments, please see the Public Comment section of this notice.

**Explanation of Purpose of Rulemaking, Summary of Text, and Statutory Authority**

**6.20.2 NMAC, Governing Budgeting and Accounting for New Mexico Public Schools and School Districts**

**Explanation:** Make updates to fiscal accountability and budget oversight requirements for public school districts, including charter schools and Regional Education Cooperatives (RECs), to reflect current department practice.

**Summary:** The proposed rulemaking would add a definition of "bonded to practical capacity" and require public school districts, not including charter schools and RECs, to be bonded to practical capacity before using operational funds for building site acquisition or new construction. It would establish procedures for department intervention when a school district's cash balance, financial condition, or fiscal practices warrant additional safeguards, including authority to reserve budget funds. It would also establish procedures for department intervention when a school district maintains a negative cash balance, including authority to issue corrective action plans, require additional financial reporting, and refer the board of finance for suspension. It would authorize the department to require additional supporting documentation and to revise projected enrollment growth and reduce budgeted projected growth units when a district's projection is unsupported or when enrollment assumptions create a material fiscal risk to the school district. The proposed rulemaking also makes technical amendments to improve conciseness and clarity.

**Statutory Authority:** Sections 9-24-8, 22-2-1, 22-2-2, 22-5-7, 22-8-5, 22-8-6 through 22-8-12.1, 22-8-39, 22-8-40, 22-8-41, 22-13-13, 22-16-1, and 22-29-1 through 22-29-10 NMSA 1978.

No technical information served as a basis for these proposed rule changes.

**Public Comment**

Interested parties may provide comments at the public hearing or may submit written comments by mail or e-mail.

Mailing Address
Policy and Legislative Affairs Division
New Mexico Public Education Department
300 Don Gaspar Avenue, Room 121
Santa Fe, New Mexico 87501

E-Mail Address
Rule.Feedback@ped.nm.gov

Written comments must be received no later than 5 p.m. (MDT) on Thursday, September 24, 2026. The PED encourages early submission of written comments.

**Public Comment Period**

The public comment period is from Tuesday, August 25, 2026, to Thursday, September 24, 2026, at 5:00 p.m. (MDT). The PED will review all feedback received during the public comment period and issue communication regarding a final decision of the proposed rulemaking at a later date.

Copies of the proposed rule may be obtained from Denise Terrazas at (505) 470-5303 during regular business hours or may be accessed through the PED Policy and Legislative Affairs webpage titled, "Proposed Rules," at http://webnew.ped.state.nm.us/bureaus/policy-innovation-measurement/rule-notification/.

Individuals with disabilities who require the above information in an alternative format or need any form of auxiliary aid to attend or participate in the public hearing are asked to contact Denise Terrazas at (505) 470-5303 as soon as possible before the date set for the public hearing. The PED requires at least 10 calendar days advance notice to provide any special accommodations requested.

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## REGULATION AND LICENSING DEPARTMENT
### ALCOHOLIC BEVERAGE CONTROL DIVISION

### NOTICE OF PUBLIC RULEMAKING HEARING

The New Mexico Regulation and Licensing Department (RLD) Alcoholic Beverage Control Division (ABC) will hold a public rule hearing on October 1, 2026, at 9:00 a.m. The hearing will take place at the Regulation and Licensing Department, located at 2550 Cerrillo Road, Santa Fe, NM, in Hearing Room #1

The hearing may also be accessed virtually via Microsoft Teams.

Meeting Link: https://teams.microsoft.com/meet/28300907727250?p=eG8ClC0qayC1k3kyDk

Meeting ID: 283 009 077 272 50
Passcode: zn3Gw7t4

**Dial in by phone**
+1 505-312-4308, United States, Albuquerque
Phone conference ID: 527 959 18#

The purpose of the rule hearing is to consider the initiation of rulemaking for the following rules:

Rule 15.10.2 Definitions
Rule 15.10.32 Premises – Location and Description of Licensed Premises
Rule 5.11.20 Licenses and Permits – Alcoholic Beverage Delivery

On Wednesday, August 26, 2026, copies of the full text of the proposed rules may be obtained through the New Mexico Alcoholic Beverage Control Division's website at https://www.rld.nm.gov/abc/ A copy of the full text of the proposed rules may also be obtained by contacting Felicia A. Norvell, ABC Division Counsel at felicia.norvell@rld.nm.gov or by calling (505) 476-4875.

The New Mexico Alcoholic Beverage Control Division will begin accepting written public comment regarding the proposed rule changes beginning Wednesday, August 26, 2026, and ending Wednesday, September 30, 2026, at 12:00 p.m. The ABC encourages the early submission of written comments. Written public comment may be submitted either by email to Felicia.Norvell@rld.nm.gov or by postal mail to the following address:
New Mexico Alcoholic Beverage Control Division
P.O. Box 25101
Santa Fe, NM 87504

Written comments received during the public comment period (beginning August 26, 2026, and ending September 30, 2026) will be posted to the website page linked above. Public comments will also be accepted during the rule hearing and may be submitted in writing or presented orally by those attending in-person. The purpose of the hearing is to give interested persons an opportunity to give oral comments. The ABC may limit the time for each comment.

If you are an individual with a disability who needs a reader, amplifier, qualified signed language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing, please contact Felicia A. Norvell, ABC Division Counsel at felicia.norvell@rld.nm.gov or by calling (505) 476-4875 at least 10 days prior to the rule hearing. Public documents, including the proposed rules, meeting agenda and minutes, can be provided in various accessible formats.

**Statutory Authority:** The rule changes are authorized by the Liquor Control Act NMSA 1978, §§60-3A-7 and 60-3A-10. The rulemaking and public rule hearing is governed by the State Rules Act, NMSA 1978, §§14-4-1 through 14-4-11, and the Default Procedural Rule for Rulemaking promulgated by the New Mexico Department of Justice, Parts 1.24.25.1 through 1.24.25.16 NMAC.

**Purpose of Proposed Rules:** The proposed rule changes are intended to amend the rules to provide for additional administrative fees and revise the continuing education audit requirements. More generally, the proposed rules are intended to provide greater clarity in existing regulatory and statutory requirements, ensure continued high levels of professionalism among licensees and certificate holders, and to generally satisfy the Advisory Board of Respiratory Care Practitioners' statutory obligation to promote, preserve and protect public health, safety and welfare.

**Summary of Proposed Changes:**

Rule 15.10.2 – Definitions. The proposed change lowers the age at which an individual may seek a server permit to conform with the 2021 amendment of NMSA 1978, NMSA 1978, §60-7B-11 (2021) which lowered the age for restaurant employees to sell or serve alcoholic beverages to 18, correct typographical error.

Rule 15.10.32 – Premises – Location and Description of Licensed Premises. The proposed change removes "military installation" from Section 8 title to conform with the 2021 repeal of NMSA 1978, NMSA 1978, §60-6B-11 relating to locations near military installations restrictions on licensing, correct typos.

Rule 5.11.20 Licenses and Permits – Alcoholic Beverage Delivery. The proposed change repeals Section 9 "Delivery Restrictions and Requirements in Class A Counties" to conform with the 2023 amendment to NMSA 1978, §60-6A-37 (2023) relating to alcoholic beverage delivery permits, correct typographical errors.

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## End of Notices of Rulemaking and Proposed Rules

# Adopted Rules

**Effective Date and Validity of Rule Filings**

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

## FINANCE AUTHORITY
### WATER TRUST BOARD

**This is an amendment to 19.25.10 NMAC, Sections 6, 7, 8, 9, 11, and 14, effective 8/25/2026.**

**19.25.10.6 OBJECTIVES:**

**A.** Section 72-4A-5, NMSA 1978 provides that the New Mexico water trust board is required to adopt rules governing terms and conditions of grants and loans recommended by the board for appropriation by the state legislature from the water project fund giving priority to projects [~~that have urgent needs, that have been identified for implementation of a completed regional water plan that is accepted by the interstate stream commission and that have matching contributions from federal or local funding sources~~] pursuant to the Water Project Finance Act; and authorizes qualifying water projects to the authority that are for: (1) storage, conveyance or delivery of water to end users; (2) implementation of federal Endangered Species Act of 1973; (3) wastewater conveyance and treatment; (4) restoration and management of watersheds; (5) flood prevention; and (6) water conservation or recycling, treatment or reuse of water as provided by law. [~~Additionally, the board shall create a drought strike team to coordinate responses to emergency water shortages caused by drought conditions.~~] Section 72-4A-9, NMSA 1978, creates the "water project fund" within the New Mexico finance authority.

**B.** [~~Section 72-4A-5, NMSA 1978, provides that the board shall give priority to qualifying water projects that (1) have been identified by the board as being urgent to address public health and safety issues; (2) have matching contributions from federal or local funding sources available and (3) have obtained all requisite state and federal permits and authorizations necessary to initiate the qualifying water project.~~] The purpose of these rules is to set forth the intent of the board and to outline, in general terms, the criteria and procedures to be used in evaluating and funding qualifying water projects.

**C.** Section 72-4A-5, NMSA 1978, provides that the board shall evaluate projects, including their environmental impacts, and recommend projects to the interstate stream commission pursuant to the provisions of Section 72-14-45, NMSA 1978.

**D.** Section 72-4A-6, NMSA 1978, provides that the authority shall provide staff support for the water trust board, develop application procedures and forms for qualifying entities to apply for grants and loans from the water project fund; and make loans or grants to qualifying entities for qualifying water projects [~~authorized by the state legislature~~] pursuant to the Water Project Finance Act, provided that the service area for the project is wholly within the boundaries of the state or the project is an interstate project that directly benefits New Mexico.

**E.** Section 72-4A-6 NMSA 1878 provides that the loan and grants made pursuant to Paragraph (3) of Subsection A of Section 72-4A-6 NMSA 1978 shall require legislative authorization on and after December 31, 2029.

[~~**E.**~~] **F.** Section 72-4A-9, NMSA 1978, provides that the authority may [~~adopt separate~~] establish procedures and adopt rules for administration of the water project fund and recover from the water project fund costs of administering the water project fund and originating grants and loans.

[19.25.10.6 NMAC - Rp, 19.25.10.6 NMAC, 7/31/2008; A, 4/22/2025; A, 8/25/2026]

**19.25.10.7 DEFINITIONS:**

**A. "Act"** means the Water Project Finance Act, Sections 72-4A-1 through 72-4A-10, NMSA 1978, as the same may be amended and supplemented.

**B. "Agreement"** means the document or documents signed by the board and a qualifying entity which specify the terms and conditions of obtaining financial assistance from the water project fund.

**C. "Applicant"** means a qualifying entity which has filed a water project proposal with the authority for initial review and referral to the board's project review committee.

**D. "Authority"** means the New Mexico finance authority.

**E. "Authorized representative"** means one or more individuals duly authorized to act on behalf of the qualifying entity in connection with its financial application, water project proposal or agreement.

**F. "Board"** means the New Mexico water trust board created by the act.

**G. "Bylaws"** means the bylaws of the board adopted on September 25, 2001, and amended on June 27, 2007, and as may be further amended and supplemented.

**H. "Financial application"** means a written document filed with the authority by an applicant for the purpose of evaluating the applicant's qualifications for types of financial assistance which may be provided by the board.

**I. "Financial assistance"** means loans, grants

and any other type of assistance authorized by the act, or a combination thereof, provided from the water project fund to a qualified entity for the financing of a qualifying water project.

**J. "Policy committee"** means a standing committee, appointed by the [~~chairman~~] chair of the board from the members of the board pursuant to the bylaws to review policies and policy related matters and make recommendations to the full board.

**K. "Political subdivision"** means a municipality, county, land grant-merced controlled and governed pursuant to Section 49-1-1 through 49-1-18 or 49-4-1 through 49-4-21 NMSA 1978, regional or local public water utility authority created by statute, irrigation district, conservancy district, special district, acequia or soil and water conservation district, water and sanitation district, or an association organized and existing pursuant to the Sanitary Projects Act, Chapter 3, Article 29 NMSA 1978.

**L. "Project review committee"** means a standing committee, appointed by the [~~chairman~~] chair of the board from the members of the board pursuant to the bylaws to review water projects to be recommended for funding from the water project fund.

**M. "Qualifying entity"** means a state agency, a political subdivision of the state, an intercommunity water or natural gas supply association or corporation organized under Chapter 3, Article 28 NMSA 1978, a recognized Indian nation, tribe or pueblo, the boundaries of which are located wholly or partially in New Mexico or an association of such entities created pursuant to the Joint Powers Agreement Act, Chapter 11, Article 1 NMSA 1978 or other authorizing legislation for the exercise of their common powers.

**N. "Qualifying water project"** means a project recommended by the board for funding by the legislature which includes a water project serving an area wholly within the boundaries of the state for (1) storage, conveyance or delivery of water to end users; (2) implementation of federal Endangered Species Act of 1973 collaborative programs; (3) wastewater conveyance and treatment; (4) restoration and management of watersheds; (5) flood prevention; or (6) conservation, recycling, treatment or reuse of water as provided by law [~~and which has been approved by the state legislature pursuant to Subsection B of Section 72-4A-9, NMSA 1978~~].

**O. "State"** means the state of New Mexico.

**P. "State agency"** means any agency or institution of the state.

**Q. "Water project account"** means a fund designated by a qualifying entity exclusively for receipt of financial assistance.

**R. "Water project fund"** means the fund of that name created in the authority by Section 72-4A-9, NMSA 1978.

**S. "Water project proposal"** means a written proposal submitted by a qualifying entity for review by the project review committee.

**T. "Water trust fund"** means the fund of that name created in the state treasury by Section 72-4A-8, NMSA 1978.

[19.25.10.7 NMAC - Rp, 19.25.10.7 NMAC, 7/31/2008; A, 12/30/2013; A, 4/22/2025; A, 8/25/2026]

**19.25.10.8 ELIGIBILITY: PRIORITIZATION OF WATER PROJECTS:** The board will develop and consider a variety of factors in reviewing and evaluating water project proposals to determine which water projects to recommend as qualifying water projects for appropriation by the state legislature. [~~The board shall give priority to projects that have urgent needs and that have matching contributions from federal or local sources as provided for in Section 72-4A-5 NMSA 1978.~~] Pursuant to Section 72-4A-5.1 NMSA 1978, the board, in conformance with the state water plan and pursuant to the provisions of the Water Project Finance Act, shall prioritize the planning and financing of water projects required to implement the plan. The board shall identify opportunities to leverage federal and other funding. The board shall establish policies for prioritization of water projects.

[19.25.10.8 NMAC - Rp, 19.25.10.8 NMAC, 7/31/2008; A, 12/30/2013; A, 4/30/2015; A, 4/22/2025; A, 8/25/2026]

**19.25.10.9 WATER PROJECT PROPOSAL, PROCEDURES AND APPROVAL PROCESS:**

**A.** The authority will administer an outreach program to notify qualifying entities that water project proposals are being accepted to identify water projects for review by the project review committee and the board [~~for recommendation for funding to the state legislature as qualifying water projects~~].

**B.** The authority will provide forms and guidelines for water project proposals and financial applications.

**C.** The authority staff will forward all completed water project proposals from qualified applicants for qualified water projects to the project review committee. The project review committee will consider the water project and may confer with outside parties, including any local interdisciplinary teams familiar with the water project, as necessary to obtain more information on the feasibility, merit, and cost of the water project. The project review committee will make a recommendation to the board on each water project proposal.

**D.** Upon the recommendation of the project review committee, the board will evaluate the qualifying water projects [~~for recommendation to the legislature.~~

~~**E.** After completion of the review process by the project review committee and the board and receipt of a favorable recommendation on the water project proposal, the water project~~

~~will be recommended by the board for approval by the state legislature, which recommendation and approval are required by Sections 72-4A-5 and 72-4A-9 NMSA 1978.~~

~~**F.** No later than January of each year, the board will recommend to the legislature a list of projects recommended for funding. After the legislature authorizes qualifying water projects, the project review committee will review evaluations of financial applications and water project proposals prepared by staff and recommend to the board a final list of projects to be authorized by the board~~] for funding by the authority. The authority will provide financial assistance for qualifying projects [~~as authorized by the legislature~~] under policies jointly established by the board and authority.

[19.25.10.9 NMAC - Rp, 19.25.10.9 NMAC, 7/31/2008; A, 12/30/2013; A, 4/30/2015; A, 8/25/2026]

**19.25.10.11 QUALIFYING WATER PROJECTS AND ELIGIBLE COSTS:**

**A.** The board may authorize the authority to provide financial assistance from the water project fund to qualifying entities only for qualifying water projects as provided by Section 72-4A-6 and Section 72-4A-7, NMSA 1978.

**B.** Financial assistance shall be made only to qualify entities that:

**(1)** agree to provide for the operation and maintenance of the water project so that it will function properly over the structural and material design life;

**(2)** require the contractor of the construction project to post a performance and payment bond in accordance with the requirements of Section 13-4-18, NMSA 1978;

**(3)** provide written assurance signed by an attorney or provide a title insurance policy that the political subdivision has proper title, easements and rights of way to the property upon or through which the water project proposed for funding is to be constructed or extended;

**(4)** meet the requirements of the financial capability set by the authority to ensure sufficient revenues to operate and maintain the water project for its useful life and to repay the loan;

**(5)** agree to properly maintain financial records in accordance with all applicable laws; and

**(6)** agree to pay costs of originating grants and loans as determined by rules adopted by the authority.

**C.** Plans and specifications for a water project shall be approved by the authority after review and upon the recommendation of the state engineer and the environment department before grant or loan disbursements to pay for construction costs are made to a qualifying entity. Plans and specifications for a water project shall incorporate available technologies and operational design for water efficiency.

**D.** Financial assistance shall be made for eligible items, which include:

**(1)** matching requirements for federal and local cost shares;

**(2)** engineering feasibility reports;

**(3)** contracted engineering design;

**(4)** inspection of construction;

**(5)** special engineering services;

**(6)** environmental or archeological surveys;

**(7)** construction;

**(8)** land acquisition;

**(9)** easements and rights of way; and

**(10)** legal costs.

**E.** A qualified entity [~~which has had financial assistance approved by the state legislature for financing a qualifying water project~~] may apply to the board to redirect the financial assistance to a different water project made necessary by unanticipated events. The decision to redirect the financial assistance to a different qualifying water project will be at the sole discretion of the board [~~and subject to approval of the state legislature as required by Subsection B of Section 72-4A-9, NMSA 1978~~].

[19.25.10.11 NMAC - Rp, 19.25.10.11 NMAC, 7/31/2008; A, 5/28/2010; A, 4/22/2025; A, 8/25/2026]

**19.25.10.14 RECONSIDERATION OF BOARD DECISIONS:** Any applicant or qualifying entity may request reconsideration of a decision of the board by notifying the board in writing within 15 days following the meeting at which the decision was made. Notice of a decision made in an open meeting of the board is deemed to be given on the date of the meeting, and the time for notification of a request for reconsideration shall run from that date, regardless whether any written notice of the decision is given by the board. A request for reconsideration shall state with particularity the grounds for reconsideration, including any factual or legal matter on which the applicant or qualifying entity believes that there was an error by the board. Upon receiving a timely and proper request for reconsideration, the [~~chairman~~] chair of the board will set the matter for reconsideration at the board's next regularly scheduled meeting or at a special meeting called for the purpose, at the [~~chairman~~] chair's discretion, Upon reconsideration by the board, the board will notify the applicant or qualifying entity of the board's decision, in writing, within five working days of the decision. The decision of the board on reconsideration is final. A request for reconsideration not timely or properly made will not be considered by the board.

[19.25.10.14 NMAC - Rp, 19.25.10.14 NMAC, 7/31/2008; A, 5/28/2010; A, 8/25/2026]

## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

The New Mexico Health Care Authority approved the repeal of 8.350.4 NMAC, Reconsideration of Utilization Review, Reconsideration of Audit Settlements (filed 12/16/2002) and replaced it with 8.350.4 NMAC, Reconsideration of Utilization Review, Reconsideration of Audit Settlements (adopted on August 25, 2026), effective September 1, 2026.

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## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**TITLE 8 SOCIAL SERVICES**
**CHAPTER 350 RECONSIDERATION OF UTILIZATION REVIEW**
**PART 4 RECONSIDERATION OF AUDIT SETTLEMENTS**

**8.350.4.1 ISSUING AGENCY:** New Mexico health care authority (HCA).
[8.350.4.1 NMAC - Rp, 9/1/2026]

**8.350.4.2 SCOPE:** The rule applies to the general public.
[8.350.4.2 NMAC - Rp, 9/1/2026]

**8.350.4.3 STATUTORY AUTHORITY:** The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et. seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.350.4.3 NMAC - Rp, 9/1/2026]

**8.350.4.4 DURATION:** Permanent.
[8.350.4.4 NMAC - Rp, 9/1/2026]

**8.350.4.5 EFFECTIVE DATE:** September 1, 2026, unless a later date is cited at the end of a section.
[8.350.4.5 NMAC - Rp, 9/1/2026]

**8.350.4.6 OBJECTIVE:** The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.350.4.6 NMAC - Rp, 9/1/2026]

**8.350.4.7 DEFINITIONS:** [**RESERVED**]

**8.350.4.8 MISSION STATEMENT:** We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
[8.350.4.8 NMAC - Rp, 9/1/2026]

**8.350.4.9 RECONSIDERATION OF AUDIT SETTLEMENTS:**

**A. General reconsideration process:** Medicaid providers who disagree with an audit settlement can submit a written request for a reconsideration to the New Mexico medical assistance division (MAD) within 30 calendar days of the date on the notice of final settlement. The written request may be submitted by facsimile or by U.S. mail but not by electronic mail. The written request must be received by MAD no later than the thirtieth day from the date of the notice. Filing of a request for reconsideration does not affect the imposition of the final settlement.

**(1) Information included in the request:** The written request for reconsideration must identify each point on which the provider takes an issue with the audit agent and include all documentation, citations of authority, and arguments on which the request is based. Any point or issue not raised in the original request for reconsideration may not be raised later and will not be considered in the final decision of the reconsideration.

**(2) Audit agent response:** The written request and supporting materials is forwarded to the audit agent for reconsideration. The audit agent must file a response with MAD within 30 calendar days of the receipt of the request and supporting material from MAD.

**(3) Submission of additional material:** MAD forwards the audit agent's response to the provider. Additional material from the audit agent or the provider must be received by MAD within 15 calendar days of the date the response was forwarded to the provider. Any additional information, the request for reconsideration and supporting documentation, and the audit agent's response constitute final submittal. The packet containing the final submittal is provided to the MAD deputy director for final submittal by the responsible bureau for program reimbursement.

**(4) Decision by MAD:** The deputy director may call on all information and call on all expertise they believe is necessary to decide the issue. The deputy director makes a determination and submits a written copy of their findings to each party within 45 calendar days of the date of final submittal to the MAD director. The decision may be sent to the parties by facsimile or U.S. mail. The provider may appeal an adverse decision on the request for reconsideration to the New Mexico health care authority's hearings bureau pursuant to the 8.353.2 NMAC. The MAD director or designee shall make the decision on the recommendation from the hearing officer.

**B. Specific reconsideration process for nursing facility, intermediate**

**care facility for individuals with intellectual disabilities providers:** The reconsideration process for audit settlement varies for the aforementioned providers. See 8.312.3 NMAC, *Cost Related Reimbursement for Nursing Facilities*, and 8.313.3 NMAC, *Cost Related Reimbursement of ICF/IID Facilities* for specific information.
[8.350.4.9 NMAC - Rp, 9/1/2026]

**HISTORY OF 8.350.4 NMAC: [RESERVED]**

**History of Repealed Material:**
8.350.4 NMAC - Reconsideration Of Audit Settlements filed 12/16/2002 Repealed effective 9.1.2026.

**Other:** 8.350.4 NMAC - Reconsideration Of Audit Settlements filed 12/16/2002 Replaced by Reconsideration Of Audit Settlements effective 9/1/2026.

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## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.200.510 NMAC, Sections 11, 12, 13, and 15, effective 9/1/2026.**

**8.200.510.11 COMMUNITY SPOUSE RESOURCE ALLOWANCE (CSRA):** The CSRA standard varies based on when the applicant or recipient become institutionalized for a continuous period. The CSRA remains constant even if it was calculated prior to submission of a formal MAP application. If institutionalization began:

**A.** Between September 30, 1989 and December 31, 1989, the state maximum CSRA is $30,000 and the federal maximum CRSA is $60,000.

**B.** On or after January 1, 1990, the state minimum is $31,290 and the federal maximum CSRA is $62,580.

**C.** On or after January 1, 1991, the state minimum is $31,290 and the federal maximum CSRA is $66,480.

**D.** On or before January 1, 1992, the state minimum is $31,290 and the federal maximum CSRA is $68,700.

**E.** On or after January 1, 1993, the state minimum is $31,290 and the federal maximum CSRA is $70,740.

**F.** On or after January 1, 1994, the state minimum is $31,290 and the federal maximum CSRA is $72,660.

**G.** On or after January 1, 1995, the state minimum is $31,290 and the federal maximum CSRA is $74,820.

**H.** On or after January 1, 1996, the state minimum is $31,290 and the federal maximum CSRA is $76,740.

**I.** On or after January 1, 1997, the state minimum is $31,290 and the federal maximum CSRA is $79,020.

**J.** On or after January 1, 1998, the state minimum is $31,290 and the federal maximum CSRA is $80,760.

**K.** On or after January 1, 1999, the state minimum is $31,290 and the federal maximum CSRA is $81,960.

**L.** On or after January 1, 2000, the state minimum is $31,290 and the federal maximum CSRA is $84,120.

**M.** On or after January 1, 2001, the state minimum is $31,290 and the federal maximum CSRA is $87,000.

**N.** On or after January 1, 2002, the state minimum is $31,290 and the federal maximum CSRA is $89,280.

**O.** On or after January 1, 2003, the state minimum is $31,290 and the federal maximum CSRA is $90,660.

**P.** On or after January 1, 2004, the state minimum is $31,290 and the federal maximum CSRA is $92,760.

**Q.** On or after January 1, 2005, the state minimum is $31,290 and the federal maximum CSRA is $95,100.

**R.** On or after January 1, 2006, the state minimum is $31,290 and the federal maximum CSRA is $99,540.

**S.** On or after January 1, 2007, the state minimum is $31,290 and the federal maximum CSRA is $101,640.

**T.** On or after January 1, 2008, the state minimum is $31,290 and the federal maximum CSRA is $104,400.

**U.** On or after January 1, 2009, the state minimum is $31,290 and the federal maximum CSRA is $109,560.

**V.** On or after January 1, 2010, the state minimum is $31,290 and the federal maximum CSRA remains $109,560.

**W.** On or after January 1, 2011, the state minimum is $31,290 and the federal maximum CSRA remains $109,560.

**X.** On or after January 1, 2012, the state minimum is $31,290 and the federal maximum CSRA is $113,640.

**Y.** On or after January 1, 2013, the state minimum is $31,290 and the federal maximum CSRA is $115,920.

**Z.** On or after January 1, 2014, the state minimum is $31,290 and the federal maximum CSRA is $117,240.

**AA.** On or after January 1, 2015, the state minimum is $31,290 and the federal maximum CSRA is $119,220.

**BB.** On or after January 1, 2016, the state minimum is $31,290 and the federal maximum CSRA is $119,220.

**CC.** On or after January 1, 2017, the state minimum is $31,290 and the federal maximum CSRA is $120,900.

**DD.** On or after January 1, 2018, the state minimum is $31,290 and the federal maximum CSRA is $123,600.

**EE.** On or after January 1, 2019, the state minimum is $31,290 and the federal maximum CSRA is $126,420.

**FF.** On or after January 1, 2020, the state minimum is $31,290

and the federal maximum CSRA is $128,640.

**GG.** On or after January 1, 2021, the state minimum is $31,290 and the federal maximum CSRA is $130,380.

**HH.** On or after January 1, 2022, the state minimum is $31,290 and the federal maximum CSRA is $137,400.

**II.** On or after January 1, 2023, the state minimum is $31,290 and the federal maximum CSRA is $148,620.

**JJ.** On or after January 1, 2024, the state minimum is $31,290 and the federal maximum CSRA is $154,140.

**KK.** On or after January 1, 2025, the state minimum is $31,584 and the federal maximum CSRA is $157,920.

**LL.** On or after January 1, 2026, the state minimum is $32,532 and the federal maximum CSRA is $162,660.

[8.200.510.11 NMAC - Rp, 8.200.510.11 NMAC, 7/1/2015; A/E, 1/1/2016; A/E, 3/1/2017; A/E, 8/30/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025; A, 8/1/2025; A/E, 4/1/2026; A, 9/1/2026]

**8.200.510.12 POST-ELIGIBILITY CALCULATION (MEDICAL CARE CREDIT):** Apply applicable deductions in the order listed below when determining the medical care credit for an institutionalized spouse.

| | DEDUCTION AMOUNT |
|---|---|
| **A.** | Personal needs allowance for institutionalized spouse: July 1, [~~2024~~] 2025 [~~$94~~] $97 |
| **B.** | Minimum monthly maintenance needs allowance (MMMNA): July 1, [~~2024~~] 2025 [~~$2,555~~] $2,643.75 |
| **C.** | The community spouse monthly income allowance (CSMIA) is calculated by subtracting the community spouse's gross income from the MMMNA: |

**(1)** If allowable shelter expenses of the community spouse exceeds the minimum allowance then deduct an excess shelter allowance from community spouse's income that includes: expenses for rent; mortgage (including interest and principal); taxes and insurance; any maintenance charge for a condominium or cooperative; and an amount for utilities (if not part of maintenance charge above); use the standard utility allowance (SUA) deduction used in the food stamp program for the utility allowance.

| | |
|---|---|
| July 1,[~~2024~~] 2025 | [~~$766.50~~] $793.13 |

**(2)** Excess shelter allowance may not exceed the maximum:

| | |
|---|---|
| | **(a)** |
| Jan. 1, 2026 | $1,422.75 |
| | [~~(a)~~] **(b)** |
| Jan. 1, 2025 | $1,393 |
| | [~~(b)~~] **(c)** |
| Jan. 1, 2024 | $1,388.50 |
| | [~~(c)~~] **(d)** |
| July 1, 2023 | $1,251 |
| | [~~(d)~~] **(e)** |
| Jan. 1, 2023 | $1,427 |
| | [~~(e)~~] **(f)** |
| July 1, 2022 | $1,146 |
| | [~~(f)~~] **(g)** |
| Jan. 1, 2022 | $1,257 |
| | [~~(g)~~] **(h)** |
| July 1, 2021 | $1,082 |
| | [~~(h)~~] **(i)** |
| Jan. 1, 2021 | $1,105 |

**D.** Any extra maintenance allowance ordered by a court of jurisdiction or a state administrative hearing officer.

**E.** Dependent family member income allowance (if applicable) calculated as follows: 1/3 X MMMNA - dependent member's income).

**F.** Non-covered medical expenses.

**G.** The maximum total of the community spouse monthly income allowance and excess shelter deduction may not exceed [~~$3,853.50~~] $4,066.50.

[8.200.510.12 NMAC - Rp, 8.200.510.12 NMAC, 7/1/2015; A/E, 3/1/2017; A/E. 8/30/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 1/16/2020; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025; A, 8/1/2025; A/E, 4/1/2026; A, 9/1/2026]

**8.200.510.13 AVERAGE MONTHLY COST OF NURSING FACILITIES FOR PRIVATE PATIENTS USED IN TRANSFER OF ASSET PROVISIONS:** Costs of care are based on the date of application registration.

| DATE | AVERAGE COST PER MONTH |
|---|---|
| **A.** | July 1, 1988 - Dec. 31, 1989 $1,726 per month |
| **B.** | Jan. 1, 1990 - Dec. 31, 1991 $2,004 per month |
| **C.** | Jan. 1, 1992 - Dec. 31, 1992 $2,217 per month |
| **D.** | Effective July 1, 1993, for application register on or after Jan. 1, 1993 $2,377 per month |
| **E.** | Jan. 1, 1994 - Dec. 31, 1994 $2,513 per month |
| **F.** | Jan. 1, 1995 - Dec. 31, 1995 $2,592 per month |
| **G.** | Jan. 1, 1996 - Dec. 31, 1996 $2,738 per month |
| **H.** | Jan. 1, 1997 - Dec. 31, 1997 $2,889 per month |
| **I.** | Jan. 1, 1998 - Dec 31, 1998 $3,119 per month |
| **J.** | Jan. 1, 1999 - Dec. 31, 1999 $3,429 per month |
| **K.** | Jan. 1, 2000 - Dec. 31, 2000 $3,494 per month |
| **L.** | Jan. 1, 2001 - Dec. 31, 2001 $3,550 per month |
| **M.** | Jan. 1, 2002 - Dec. 31, 2002 $3,643 per month |
| **N.** | Jan. 1, 2003 - Dec. 31, 2003 $4,188 per month |
| **O.** | Jan. 1, 2004 - Dec. 31, 2004 $3,899 per month |
| **P.** | Jan. 1, 2005 - Dec. 31, 2005 $4,277 per month |
| **Q.** | Jan. 1, 2006 - Dec. 31, 2006 $4,541 per month |
| **R.** | Jan. 1, 2007 - Dec. 31, 2007 $4,551 per month |
| **S.** | Jan. 1, 2008 - Dec. |

| | |
|---|---|
| 31, 2008 | $4,821 per month |
| **T.** | Jan. 1, 2009 - Dec. 31, 2009 $5,037 per month |
| **U.** | Jan. 1, 2010 - Dec. 31, 2010 $5,269 per month |
| **V.** | Jan. 1, 2011 - Dec. 31, 2011 $5,774 per month |
| **W.** | Jan. 1, 2012 - Dec. 31, 2012 $6,015 per month |
| **X.** | Jan. 1, 2013 - Dec. 31, 2013 $6,291 per month |
| **Y.** | Jan. 1, 2014 - Dec. 31, 2014 $6,229 per month |
| **Z.** | Jan. 1, 2015 - Dec. 31, 2015 $6,659 per month |
| **AA.** | Jan. 1, 2016 - Dec. 31, 2016 $7,786 per month |
| **BB.** | Jan. 1, 2017 - Dec. 31, 2017 $7,485 per month |
| **CC.** | Jan. 1, 2018 - Dec. 31, 2018 $7,025 per month |
| **DD.** | Jan. 1, 2019 - Dec. 31, 2019 $7,285 per month |
| **EE.** | Jan. 1, 2020 - Dec. 31, 2020 $7,480 per month |
| **FF.** | Jan. 1, 2021 - Dec. 31, 2021 $7,590 per month |
| **GG.** | Jan. 1, 2022 - Dec. 31, 2021 $7,811 per month |
| **HH.** | Jan. 1, 2023 - Dec. 31, 2023 $8,275 per month |
| **II.** | Jan. 1, 2024 - Dec. 31, 2024 $8,919 per month |
| **JJ**. | Jan. 1, 2025 - Dec. 31, 2025 $8,947 per month |
| **KK.** | Jan. 1, 2026 - $9,209 per month |

[8.200.510.13 NMAC - Rp, 8.200.510.13 NMAC, 7/1/2015; A/E, 1/1/2016; A/E, 3/1/2017; A/E, 8/30/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025; A, 8/1/2025; A/E, 4/1/2026; A, 9/1/2026]

**8.200.510.15 EXCESS HOME EQUITY AMOUNT FOR LONG-TERM CARE SERVICES:**

| | |
|---|---|
| **A.** | Jan. 2026 $752,000 |
| [~~**A.**~~] **B.** | Jan. 2025 $730,000 |
| [~~**B.**~~] **C.** | Jan. 2024 $713,000 |
| [~~**C.**~~] **D.** | Jan. 2023 $688,000 |
| [~~**D.**~~] **E.** | Jan. 2022 $636,000 |
| [~~**E.**~~] **F.** | Jan. 2021 $603,000 |
| [~~**F.**~~] **G.** | Jan. 2020 $595,000 |
| [~~**G.**~~] **H.** | Jan. 2019 $585,000 |
| [~~**H.**~~] **I.** | Jan. 2018 $572,000 |
| [~~**I.**~~] **J.** | Oct. 2017 $560,000 |
| [~~**J.**~~] **K.** | Jan. 2017 $840,000 |
| [~~**K.**~~] **L.** | Jan. 2016 $828,000 |
| [~~**L.**~~] **M.** | Jan. 2015 $828,000 |
| [~~**M.**~~] **N.** | Jan. 2014 $814,000 |
| [~~**N.**~~] **O.** | Jan. 2013 $802,000 |
| [~~**O.**~~] **P.** | Jan. 2012 $786,000 |
| [~~**P.**~~] **Q.** | Jan. 2011 $758,000 |
| [~~**Q.**~~] **R.** | Jan. 2010 $750,000 |

[8.200.510.15 NMAC - Rp, 8.200.510.15 NMAC, 7/1/2015; A/E, 1/1/2016; A/E, 3/1/2017; A, 3/1/18; A/E, 8/30/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025; A, 8/1/2025; A/E, 4/1/2026; A, 9/1/2026]

## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.200.520 NMAC, Sections 11, 12, 13, 15, 16, and 20, effective 9/1/2026.**

**8.200.520.11 FEDERAL POVERTY INCOME GUIDELINES:**

**A.** One hundred percent federal poverty limits (FPL):

| Size of budget group | FPL per month |
|---|---|
| [~~1~~ | ~~$1,305*~~ |
| ~~2~~ | ~~$1,763*~~ |
| ~~3~~ | ~~$2,221~~ |
| ~~4~~ | ~~$2,680~~ |
| ~~5~~ | ~~$3,138~~ |
| ~~6~~ | ~~$3,596~~ |
| ~~7~~ | ~~$4,055~~ |
| ~~8~~ | ~~$4,513~~] |
| 1 | $1,330* |
| 2 | $1,804* |
| 3 | $2,277 |
| 4 | $2,750 |
| 5 | $3,224 |
| 6 | $3,697 |
| 7 | $4,170 |
| 8 | $4,644 |

Add [~~$458~~] $474 for each additional person in the budget group.

*FPL must be below one hundred percent for an individual or couple for qualified medicare beneficiary (QMB) program.

**B.** One hundred twenty percent FPL: This income level is used only in the determination of the maximum income limit for specified low income medicare beneficiaries (SLIMB) applicants or eligible recipients.

| Applicant or eligible recipient | Amount |
|---|---|
| 1 | |
| Individual | At least [~~$1,305~~] $1,330 per month but no more than [~~$1,565~~] $1,596 per month. |
| 2 | |
| Couple | At least [~~$1,763~~] $1,804 per month but no more than [~~$2,115~~] $2,164 per month. |

For

purposes of this eligibility calculation, "couple" means an applicant couple or an applicant with an ineligible spouse when income is deemed.

**C.** One hundred thirty-three percent FPL:

| Size of budget group | FPL per month |
|---|---|
| [~~1~~ | ~~$1,735~~ |
| ~~2~~ | ~~$2,345~~ |
| ~~3~~ | ~~$2,954~~ |
| ~~4~~ | ~~$3,564~~ |
| ~~5~~ | ~~$4,173~~ |
| ~~6~~ | ~~$4,783~~ |
| ~~7~~ | ~~$5,393~~ |
| ~~8~~ | ~~$6,002~~] |
| 1 | $1,769 |
| 2 | $2,399 |
| 3 | $3,028 |
| 4 | $3,658 |
| 5 | $4,288 |
| 6 | $4,917 |
| 7 | $5,547 |
| 8 | $6,176 |

Add [~~$609~~] $629 for each additional person in the budget group.

**D.** One hundred thirty-five percent FPL: This income level is used only in the determination of the maximum income limit for a qualified individual 1 (QI1) applicant or eligible recipient. For purposes of this eligibility calculation, "couple" means an applicant couple or an applicant with an ineligible spouse when income is deemed. The following income levels apply:

| Applicant or eligible recipient | Amount |
|---|---|
| 1 Individual | At least [~~$1,565~~] $1,596 per month but no more than [~~$1,761~~] $1,796 per month. |
| 2 Couple | At least [~~$2,115~~] $2,164 per month but no more than [~~$2,380~~] $2,435 per month. |

**E.** One hundred eighty-five percent FPL:

| Size of budget group | FPL per month |
|---|---|
| [~~1~~ | ~~$2,413~~ |
| ~~2~~ | ~~$3,261~~ |
| ~~3~~ | ~~$4,109~~ |
| ~~4~~ | ~~$4,957~~ |
| ~~5~~ | ~~$5,805~~ |
| ~~6~~ | ~~$6,653~~ |
| ~~7~~ | ~~$7,501~~ |
| ~~8~~ | ~~$8,349~~] |
| 1 | $2,461 |
| 2 | $3,337 |
| 3 | $4,212 |
| 4 | $5,088 |
| 5 | $5,964 |
| 6 | $6,839 |
| 7 | $7,715 |
| 8 | $8,591 |

Add [~~$848~~] $876 for each additional person in the budget group.

**F.** Two hundred percent FPL:

| Size of budget group | FPL per month |
|---|---|
| [~~1~~ | ~~$2,609~~ |
| ~~2~~ | ~~$3,525~~ |
| ~~3~~ | ~~$4,442~~ |
| ~~4~~ | ~~$5,359~~ |
| ~~5~~ | ~~$6,275~~ |
| ~~6~~ | ~~$7,192~~ |
| ~~7~~ | ~~$8,109~~ |
| ~~8~~ | ~~$9,025~~] |
| 1 | $2,660 |
| 2 | $3,607 |
| 3 | $4,554 |
| 4 | $5,500 |
| 5 | $6,447 |
| 6 | $7,394 |
| 7 | $8,340 |
| 8 | $9,287 |

Add [~~$916~~] $947 for each additional person in the budget group.

**G.** Two hundred thirty-five percent FPL:

| Size of budget group | FPL per month |
|---|---|
| [~~1~~ | ~~$3,065~~ |
| ~~2~~ | ~~$4,142~~ |
| ~~3~~ | ~~$5,219~~ |
| ~~4~~ | ~~$6,297~~ |
| ~~5~~ | ~~$7,374~~ |
| ~~6~~ | ~~$8,451~~ |
| ~~7~~ | ~~$9,528~~ |
| ~~8~~ | ~~$10,605~~] |
| 1 | $3,126 |
| 2 | $4,238 |
| 3 | $5,351 |
| 4 | $6,463 |

5 $7,575
6 $8,688
7 $9,800
8 $10,912
Add [~~$1,077~~] $1,112 for each additional person in the budget group.

**H.** Two hundred fifty percent FPL:

| Size of budget group | FPL per month |
|---|---|
| [~~1~~ | ~~$3,261~~ |
| ~~2~~ | ~~$4,407~~ |
| ~~3~~ | ~~$5,553~~ |
| ~~4~~ | ~~$6,698~~ |
| ~~5~~ | ~~$7,844~~ |
| ~~6~~ | ~~$8,990~~ |
| ~~7~~ | ~~$10,136~~ |
| ~~8~~ | ~~$11,282~~] |
| 1 | $3,325 |
| 2 | $4,509 |
| 3 | $5,692 |
| 4 | $6,875 |
| 5 | $8,059 |
| 6 | $9,242 |
| 7 | $10,425 |
| 8 | $11,609 |

Add [~~$1,146~~] $1,184 for each additional person in the budget group.

[8.200.520.11 NMAC - Rp, 8.200.520.11 NMAC, 8/28/2015; A/E, 4/1/2016; A/E, 9/14/2017; A, 2/1/2018; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019, A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; 8/1/2024; A/E, 4/1/2025; A, 8/1/2025; A/E, 4/1/2026; A, 9/1/2026]

**8.200.520.12 COST OF LIVING ADJUSTMENT (COLA) DISREGARD COMPUTATION:** The countable social security benefit without the COLA is calculated using the COLA increase table as follows:

**A.** divide the current gross social security benefit by the COLA increase in the most current year; the result is the social security benefit before the COLA increase;

**B.** divide the result from Subsection A above by the COLA increase from the previous period or year; the result is the social security benefit before the increase for that period or year; and

**C.** repeat Subsection B above for each year, through the year that the applicant or eligible recipient received both social security benefits and supplemental security income (SSI); the final result is the countable social security benefit.

_

| COLA Increase and disregard table | | | |
|---|---|---|---|
| | Period and year | COLA increase | = benefit before |
| **1** | 2026 Jan - Dec | 2.8 | Jan 26 |
| **[~~1~~] 2** | 2025 Jan - Dec | 2.5 | Jan 25 |
| **[~~2~~] 3** | 2024 Jan - Dec | 3.2 | Jan 24 |
| **[~~3~~] 4** | 2023 Jan - Dec | 8.7 | Jan 23 |
| **[~~4~~] 5** | 2022 Jan - Dec | 5.9 | Jan 22 |
| **[~~5~~] 6** | 2021 Jan - Dec | 1.3 | Jan 21 |
| **[~~6~~] 7** | 2020 Jan - Dec | 1.6 | Jan 20 |
| **[~~7~~] 8** | 2019 Jan - Dec | 2.8 | Jan 19 |
| **[~~8~~] 9** | 2018 Jan - Dec | 2.0 | Jan 18 |
| **[~~9~~] 10** | 2017 Jan - Dec | 0.3 | Jan 17 |
| **[~~10~~] 11** | 2016 Jan - Dec | 0 | Jan 16 |
| **[~~11~~] 12** | 2015 Jan - Dec | 1.017 | Jan 15 |
| **[~~12~~] 13** | 2014 Jan - Dec | 1.015 | Jan 14 |
| **[~~13~~] 14** | 2013 Jan - Dec | 1.017 | Jan 13 |
| **[~~14~~] 15** | 2012 Jan - Dec | 1.037 | Jan 12 |
| **[~~15~~] 16** | 2011 Jan - Dec | 0 | Jan 11 |
| **[~~16~~] 17** | 2010 Jan - Dec | 1 | Jan 10 |
| **[~~17~~] 18** | 2009 Jan - Dec | 1 | Jan 09 |
| **[~~18~~] 19** | 2008 Jan - Dec | 1.058 | Jan 08 |
| **[~~19~~] 20** | 2007 Jan - Dec | 1.023 | Jan 07 |
| **[~~20~~] 21** | 2006 Jan - Dec | 1.033 | Jan 06 |
| **[~~21~~] 22** | 2005 Jan - Dec | 1.041 | Jan 05 |
| **[~~22~~] 23** | 2004 Jan - Dec | 1.027 | Jan 04 |
| **[~~23~~] 24** | 2003 Jan - Dec | 1.021 | Jan 03 |
| **[~~24~~] 25** | 2002 Jan - Dec | 1.014 | Jan 02 |
| **[~~25~~] 26** | 2001 Jan - Dec | 1.026 | Jan 01 |
| **[~~26~~] 27** | 2000 Jan - Dec | 1.035 | Jan 00 |
| **[~~27~~] 28** | 1999 Jan - Dec | 1.025 | Jan 99 |
| **[~~28~~] 29** | 1998 Jan - Dec | 1.013 | Jan 98 |
| **[~~29~~] 30** | 1997 Jan - Dec | 1.021 | Jan 97 |
| **[~~30~~] 31** | 1996 Jan - Dec | 1.029 | Jan 96 |
| **[~~31~~] 32** | 1995 Jan - Dec | 1.026 | Jan 95 |
| **[~~32~~] 33** | 1994 Jan - Dec | 1.028 | Jan 94 |
| **[~~33~~] 34** | 1993 Jan - Dec | 1.026 | Jan 93 |
| **[~~34~~] 35** | 1992 Jan - Dec | 1.03 | Jan 92 |
| **[~~35~~] 36** | 1991 Jan - Dec | 1.037 | Jan 91 |

| | | | |
|---|---|---|---|
| [~~36~~] 37 | 1990 Jan - Dec | 1.054 | Jan 90 |
| [~~37~~] 38 | 1989 Jan - Dec | 1.047 | Jan 89 |
| [~~38~~] 39 | 1988 Jan - Dec | 1.04 | Jan 88 |
| [~~39~~] 40 | 1987 Jan - Dec | 1.042 | Jan 87 |
| [~~40~~] 41 | 1986 Jan - Dec | 1.013 | Jan 86 |
| [~~41~~] 42 | 1985 Jan - Dec | 1.031 | Jan 85 |
| [~~42~~] 43 | 1984 Jan - Dec | 1.035 | Jan 84 |
| [~~43~~] 44 | 1982 Jul - 1983 Dec | 1.035 | Jul 82 |
| [~~44~~] 45 | 1981 Jul - 1982 Jun | 1.074 | Jul 81 |
| [~~45~~] 46 | 1980 Jul - 1981 Jun | 1.112 | Jul 80 |
| [~~46~~] 47 | 1979 Jul - 1980 Jun | 1.143 | Jul 79 |
| [~~47~~] 48 | 1978 Jul - 1979 Jun | 1.099 | Jul 78 |
| [~~48~~] 49 | 1977 Jul - 1978 Jun | 1.065 | Jul 77 |
| [~~49~~] 50 | 1977 Apr - 1977 Jun | 1.059 | Apr 77 |

[8.200.520.12 NMAC - Rp, 8.200.520.12 NMAC, 8/28/2015; A/E, 1/1/2016; A/E, 3/1/2017; A/E, 5/17/2018; A, 9/11/2018; A, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024, 8/1/2024; A/E, 4/1/2025; A, 8/1/2025; A/E, 4/1/2026; A, 9/1/2026]

**8.200.520.13 FEDERAL BENEFIT RATES (FBR) AND VALUE OF ONE-THIRD REDUCTION (VTR):**

| Year | Individual | Institution | Individual | Couple | Institution | Couple |
|---|---|---|---|---|---|---|
| | FBR | FBR | VTR | FBR | FBR | VTR |
| 1/89 to 1/90 | $368 | $30 | $122.66 | $553 | $60 | $184.33 |
| 1/90 to 1/91 | $386 | $30 | $128.66 | $579 | $60 | $193.00 |
| 1/91 to 1/92 | $407 | $30 | $135.66 | $610 | $60 | $203.33 |
| 1/92 to 1/93 | $422 | $30 | $140.66 | $633 | $60 | $211.00 |
| 1/93 to 1/94 | $434 | $30 | $144.66 | $652 | $60 | $217.33 |
| 1/94 to 1/95 | $446 | $30 | $148.66 | $669 | $60 | $223.00 |
| 1/95 to 1/96 | $458 | $30 | $152.66 | $687 | $60 | $229.00 |
| 1/96 to 1/97 | $470 | $30 | $156.66 | $705 | $60 | $235.00 |
| 1/97 to 1/98 | $484 | $30 | $161.33 | $726 | $60 | $242.00 |
| 1/98 to 1/99 | $494 | $30 | $164.66 | $741 | $60 | $247.00 |
| 1/99 to 1/00 | $500 | $30 | $166.66 | $751 | $60 | $250.33 |
| 1/00 to 1/01 | $512 | $30 | $170.66 | $769 | $60 | $256.33 |
| 1/01 to 1/02 | $530 | $30 | $176.66 | $796 | $60 | $265.33 |
| 1/02 to 1/03 | $545 | $30 | $181.66 | $817 | $60 | $272.33 |
| 1/03 to 1/04 | $552 | $30 | $184.00 | $829 | $60 | $276.33 |
| 1/04 to 1/05 | $564 | $30 | $188 | $846 | $60 | $282.00 |
| 1/05 to 1/06 | $579 | $30 | $193 | $869 | $60 | $289.66 |
| 1/06 to 1/07 | $603 | $30 | $201 | $904 | $60 | $301.33 |
| 1/07 to 1/08 | $623 | $30 | $207.66 | $934 | $60 | $311.33 |
| 1/08 to 1/09 | $637 | $30 | $212.33 | $956 | $60 | $318.66 |
| 1/09 to 1/10 | $674 | $30 | $224.66 | $1,011 | $60 | $337 |
| 1/10 to 1/11 | $674 | $30 | $224.66 | $1,011 | $60 | $337 |
| 1/11 to 1/12 | $674 | $30 | $224.66 | $1,011 | $60 | $337 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 1/12 to 1/13 | $698 | $30 | $232.66 | $1,048 | $60 | $349.33 |
| 1/13 to 1/14 | $710 | $30 | $237 | $1,066 | $60 | $355 |
| 1/14 to 1/15 | $721 | $30 | $240 | $1,082 | $60 | $361 |
| 1/15 to 12/15 | $733 | $30 | $244 | $1,100 | $60 | $367 |
| 1/16 to 12/16 | $733 | $30 | $244 | $1,100 | $60 | $367 |
| 1/17 to 12/17 | $735 | $30 | $245 | $1,103 | $60 | $368 |
| 1/18 to 12/18 | $750 | $30 | $250 | $1,125 | $60 | $375 |
| 1/19 to 12/19 | $771 | $30 | $257 | $1,157 | $60 | $386 |
| 1/20 to 12/20 | $783 | $30 | $261 | $1,175 | $60 | $392 |
| 1/21 to 12/21 | $794 | $30 | $264.66 | $1,191 | $60 | $397 |
| 1/22 to 12/22 | $841 | $30 | $280.33 | $1,261 | $60 | $420.50 |
| 1/23 to 12/23 | $914 | $30 | $304.66 | $1,371 | $60 | $456.99 |
| 1/24 to 12/24 | $943 | $30 | $314.33 | $1,415 | $60 | $471.66 |
| 1/25 to 12/25 | $967 | $30 | $322.33 | $1,450 | $60 | $483.33 |
| 1/26 to 12/26 | $994 | $30 | $331.33 | $1,491 | $60 | $496.99 |

**A.** Ineligible child deeming allocation is [~~$483~~] $497.

**B.** Part B premium is [~~$185~~] $202.90 per month.

**C.** VTR (value of one third reduction) is used when an individual or a couple lives in the household of another and receives food and shelter from the household or when the individual or the couple is living on their own household but receiving support and maintenance from others.

**D.** The SSI resource standard is $2000 for an individual and $3000 for a couple.

[8.200.520.13 NMAC - Rp, 8.200.520.13 NMAC, 8/28/2015; A/E, 1/1/2016; A/E, 3/1/2017; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; 8/1/2024; A/E, 4/1/2025; A, 8/1/2025; A/E, 4/1/2026; A, 9/1/2026]

**8.200.520.15 SUPPLEMENTAL SECURITY INCOME (SSI) LIVING ARRANGEMENTS:**

**A.** Individual living in their own household who own or rent:

Payment amount: [~~$967~~] $994 Individual
[~~$1,450~~] $1,491 Couple

**B.** Individual receiving support and maintenance payments: For an individual or couple living in their own household, but receiving support and maintenance from others (such as food, shelter or clothing), subtract the value of one third reduction (VTR).

Payment amount:
[~~$967 - $322.33 = $644.67~~] $994 - $331.33 = $662.67 Individual
[~~$1,450 – $483.33 = $966.67~~] $1,491 - $469.99 = $1,021.01 Couple

**C.** Individual or couple living household of another: For an individual or couple living in another person's household and not contributing their pro-rata share of household expenses, subtract the VTR.

Payment amount:
[~~$967 - $322.33 = $644.67~~] $994 - $331.33 = $662.67 Individual
[~~$1,450 – $483.33 = $966.67~~] $1,491 - $469.99 = $1,021.01 Couple

**D.** Child living in home with their parent:

Payment amount: [~~$967~~] $994

**E.** Individual in institution:

Payment amount: $30.00

[8.200.520.15 NMAC - Rp, 8.200.520.15 NMAC, 8/28/2015; A/E, 3/1/2017; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025; A, 8/1/2025; A/E, 4/1/2026; A, 9/1/2026]

**8.200.520.16 MAXIMUM COUNTABLE INCOME FOR INSTITUTIONAL CARE MEDICAID AND HOME AND COMMUNITY BASED WAIVER SERVICES (HCBS) CATEGORIES:** Effective January 1, [~~2024~~] 2026, the maximum countable monthly income standard for institutional care medicaid and the home and community based waiver categories is [~~$2,901~~] $2,982.
[8.200.520.16 NMAC - Rp, 8.200.520.16 NMAC, 8/28/2015; A/E, 3/1/2017; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025; A, 8/1/2025; A/E. 4/1/2026; A, 9/1/2026]

**8.200.520.20 COVERED QUARTER INCOME STANDARD:**

| Date Calendar Quarter | Amount |
|---|---|
| Jan. 2026 - Dec. 2026 | $1,890 per calendar quarter |
| Jan. 2025 - Dec. 2025 | $1,810 per calendar quarter |
| Jan. 2024 - Dec. 2024 | $1,730 per calendar quarter |
| Jan. 2023 - Dec. 2023 | $1,640 per calendar quarter |
| Jan. 2022 - Dec. 2022 | $1,510 per calendar quarter |
| Jan. 2021 - Dec. 2021 | $1,470 per calendar quarter |
| Jan. 2020 - Dec. 2020 | $1,410 per calendar quarter |
| Jan. 2019 - Dec. 2019 | $1,360 per calendar quarter |
| Jan. 2018 - Dec. 2018 | $1,320 per calendar quarter |
| Jan. 2017 - Dec. 2017 | $1,300 per calendar quarter |
| Jan. 2016 - Dec. 2016 | $1,260 per calendar quarter |
| Jan. 2015 - Dec. 2015 | $1,220 per calendar quarter |
| Jan. 2014 - Dec. 2014 | $1,200 per calendar quarter |
| Jan. 2013 - Dec. 2013 | $1,160 per calendar quarter |
| Jan. 2012 - Dec. 2012 | $1,130 per calendar quarter |
| Jan. 2011 - Dec. 2011 | $1,120 per calendar quarter |
| Jan. 2010 - Dec. 2010 | $1,120 per calendar quarter |
| Jan. 2009 - Dec. 2009 | $1,090 per calendar quarter |
| Jan. 2008 - Dec. 2008 | $1,050 per calendar quarter |
| Jan. 2007 - Dec. 2007 | $1,000 per calendar quarter |
| Jan. 2006 - Dec. 2006 | $970 per calendar quarter |
| Jan. 2005 - Dec. 2005 | $920 per calendar quarter |
| Jan. 2004 - Dec. 2004 | $900 per calendar quarter |
| Jan. 2003 - Dec. 2003 | $890 per calendar quarter |
| Jan. 2002 - Dec. 2002 | $870 per calendar quarter |

[8.200.520.20 NMAC - Rp, 8.200.520.20 NMAC, 8/28/2015; A/E, 1/1/2016; A/E, 03/01/2017; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019; A/E, 8/11/2020; A, 12/15/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025; A, 8/1/2025; A/E, 4/1/2026; A, 9/1/2026]

## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.281.510 NMAC, Sections 1, 7-13, and 18, effective 9/1/2026.**

**8.281.510.1 ISSUING AGENCY:** New Mexico health care authority (HCA).
[8.281.510.1 NMAC - N, 10/1/2012; A,7/1/2024; A, 9/1/2026]

**8.281.510.7 DEFINITIONS:**
[~~**A. "Assets"** include all income and resources as described in Section 8.281.500 NMAC of an applicant/recipient and [his/her] their spouse. Assets not in a trust are considered under the applicable rule to determine if they are countable or excludable for the purposes of medicaid eligibility.~~

~~**B. "Beneficiary"** is the individual(s) for whose benefit the assets are held by the trustee.~~

~~**C. "Benefit"** is something to the advantage of or profit to the recipient.~~

~~**D. "Community spouse"** is an individual as described in Subsection E of Section 8.281.500.7 NMAC, *definitions*.~~

~~**E. "Corporate trustee"** means a bank, trust company, or company whose primary business is trust services. A corporate trustee may not have any affiliation with the beneficiary either through relatives working for the corporate trustee or investments by the beneficiary with the company other than for administrative fees.~~

~~**F. "Corpus"** is the body of the trust or the original asset used to establish the trust (to include principal, interest, and subsequent additions), such as a sum of money or real property.~~

~~**G. "Department"** is the New Mexico [human services department] health care authority or successor agency.~~

~~**H. "Grantor"** is the owner of or has legal control over the assets placed into a trust. A grantor~~

~~may also be referred to as a settlor or trustor.~~

~~**I. "Institutionalized individual"** is an individual as described in Subsection K of 8.281.500.7 NMAC.~~

~~**J. "Irrevocable trust"** is created when the grantor does not reserve any right to cancel or revoke any provision of the trust.~~

~~**(1)** Although termed irrevocable, a trust which provides that the trust can only be modified or terminated by a court is a revocable trust because the applicant/recipient (or [his/her] their responsible party) or the trustee can petition the court to amend or terminate the trust.~~

~~**(2)** Although termed irrevocable, a trust that will terminate if a certain circumstance occurs during the lifetime of the applicant/recipient, such as the applicant/recipient leaving the nursing facility and returning home, is a revocable trust.~~

~~**(3)** Although termed irrevocable, a trust that can be revoked or terminated upon the agreement of any or all beneficiaries (including residual beneficiaries) is a revocable trust.~~

~~**K. "Payment"** means any disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as non-cash or property disbursements, such as the right to use and occupy real property.~~

~~**L. "Residual beneficiary"** is a person or entity that receives the remaining trust principal upon the death of the original trust beneficiary.~~

~~**M. "Revocable trust"** is created when the grantor reserves any right to cancel any provision of the trust.~~

~~**N. "Sole benefit of"** means that no individual or entity, except the person for whom the trust was established, may benefit from the assets in any way whether at the time the trust is created or at any time in the future except after medicaid is reimbursed.~~

~~**O. "Trust"** includes any legal instrument, device or arrangement, that is reduced to writing, signed and executed, which may not be called a trust under state law, or which is similar to a trust. A trust is a legal device in which property (real or personal) or other assets are held by one or more individuals for the benefit of others. A trust is usually created by a transfer of assets from the owner (grantor) to the trustee. Assets are not part of a trust and are considered outside of the trust until the date they are actually transferred into the trust, as demonstrated by verifiable documentation, regardless of the effective date of the trust. The transfer may be made while the grantor is alive or it may be made by will. The transfer of assets into a trust divests the original owner of legal title or restricts access to those assets. Trusts may also include structured settlements meeting the requirements stated above.~~

~~**P. "Trust records"** include, but are not limited to verifiable documentation of all transactions paid by or paid into a trust. Minimal documentation of distributions includes date of transaction, amount of payment (or if not paid by cash or other legal tender, type of asset distributed), person or entity receiving distribution, purpose of distribution, if distribution was made to acquire a non-consumable good, the location of that non-consumable good, and person or entity authorizing the distribution. Minimal documentation of additions to the trust includes the date of the transaction and a description of or amount of the asset transferred into the trust. The department shall not pay any costs or fees for obtaining trust records from the applicant/recipient or the trustee.~~

~~**Q. "Trustee"** is a person or entity who holds and controls the assets in the trust. The trustee usually has legal title to the assets held in the trust and is considered the owner of the trust assets in most dealings with third parties.~~]

**A. Definitions beginning with "A": "Assets"** include all income and resources as described in 8.281.500 NMAC of an applicant/recipient and their spouse. Assets not in a trust are considered under the applicable rule to determine if they are countable or excludable for the purposes of medicaid eligibility.

**B. Definitions beginning with "B":**

**(1) "Beneficiary"** is the individual(s) for whose benefit the assets are held by the trustee.

**(2) "Benefit"** is something to the advantage of or profit to the recipient.

**C. Definitions beginning with "C":**

**(1) "Community spouse"** is an individual as described in Subsection E of 8.281.500.7 NMAC, *Definitions*.

**(2) "Corporate trustee"** means a bank, trust company, or company whose primary business is trust services. A corporate trustee may not have any affiliation with the beneficiary either through relatives working for the corporate trustee or investments by the beneficiary with the company other than for administrative fees.

**(3) "Corpus"** is the body of the trust or the original asset used to establish the trust (to include principal, interest, and subsequent additions), such as a sum of money or real property.

**D. Definitions beginning with "D": "Department"** is the New Mexico health care authority or successor agency.

**E. Definitions beginning with "E": [RESERVED]**

**F. Definitions beginning with "F": [RESERVED]**

**G. Definitions beginning with "G": "Grantor"** is the owner of or has legal control over the assets placed into a trust. A grantor may also be referred to as a settlor or trustor.

**H. Definitions beginning with "H": [RESERVED]**

**I. Definitions beginning with "I":**

**(1)** **"Institutionalized individual"** is an individual as described in Subsection K of 8.281.500.7 NMAC.

**(2)** **"Irrevocable trust"** is created when the grantor does not reserve any right to cancel or revoke any provision of the trust.

**(a)** Although termed irrevocable, a trust which provides that the trust can only be modified or terminated by a court is a revocable trust because the applicant/recipient (or their responsible party) or the trustee can petition the court to amend or terminate the trust.

**(b)** Although termed irrevocable, a trust that will terminate if a certain circumstance occurs during the lifetime of the applicant/recipient, such as the applicant/recipient leaving the nursing facility and returning home, is a revocable trust.

**(c)** Although termed irrevocable, a trust that can be revoked or terminated upon the agreement of any or all beneficiaries (including residual beneficiaries) is a revocable trust.

**J. Definitions beginning with "J": [RESERVED]**

**K. Definitions beginning with "K": [RESERVED]**

**L. Definitions beginning with "L": [RESERVED]**

**M. Definitions beginning with "M": [RESERVED]**

**N. Definitions beginning with "N": [RESERVED]**

**O. Definitions beginning with "O": [RESERVED]**

**P. Definitions beginning with "P": "Payment"** means any disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as non-cash or property disbursements, such as the right to use and occupy real property.

**Q. Definitions beginning with "Q": [RESERVED]**

**R. Definitions beginning with "R":**

**(1)** **"Residual beneficiary"** is a person or entity that receives the remaining trust principal upon the death of the original trust beneficiary.

**(2)** **"Revocable trust"** is created when the grantor reserves any right to cancel any provision of the trust.

**S. Definitions beginning with "S": "Sole benefit of"** means that no individual or entity, except the person for whom the trust was established, may benefit from the assets in any way whether at the time the trust is created or at any time in the future except after medicaid is reimbursed.

**T. Definitions beginning with "T":**

**(1)** **"Trust"** includes any legal instrument, device or arrangement, that is reduced to writing, signed and executed, which may not be called a trust under state law, or which is similar to a trust. A trust is a legal device in which property (real or personal) or other assets are held by one or more individuals for the benefit of others. A trust is usually created by a transfer of assets from the owner (grantor) to the trustee. Assets are not part of a trust and are considered outside of the trust until the date they are actually transferred into the trust, as demonstrated by verifiable documentation, regardless of the effective date of the trust. The transfer may be made while the grantor is alive or it may be made by will. The transfer of assets into a trust divests the original owner of legal title or restricts access to those assets. Trusts may also include structured settlements meeting the requirements stated above.

**(2)** **"Trust records"** include, but are not limited to verifiable documentation of all transactions paid by or paid into a trust. Minimal documentation of distributions includes date of transaction, amount of payment (or if not paid by cash or other legal tender, type of asset distributed), person or entity receiving distribution, purpose of distribution, if distribution was made to acquire a non-consumable good, the location of that non-consumable good, and person or entity authorizing the distribution. Minimal documentation of additions to the trust includes the date of the transaction and a description of or amount of the asset transferred into the trust. The department shall not pay any costs or fees for obtaining trust records from the applicant/recipient or the trustee.

**(3)** **"Trustee"** is a person or entity who holds and controls the assets in the trust. The trustee usually has legal title to the assets held in the trust and is considered the owner of the trust assets in most dealings with third parties.

**U. Definitions beginning with "U": [RESERVED]**

**V. Definitions beginning with "V": [RESERVED]**

**W. Definitions beginning with "W": [RESERVED]**

**X. Definitions beginning with "X": [RESERVED]**

**Y. Definitions beginning with "Y": [RESERVED]**

**Z. Definitions beginning with "Z": [RESERVED]**

[8.281.510.7 NMAC - N, 10/1/2012; A, 9/1/2026]

**8.281.510.8** [~~**[RESERVED]**~~]

**MISSION:** We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.281.510.8 NMAC - N, 9/1/2026]

**8.281.510.9 MEDICAID QUALIFYING TRUSTS (MQT):** An MQT is a trust created prior to August 11, 1993. An MQT is a trust, or similar legal device, established (other than by will) by an applicant/recipient or an applicant/recipient's spouse, under which the applicant/recipient may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any

discretion with respect to distributions to the applicant/recipient. A trust established by an applicant/recipient or an applicant/recipient's spouse includes trusts created or approved by a representative of the applicant/recipient (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the applicant/recipient or the applicant/recipient's spouse. This includes trust accounts or similar devices established for a minor child. In addition, a trust established jointly by at least one of the applicant/recipients who can establish an MQT and another party or parties (who do not qualify as one of these applicant/recipients) is an MQT as long as it meets the other MQT criteria. The provisions regarding MQTs apply even though an MQT is irrevocable or is established for purposes other than enabling an applicant/recipient to qualify for medicaid; and, whether or not discretion is actually exercised.

**A. Similar legal device:** MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. The determination whether a given document or arrangement constitutes a "similar legal device" shall be made by the department.

**B. MQT resource treatment:** For revocable MQTs, the entire principal is an available resource to the applicant/recipient. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the applicant/recipient, using [~~his/her~~] their full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the applicant/recipient (or to use it for the applicant/recipient's benefit), the entire principal is an available resource to the applicant/recipient. Placement of an asset excluded by 8.281.500.13 NMAC, [~~*resource exclusions*~~] *Resource Exclusions*, into a trust does not change the nature of the asset. The asset remains excluded, except for the home of an institutionalized individual. If the home of an institutionalized individual is placed in a trust, it becomes a countable resource. The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the applicant/recipient (or to be used for [~~his/her~~] their benefit), but those distributions are not made, the applicant/recipient's countable resources increase cumulatively by the undistributed amount.

**C. Income treatment:** Amounts of MQT income distributed to the applicant/recipient or to third parties for the applicant/recipient's benefit are countable income when distributed.

**D. Transfer of resources:** If the MQT is irrevocable, a transfer of resources has occurred to the extent that the applicant/recipient or grantor's access to the principal is restricted (e.g., if the trust states that the trustee cannot access the principal, but must distribute the income produced by that principal to the applicant/recipient, the principal is not an available resource and has, therefore, been transferred). See 8.281.500.14 NMAC.

**E. Beneficiary of trust lives in an [~~ICF-MR~~] ICF/IID:** If the beneficiary of a trust is an applicant/recipient who is [~~mentally retarded~~] an individual with intellectual disabilities and resides in an intermediate care facility for [~~the mentally retarded (ICF-MR)~~] individuals with intellectual disabilities (ICF/IID), that applicant/recipient's trust is not considered an MQT if the trust or trust decree was established prior to April 7, 1986, and is solely for the benefit of that applicant/recipient.

**F. Treatment of SSI or social security lump sum payments:** SSI or social security lump sum payments for retroactive periods which are placed in an MQT do not qualify for the nine-month exclusion from countable resources. The trust is evaluated as an MQT for purposes of medicaid eligibility.

**G.** Trust records shall be open at all reasonable times to inspection by the department and copies shall be provided upon the request of an authorized representative of the department.

[8.281.510.9 NMAC - Rp, 8.281.510.15 NMAC, 10/1/2012; A, 9/1/2026]

**8.281.510.10 TRUSTS ESTABLISHED ON OR AFTER AUGUST 11, 1993:** Trusts established on or after August 11, 1993 are evaluated using the provisions of OBRA 93. The term "medicaid qualifying trust" or MQT is no longer used after that date. Any trust which meets the basic definition of a trust can be counted in determining eligibility for medicaid. No clause or requirement in a trust, no matter how specifically it applies to medicaid or other federal or state programs (i.e. exculpatory clauses) precludes a trust from being considered under 8.281.500 NMAC. Depending on how the trust is structured, the amounts in the trust may count as resources, income, or a transfer of assets. All trusts submitted for review by the department must be in writing, signed, and fully executed. Trusts that are not signed and executed will not be considered as effective trusts until they are signed and executed. Assets are not part of a trust and are considered outside of the trust until the date they are actually transferred into the trust, as demonstrated by verifiable documentation, regardless of the effective date of the trust.

**A.** The standards set forth in this section shall apply to trusts or similar legal devices without regard to:

**(1)** the purposes for which the trust is established;

**(2)** whether the trustee(s) has discretion or exercises such discretion under the trust;

**(3)** any restrictions on when or whether distributions can be made from the trust; and

**(4)** or any restrictions on the use of distributions from the trust.

**B. Trust establishment:** An applicant/recipient is considered to have established a trust and that trust is considered to belong to that applicant/recipient if [~~his/her~~] their assets were used to form all or part of the corpus of the trust. Applicants/recipients to whom the trust provisions apply shall include any applicant/recipient who establishes a trust and who is an applicant/recipient for medicaid services. An applicant/recipient shall be considered to have established a trust if any of [~~his/her~~] their assets, regardless of the amount, were used to form part or all of the corpus of the trust.

**(1)** The trust must have been established, other than by will, by any of the following individuals:

**(a)** applicant/recipient;

**(b)** applicant/recipient's spouse;

**(c)** an individual, including a court or administrative body, with legal authority to act in place of, or on behalf of, the applicant/recipient or [~~his/her~~] their spouse; or

**(d)** an individual, including a court or administrative body, acting at the direction of, or upon the request of, the applicant/recipient or [~~his/her~~] their spouse.

**(2)** When the corpus of a trust includes assets of another person or persons not described in Subparagraphs (a) through (d) above, as well as assets of the applicant/recipient, the rules apply only to the portion of the trust attributable to the assets of the applicant/recipient. Thus, in determining countable income and resources in the trust for eligibility and post-eligibility purposes, the ISD caseworker shall prorate any amounts of income and resources, based on the proportion of the applicant/recipient's assets in the trust to those of other persons. (For example: if the applicant/recipient and [~~his~~] their two sisters create a trust and each sister contributes a total value of [~~fifty thousand dollars ($50,000)~~] $50,0000 and the applicant contributes [~~twenty-five thousand dollars ($25,000)~~] $25,000, the applicant's prorated share is twenty percent of the entire value of the trust.)

**C. Treatment of trusts:** For purposes of determining medicaid eligibility, the treatment of trusts shall be dependent on the characteristics of the trust.

**D. Revocable trusts:**

**(1)** the entire corpus of the trust shall be counted as a resource available to the applicant/recipient; and

**(2)** any payments from the trust made to or for the benefit of the applicant/recipient shall be counted as income (unless otherwise excludable, see [~~Section 8.281.500.20 NMAC, *unearned income*, and Section 8.281.500.21 NMAC, *deemed income*~~] 8.281.500.19 NMAC, *Unearned Income*, and 8.281.500.20 NMAC, *Deemed Income*); and

**(3)** any payments from the trust which are not made to or for the benefit of the applicant/recipient shall be considered as assets transferred for less than fair market value (see [~~Section~~] 8.281.500.14 NMAC, [*asset transfers*] *Asset Transfers*).

**E. Irrevocable trusts:** In an irrevocable trust from which payment can be made under the terms of the trust to or for the benefit of the applicant/recipient from all or a portion of the trust.

**(1)** The following shall apply to that trust or that portion of the trust:

**(a)** payments from income or from the corpus made to or for the benefit of the applicant/recipient shall be treated as income to the applicant/recipient unless otherwise excludable (see [~~Section 8.281.500.20 NMAC and Section 8.281.500.21~~] 8.281.500.19 NMAC and 8.281.500.20 NMAC);

**(b)** income on the corpus of the trust which could be paid to or for the benefit of the applicant/recipient shall be counted as a resource available to the applicant/recipient;

**(c)** the portion of the corpus that could be paid to or for the benefit of the applicant/recipient shall be treated as a resource available to the applicant/recipient; and

**(d)** payments from income or from the corpus that are made, but not to or for the benefit of the applicant/recipient, shall be treated as a transfer of assets for less than fair market value (see [~~Section~~] 8.281.500.14 NMAC).

**(2)** In the case of an irrevocable trust from which payments from all or a portion of the trust cannot, under any circumstances, be made to or for the benefit of the applicant/recipient, all of the trust, or any such portion or income thereof, shall be treated as a transfer of assets for less than fair market value (see [~~Section~~] 8.281.500.14 NMAC).

**(a)** In treating these portions as a transfer of assets, the date of transfer shall be considered to be the date the trust was established, or, if later, the date on which the applicant/recipient no longer had a right of payment.

**(b)** For transfer of assets purposes, in determining the value of the portion of the trust which cannot be paid to the applicant/recipient, amounts that have been paid, for whatever purpose, shall not be subtracted from the value of the trust on the date the trust was created or, if later, the date that payment could no longer be made. The value of the transferred amount shall be no less than the value on the date the trust is established or, if later, on the date that payment could no longer be made. If additional funds are added to this portion of the trust, those funds shall be treated as a new transfer of assets for less than fair market value, as of the date the additional funds were added to the

trust (See [~~Section~~] 8.281.500.14 NMAC).

**F.** Payments are considered countable to the applicant/recipient when made from a revocable or irrevocable trust to or on behalf of the applicant/recipient including payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the applicant/recipient derives some benefit from the payment.

**G.** In determining whether payments can or cannot be made from a trust to or for an applicant/recipient, the department shall take into account any restrictions on payments, such as use restrictions, exculpatory clauses, or limits on trustee discretion that may be included in the trust. Any amount in a trust for which payment can be made, no matter how unlikely the circumstance of payment might be or how distant in the future, shall be considered a payment that can be made under some circumstances. For example, if an irrevocable trust provides that the trustee can disburse only [~~one thousand dollars ($1,000)~~] $1,000 to or for the applicant/recipient out of a [~~ten thousand dollars ($10,000)~~] $10,000 trust, only the [~~one thousand dollars ($1,000)~~] $1,000 is treated as a payment that could be made. The remaining [~~nine thousand dollars ($9,000)~~] $9,000 is treated as an amount which cannot, under any circumstances, be paid to or for the benefit of the applicant/recipient and may be subject to a transfer penalty. On the other hand, if a trust contains [~~twenty-five thousand dollars ($25,000)~~] $25,000 that the trustee can pay to the applicant/recipient only in the event that the applicant/recipient needs, for example, a heart transplant, this full amount is considered as a payment that could be made under some circumstance, even though the likelihood of payment is remote. Similarly, if a payment cannot be made until some point in the distant future, it is still payment that can be made under some circumstances and the funds are counted as a resource.

**H.** Institutionalized individuals with a community spouse: A transfer to a trust (or similar instrument) for the sole benefit of a community spouse shall be treated in accordance with the provisions above. If the trust is established by either spouse (using at least some of the couple's assets) the trust shall be reviewed by the department for availability of resources, in accordance with the provisions above. If the payment from such a trust shall be considered an available resource to either spouse, the trust shall be included as a countable resource in determining medicaid eligibility for the institutionalized spouse.

**I.** Trust records shall be open at all reasonable times to inspection by the department and copies shall be provided upon the request of an authorized representative of the department. The department shall not be charged any fees or costs associated with providing trust records to the department.

[8.281.510.10 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012; A, 9/1/2026]

**8.281.510.11 RECOGNIZED MEDICAID TRUSTS:** The trust provisions set forth in 8.281.510.9 NMAC and 8.281.510.10 NMAC shall not apply to the following trusts so long as the trust document meets all the requirements set forth in this section.

**A.** The recognized medicaid trusts described in this section (special needs trusts and non-profit trusts for certain disabled individuals) are subject to the following.

**(1)** Only income and resources distributed directly to the applicant/recipient or to a third party on the applicant/recipient's behalf by the trustee are considered available to the applicant/recipient in determining medicaid eligibility if the applicant/recipient could use the payment for food or shelter for [~~him/herself~~] themselves.

**(2)** The trusts are reversionary trusts meaning the trust must provide that, upon the death of the applicant/recipient, any funds remaining in the trust revert to the state medicaid agency, up to the amount paid in medicaid benefits on the applicant/recipient's behalf. If the applicant/recipient has resided in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the applicant/recipient received medicaid, based on the state's proportionate share of the total amount of medicaid benefits paid by all of the states on the applicant/recipient's behalf.

**(3)** All trusts submitted for review to the department must be in writing, signed, and fully executed. Trusts that are not signed and executed will not be considered as effective trusts until they are signed and executed. Trusts must also be funded as demonstrated by verifiable documentation prior to review by the department.

**(4)** Assets are not part of a trust and are considered outside of the trust until the date they are actually transferred into the trust, as demonstrated by verifiable documentation, regardless of the effective date of the trust. Assets outside of a trust will be evaluated according to the applicable regulations regarding the counting of resources.

**(5)** Since the department is a reversionary beneficiary for all of the trusts described in the rest of this section, any legal action concerning one of these trusts must name the department as an interested party and the department must be notified by service of process in accordance with the New Mexico Rules of Civil Procedure.

**(6)** The applicant/recipient may not be the trustee and may not have any ability, access, or authority to manage or control the trust account.

**(7)** Each trust document must identify the person or organization that drafted the trust document.

**(8)** If the department approves or previously approved a recognized medicaid trust, the trust and administration of the trust are subject to review by the department, at least annually, and more frequently upon the request of the department, to determine if the trust remains a valid trust for the purposes of meeting the requirements of a recognized medicaid trust.

**(9)** If the department determines that a trust is invalid under Paragraph (8) above, the department will evaluate the applicant/recipient's medicaid eligibility, applying the provisions of [~~Section~~] 8.281.500 NMAC to the corpus of any existing trust. If the corpus of the trust is not disclosed, or cannot be identified by the department due to a lack of documentation, the department will presume that the corpus of the trust is a countable resource in excess and will be counted toward the allowable resource limit in 8.281.500.11 NMAC, [~~*applicable resource standards*~~] *Applicable Resource Standards*.

**(10)** The trustee and any alternate trustees shall be specifically identified by name and address.

**(11)** The department shall not be charged any fees or costs for obtaining trust records or documents.

**(12)** The trust may not under any circumstances provide a loan to the beneficiary or any other individual or entity.

**(13)** The trust must be in compliance with all applicable criteria as set forth in 8.281.510.11 NMAC.

**(14)** All trusts under Subsection B below must terminate upon the death of the beneficiary and provision made to immediately disburse the remaining corpus in accordance with the terms of the trust.

**B. Special needs trusts:** A special needs trust is a trust containing the assets of a disabled applicant/recipient established and funded prior to the time the disabled applicant/recipient reaches the age of 65 and which is established for the sole benefit of the disabled applicant/recipient by a parent, grandparent, legal guardian of the disabled applicant/recipient, or a court. A trust established on or after December 13, 2016, by an individual (i.e. the trust beneficiary) with a disability under age 65 for [~~his or her~~] their own benefit can qualify as a special needs trust, conferring the same benefits as a special needs trust set up by a parent, grandparent, legal guardian, or court. To qualify as a special needs trust, the trust shall contain the following provisions.

**(1)** The trust shall be identified as an OBRA '93 trust established pursuant to 42 U.S.C. Section 1396p(d)(4)(A).

**(2)** The trust shall not contain any provisions to automatically alter the form of the trust from an individual trust to a "pooled trust" under 42 U.S.C. Section 1396p(d)(4)(C). The special needs trust should be properly dissolved and a pooled trust should be created in accordance with federal and state laws.

**(3)** The trust shall specifically state that the trust is for the sole benefit of the trust beneficiary. Only trusts which are intended for the sole benefit of the disabled applicant/recipient are special needs trusts. Any trust which provides benefits to other persons is not for the sole benefit of the trust beneficiary and shall not be considered a special needs trust. The trust may provide for reasonable compensation to a trustee and shall provide for the reimbursement to the department on the death of the trust beneficiary.

**(4)** The trust shall specifically state that its purpose is to permit the use of trust assets to supplement, and not to supplant, impair or diminish, any benefits or assistance of any federal, state or other governmental entity for which the beneficiary may otherwise be eligible or for which the beneficiary may be receiving.

**(5)** Parents shall not be relieved of their duty to support a minor child. A minor's funds in a trust shall not be expended on routine support that should be provided by the parents.

**(6)** The trust shall specifically state the age of the trust beneficiary, whether the trust beneficiary is disabled within the definition of 42 U.S.C. Section 1382c(a)(3), and whether the trust beneficiary is competent at the time the trust is established.

**(7)** If the trust beneficiary is a minor, the trustee shall execute a bond to protect the child's funds or shall get a court's written order exempting [~~him/her~~] them from the bond requirement.

**(8)** If there is some question about the trust beneficiary's disability, independent proof may be required.

**(9)** If the trust beneficiary is a minor, the trust shall state whether the trust beneficiary is expected to be competent at [~~his or her~~] their majority.

**(10)** The trust shall specifically identify, in an attached schedule, the source of the initial trust property and all assets of the trust. If the trust is being established with funds from the proceeds of a settlement or judgment subsequent to the bringing of a legal cause of action, medicaid's claim for its expenditures that are related to the cause of action shall be repaid immediately upon the receipt of such proceeds and prior to the establishment of the trust.

**(11)** Subsequent additions made to the trust corpus shall be reported to the ISD caseworker upon application and recertification. Subsequent additions to the trust (other than interest on the corpus) after the applicant/recipient reaches age 65 may be subject to transfer of asset provisions (unless an exception to transfer of asset provisions applies).

**(12)** If subsequent additions are to be made to the trust corpus with funds not belonging to the trust beneficiary, it shall be understood that those funds are a gift to the trust beneficiary and

cannot be reclaimed by the donor.

**(13)** If the trust makes provisions which are intended to limit invasion by creditors or to insulate the trust from liens or encumbrances, the trust shall state that such provisions are not intended to limit the state's right to reimbursement or to recoup incorrectly paid benefits.

**(14)** The special needs trust shall identify the grantor by name, indicate [~~his/her~~] their relationship to the primary beneficiary, and state that it is established by a parent, grandparent, or legal guardian of the trust beneficiary, or by a court. A court can be named as the grantor, if the trust is established pursuant to a settlement of a case before it, or if the court is otherwise involved in the creation of the trust.

**(15)** The trust may pay administration fees and legal bills incurred by the beneficiary related to the trust administration.

**(16)** The trust shall specifically state that it is irrevocable. Neither the grantor, nor the beneficiary, or any remainder beneficiaries shall have any right or power, whether alone or in conjunction with others, in whatever capacity, to revoke or terminate the trust or to designate the persons who shall possess or enjoy the trust estate during [~~his/her~~] their lifetime. However, the trustee may seek an amendment for the limited purpose of ensuring that the trust complies with any changes to the laws governing the trust, per the agreement of all interested parties, to include the department. All such amendments shall be reviewed, consented to, and approved in writing by the department or its successor agency prior to finalizing the amendments. Any amendments not agreed to in writing by the department are void. Trust records shall be open at all reasonable times to inspection by the department and copies shall be provided, at no cost to the department, upon the request of an authorized representative of the department.

**(17)** The trustee shall be specifically identified by name and address. The trust shall state that the original trust beneficiary cannot be the trustee. The trust shall make provisions for naming a successor trustee in the event that any trustee is unable or unwilling to serve. The department as well as the trust beneficiary or guardian (if applicable), shall be given prior notice if there is a change in the trustee.

**(18)** The trust shall specifically state that the trustee shall fully comply with all state laws and regulations, including prudent administration per, Section 46A-8-804 (2003) NMSA 1978. The trust shall provide that the trustee cannot take any actions not authorized by, or without regard to, state laws and regulations.

**(19)** The trust shall specifically state that the trustee shall be compensated only as provided by law. The costs of administration must comply with Section 46A-8-805 (2003) NMSA 1978. If the trust identifies a guardian, the trust shall specifically identify [~~him or her~~] them by name. A guardian shall be compensated only as provided by law. The parent of a minor child shall not be compensated from the trust as the child's guardian.

**(20)** The trust shall specifically name the department as a remainder beneficiary with priority over any other beneficiaries except the primary beneficiary for whom the trust was created. The trust shall specifically state that, upon the death of the primary beneficiary, the department will be immediately notified by the trustee in writing, and shall be paid all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of the primary beneficiary. The trustee shall comply fully with this obligation to first repay the department, without requiring the department to take any action except to establish the amount to be repaid. Repayment shall be made by the trustee to the department or to any successor agency within 30 days after receiving written notification by the department of the amounts expended on behalf of the primary beneficiary.

**(a)** Allowable administrative expenses: The following types of administrative expenses may be paid from the trust prior to reimbursement to the department for medical assistance paid: taxes due from the trust to the state or federal government because of the death of the beneficiary, and reasonable fees for administration of the trust estate such as an accounting of the trust to a court, completion and filing of documents, or other required actions associated with termination and wrapping up of the trust. Payment of such expenses must be fully documented and copies of the documentation provided to the department within seven calendar days of making such payments.

**(b)** Prohibited expenses and payments: Examples of some types of expenses that are not permitted prior to reimbursement to the department for medical assistance, include but are not limited to: taxes due from the estate of the beneficiary other than those arising from inclusion of the trust in the estate, inheritance taxes due for residual beneficiaries, payment of debts owed to third parties other than the department, funeral expenses, and payments to residual beneficiaries.

**(21)** If there is a provision for repayment of other assistance programs, the trust shall specifically state that the medicaid program shall be repaid prior to making repayment to any other assistance programs.

**(22)** The trust shall specifically state that if the beneficiary has received medicaid benefits in more than one state, each state that provided medicaid benefits shall be repaid. If there is an insufficient amount left to cover all benefits paid, then each state shall be paid its proportionate share of the amount left in the trust, based upon the amount of support provided by each state to the beneficiary.

**(23)** No provisions in the trust shall permit the trustee or the estate's representative to

first repay other persons or creditors at the death of the beneficiary. Only what remains in the trust after the repayments specified in Paragraphs (20) through (22) above have been made shall be considered available for other expenses or beneficiaries of the estate.

**(24)** The trust shall specify that an accounting of all additions and expenditures made by or into the trust shall be submitted to the department on an annual basis, or more frequently upon the request of the department. The department shall not be charged any fees or costs for obtaining these records.

**(25)** The trust shall not create other trusts within it.

**(26)** If the trust is funded, in whole or in part, with an annuity or other periodic payment arrangement, the department must be named in the controlling documents as the primary remainder beneficiary up to the total amount of medical assistance paid on behalf of the individual.

**(27)** Distributions from the trust made to or for the benefit of a third party that are not for the sole primary benefit of the disabled individual are treated as a transfer of assets for less than fair market value and may create a period of ineligibility for certain medicaid services.

**C. Income diversion trusts:** An applicant/recipient whose income exceeds the income standard may be eligible to receive medicaid through the creation and funding of an income diversion trust. The trust terminates upon the death of the beneficiary. An income diversion trust must meet all of the following requirements.

**(1)** The trust is composed only of pension, social security, and other income to the applicant/recipient, including accumulated income in the trust.

**(2)** Only income distributed directly to the applicant/recipient or to a third party on the applicant/recipient's behalf by the trustee are considered available to the applicant/recipient in determining medicaid eligibility if the applicant/recipient could use the payment for food or shelter for [~~him/herself~~] themselves.

**(3)** An income diversion trust is a reversionary trust meaning the trust must provide that, upon the death of the applicant/recipient, any funds remaining in the trust revert to the state medicaid agency, up to the amount paid in medicaid benefits on the applicant/recipient's behalf.

**(4)** If the applicant/recipient has resided in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the applicant/recipient received medicaid, based on the state's proportionate share of the total amount of medicaid benefits paid by all the states on the applicant/recipient's behalf.

**(5)** The trustee may, upon the death of the beneficiary, pay the expenses of the beneficiary's burial or cremation up to the amount then authorized for burial expenses under federal and state medicaid law and regulations, to the extent other resources are not so designated.

**(6)** The trusts described in this section are also known in New Mexico as Maxwell v. Heim income diversion trusts; those trusts executed on or after August 11, 1993 no longer have to be court ordered or approved.

**D. Non-profit trusts for certain disabled individuals:** Trusts containing the assets of applicants/recipients who meet the social security administration's definition of disability.

**(1)** The trust must meet all the following criteria to be considered a non-profit trust for certain disabled individuals:

**(a)** the trust is established and managed by a non-profit association;

**(b)** a separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools these accounts;

**(c)** accounts in the trust are established solely for the benefit of applicants/recipients who meet the social security administration's definition of disability and are established by the parent, grandparent, or legal guardian of such applicants/recipients, by such applicants/recipients themselves, or by a court;

**(d)** to the extent that any amounts remaining in the applicant/recipient's trust account upon [~~his/her~~] their death are not retained by the trust, the trust pays to the department an amount equal to the total amount of medicaid benefits paid on behalf of the applicant/recipient;

**(i)** allowable administrative expenses: the following types of administrative expenses may be paid from the trust prior to reimbursement to the department for medical assistance paid: taxes due from the trust to the state or federal government because of the death of the beneficiary, and reasonable fees for administration of the trust estate such as an accounting of the trust to a court, completion and filing of documents, or other required actions associated with termination and wrapping up of the trust; payment of such expenses must be fully documented and copies of the documentation provided to the department within seven calendar days of making such payments;

**(ii)** prohibited expenses and payments: examples of some types of expenses that are not permitted prior to reimbursement to the department for medical assistance, include but are not limited to: taxes due from the estate of the beneficiary other than those arising from inclusion of the trust in the estate, inheritance taxes due for residual beneficiaries, payment of debts owed to third parties, funeral expenses, and payments to residual beneficiaries; and

**(iii)** any income or resources added to the trust after the applicant/recipient reaches 65 years of age may subject [~~him or her~~] them to a transfer of assets penalty.

**(2)** A trustee of a non-profit trust, in order to fulfill [~~his or her~~] their fiduciary obligations with respect to the state's remainder interest in the trust, must:

**(a)** notify the department, in writing, of the creation or funding of the trust for the benefit of an applicant/recipient; and

**(b)** notify the department, in writing, of the death of the beneficiary of the trust; and

**(c)** notify the department, in writing, in advance of any transactions involving transfers from the trust principal for less than fair market value.

**(3)** Trust records shall be open at all reasonable times to inspection by the department and copies shall be provided, at no cost to the department, upon the request of an authorized representative of the department.

[8.281.510.11 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012; A, 3/1/2018; A, 9/1/2026]

**8.281.510.12 OTHER TRUSTS:**

**A. Limited partnerships**: A limited partnership is a "similar legal device" to a trust. Trust provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) direct that the term "trust" includes any legal device similar to a trust. Therefore, OBRA 93 trust provisions of this section apply to limited partnerships. The general partners act as trustee, and the limited partners are the equivalent of beneficiaries of an irrevocable trust. To the extent that the general partners can make each limited partner's ownership interest available to [~~him~~] them, that interest is a countable resource and not a transfer of assets. However, a transfer of assets has occurred to the extent that:

**(1)** the value of the share of ownership purchased by the limited partner is less than the amount he invested;

**(2)** the general partners cannot make the limited partner's share available to [~~him~~] them;

**(3)** if transfer-of-assets provisions apply, the look-back period is 60 months.

**B. Trusts created by will:** Trusts that are created by will, but are not in effect (i.e., the testator is not deceased) are not considered as countable resources. Once a trust created by will is in effect and funded (i.e., the testator is deceased), the trust will be reviewed according to Subsection C, below.

**C. Third party trusts:**

**(1)** Third party trusts are trusts which are established with assets contributed by individuals other than the applicant/recipient or the applicant/recipient's spouse for the benefit of an applicant/recipient.

**(2)** The terms of the trust will determine whether the trust fund is countable as a resource or income for medicaid eligibility.

**(a)** Trusts which limit distributions to non-support or supplemental needs will not be considered as a countable resource in their entirety.

**(b)** If the applicant/recipient has the right to demand a distribution, the amount that may be demanded is countable, whether or not it is actually distributed.

**(c)** If the trustee may exercise discretion in distributing income or resources to the applicant/recipient or on behalf of the applicant/recipient, only the actual distributions of income or resources are countable in determining eligibility.

**(d)** If the applicant/recipient as the beneficiary of the trust may revoke or direct distributions from the trust, the trust is considered a countable resource.

**(3)** Trust records shall be open at all reasonable times to inspection by the department and copies shall be provided, at no cost to the department, upon the request of an authorized representative of the department.

[8.281.510.12 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012; A, 9/1/2026]

**8.281.510.13 UNDUE HARDSHIP:** An applicant/recipients who has excess resources and is unable to access resources from an existing trust will not be found ineligible for medicaid where the department determines, on a case by case basis, that denial of eligibility on the basis of excess resources would work an undue hardship.

**A.** The applicant/recipient must demonstrate that the application of the trust regulation would deprive the applicant/recipient or [~~his/her~~] their spouse of:

**(1)** medical care such that the applicant/recipient's health or life would be endangered; or

**(2)** food, clothing, shelter or other necessities of life.

**B.** The applicant/recipient must submit any documentation to support the claim that application of the trust regulation would constitute an undue hardship within 30 days of the date of the notice regarding eligibility for medicaid.

**C.** Undue hardship does not exist when the application of the trust regulation causes an applicant/recipient or [~~his/her~~] their family members inconvenience or restricts their lifestyle.

**D.** The county director of the ISD office will make a decision regarding an application for waiver of the trust regulation within 30 days of receipt of the application. The decision to grant a waiver shall be reviewed at every re-certification to determine if the circumstances justifying a waiver are still applicable.

**E.** Notice of the decision shall be mailed to the applicant/recipient or [~~his/her~~] their representative.

**F.** The applicant/recipient or [~~his/her~~] their representative must notify the ISD caseworker of any change in circumstances which affects the application of the undue hardship waiver exception within 10 days of the change in circumstances. The department will review the change of circumstances and determine the next

appropriate action, which may include withdrawal of the waiver.
[8.281.510.13 NMAC - Rp, 8.281.500.15 NMAC, 10/1/2012; A, 9/1/2026]

**8.281.510.18 NON-COMPLIANCE WITH TERMS OF TRUST:** If the department suspects or determines that the trustee is not complying with the terms of a trust that has been approved by the department, the department will send a letter to the recipient of services or [~~his or her~~] their representative requesting more information or describing the specific actions that are not in compliance with the trust which may include but is not limited to proper management of the funds in the trust. The recipient will have 15 days to provide the requested information or demonstrate, through documentation, that the actions of the trustee are not in violation of the terms of the trust. Failure to respond or to adequately demonstrate that the terms of the trust have not been violated may result in a transfer of assets penalty, disqualification from eligibility to receive benefits, and legal action, as appropriate. If the department identifies that the violation of the terms of the trust has been to inadequately fund the trust, the recipient shall immediately obtain a corporate trustee and amend the trust to be managed by that corporate trustee.
[8.281.510.18 NMAC - N, 10/1/2012; A, 9/1/2026]

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## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.291.430 NMAC, Section 10, effective 9/1/2026.**

**8.291.430.10 FEDERAL POVERTY LEVEL (FPL):** This part contains the monthly federal poverty level table for use in determining monthly income standards for MAP categories of eligibility outlined in 8.291.400.10 NMAC:

| HOUSEHOLD SIZE | 100% | 133% | 138% | 190% | 240% | 250% | 300% |
|---|---|---|---|---|---|---|---|
| 1 | [~~$1,305~~] $1,330 | [~~$1,735~~] $1,769 | [~~$1,800~~] $1,836 | [~~$2,478~~] $2,527 | [~~$3,130~~] $3,192 | [~~$3,261~~] $3,325 | [~~$3,913~~] $3,990 |
| 2 | [~~$1,763~~] $1,804 | [~~$2,345~~] $2,399 | [~~$2,433~~] $2,489 | [~~$3,349~~] $3,427 | [~~$4,230~~] $4,328 | [~~$4,407~~] $4,509 | [~~$5,288~~] $5,410 |
| 3 | [~~$2,221~~] $2,277 | [~~$2,954~~] $3,028 | [~~$3,065~~] $3,142 | [~~$4,220~~] $4,326 | [~~$5,330~~] $5,464 | [~~$5,553~~] $5,692 | [~~$6,663~~]- $6,830 |
| 4 | [~~$2,680~~] $2,750 | [~~$3,564~~] $3,658 | [~~$3,698~~] $3,795 | [~~$5,091~~] $5,225 | [~~$6,430~~] $6,600 | [~~$6,698~~] $6,875 | [~~$8,038~~] $8,250 |
| 5 | [~~$3,138~~] $3,224 | [~~$4,173~~] $4,288 | [~~$4,330~~] $4,449 | [~~$5,962~~] $6,125 | [~~$7,530~~] $7,736 | [~~$7,844~~] $8,059 | [~~$9,413~~] $9,670 |
| 6 | [~~$3,596~~] $3,697 | [~~$4,783~~] $4,917 | [~~$4,963~~] $5,102 | [~~$6,833~~] $7,024 | [~~$8,630~~] $8,872 | [~~$8,990~~] $9,242 | [~~$10,788~~] $11,090 |
| 7 | [~~$4,055~~] $4,170 | [~~$5,393~~] $5,547 | [~~$5,595~~] $5,755 | [~~$7,703~~] $7,923 | [~~$9,730~~] $10,008 | [~~$10,136~~] $10,425 | [~~$12,163~~] $12,510 |
| 8 | [~~$4,513~~] $4,644 | [~~$6,002~~] $6,176 | [~~$6,228~~] $6,408 | [~~$8,574~~] $8,823 | [~~$10,830~~] $11,144 | [~~$11,282~~] $11,609 | [~~$13,538~~] $13,930 |
| +1 | [~~$458~~] $474 | [~~$609~~] $629 | [~~$633~~] $653 | [~~$871~~] $900 | [~~$1,100~~] $1,136 | [~~$1,146~~] $1,184 | [~~$1,375~~] $1,420 |

[8.291.430.10 NMAC - Rp, 8.291.430.10 NMAC, 11/16/2015; A/E, 4/1/2016; A/E, 9/14/2017; A, 2/1/2018; A/E, 5/17/2018; A, 9/11/2018; A/E, 4/11/2019; A, 7/30/2019; A, 12/1/2020; A/E, 4/1/2021; A, 9/1/2021; A/E, 4/1/2022; A, 8/9/2022; A/E, 4/1/2023; A/E, 4/1/2024; A, 8/1/2024; A/E, 4/1/2025; A, 8/1/2025; A/E, 4/1/2026; A, 9/1/2026]

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## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.313.3 NMAC, Sections 1, 7-13, 16 and 17, effective 9/1/2026.**

**8.313.3.1 ISSUING AGENCY:** Health care authority (HCA), medical assistance division. [8.313.3.1 NMAC - Rp 8.313.3.1 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.7 DEFINITIONS:**

[~~**A. Accrual basis of accounting:** Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected. The expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.~~

~~**B. 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.~~

~~**C. Governmental institution:** A provider of services owned and operated by a federal, state or local governmental agency.~~

~~**D. 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.~~

~~**E. Applicable credits:** Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the federal government to finance hospital activities or service operations should be treated as applicable credits.~~

~~**F. 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 HCA shall be the usual and customary rate charged to all patients.~~

~~**G. 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.~~

~~**H. 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.~~

~~**I. 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.~~

~~**J. 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.~~

~~**K. 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.~~

~~**L. 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.~~

~~**M. Facility:** The actual physical structure in which services are provided.~~

~~**N. Owner:** The entity holding legal title to the facility.~~]

**A. Definitions beginning with "A":**

**(1) "Accrual basis of accounting"** means 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.

**(2) "Allocable costs"** means 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.

**(3) "Applicable credits"** means those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the federal government to finance hospital activities or service operations should be treated as applicable credits.

**B. Definitions beginning with "B": [RESERVED]**

**C. Definitions beginning with "C":**

**(1) "Cash basis of accounting"** means 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.

**(2) "Charges"** means 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 HCA shall be the usual and customary rate charged to all patients.

**(3)** "**Cost center"** means 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.

**(4)** "**Cost finding"** means 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.

**D. Definitions beginning with "D": [RESERVED]**

**E. Definitions beginning with "E": [RESERVED]**

**F. Definitions beginning with "F": "Facility"** means the actual physical structure in which services are provided.

**G. Definitions beginning with "G":**

**(1) "General service cost centers"** means 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.

**(2)** "**Governmental institution"** means a provider of services owned and operated by a federal, state or local governmental agency.

**H. Definitions beginning with "H": [RESERVED]**

**I. Definitions beginning with "I":** "**Inpatient cost centers**" means cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

**J. Definitions beginning with "J": [RESERVED]**

**K. Definitions beginning with "K": [RESERVED]**

**L. Definitions beginning with "L": [RESERVED]**

**M. Definitions beginning with "M": [RESERVED]**

**N. Definitions beginning with "N": [RESERVED]**

**O. Definitions beginning with "O": "Owner"** means the entity holding legal title to the facility.

**P. Definitions beginning with "P": "Provider"** means 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.

**Q. Definitions beginning with "Q": [RESERVED]**

**R. Definitions beginning with "R": [RESERVED]**

**S. Definitions beginning with "S": "Special service cost centers"** is 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.

**T. Definitions beginning with "T": [RESERVED]**

**U. Definitions beginning with "U": [RESERVED]**

**V. Definitions beginning with "V": [RESERVED]**

**W. Definitions beginning with "W": [RESERVED]**

**X. Definitions beginning with "X": [RESERVED]**

**Y. Definitions beginning with "Y": [RESERVED]**

**Z. Definitions beginning with "Z": [RESERVED]**

[8.313.3.7 NMAC - Rp 8.313.3.7 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.8 MISSION STATEMENT:** [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.313.3.8 NMAC - Rp 8.313.3.8 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.9 COST RELATED REIMBURSEMENT OF [~~ICF-MR~~] ICF/IID FACILITIES:** The New Mexico title XIX program makes reimbursement for appropriately licensed and certified intermediate care facilities for [~~the mentally retarded~~] individuals with intellectual disabilities as outlined in this material.

[8.313.3.9 NMAC - Rp 8.313.3.9 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.10 GENERAL REIMBURSEMENT POLICY:** The HCA will [~~reimbursement ICF/MR~~] reimburse ICF/IID facilities the lower of the following, effective September 1, 1990:

**A.** billed charges;

**B.** the prospective rate as constrained by the ceilings established by the HCA as described in this plan.

[8.313.3.10 NMAC - Rp 8.313.3.10 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.11 DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS AND SETTING OF PROSPECTIVE RATES:**

**A. Adequate cost data:**

**(1)** Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will

be acceptable, subject to appropriate treatment of capital expenditures.

**(2)** The cost finding method to be used by [~~ICF-MR~~] ICF/IID providers will be the step-down method. This method recognizes that services rendered by certain non-revenue producing departments or centers are utilized by certain other non-revenue producing centers. All cost of non-revenue producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the non-revenue producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greater amount of expense will be allocated first.

**B.** Reporting year: For the purpose of determining a prospective per diem rate related to cost for [~~ICF-MR~~] ICF/IID services, the reporting year is the provider's fiscal year. The provider will submit a cost report each fiscal year.

**C.** Cost reporting:

**(1)** At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable costs (financial and statistical report) on the N.M. title XIX cost reporting form. This cost report must be submitted on an annual basis to [~~MAD~~] the medical assistance division (MAD) or its designee within the time frames specified by medicare. [~~ICFs-MR~~] ICF/IIDs will not be granted an extension to the cost report filing time frames. Failure to file a cost report within the specified time frames will result in suspension of title XIX payments.

**(2)** In the case of a change of ownership, the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The HCA will withhold the last two month's payment to the previous provider as security against any outstanding obligations to the HCA. The provider must notify the HCA 60 days prior to any change of ownership.

**D.** Retention of records:

**(1)** Each [~~ICF-MR~~] ICF/IID provider shall maintain financial and statistical records of the period covered by a cost report for a period of not less than four years following the date of submittal of the 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.

**(1)** Desk audit: Each cost report submitted will be subject to a comprehensive desk audit by the state audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the state agency.

**(2)** Field audit: Field audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost. The field audit will also determine whether the expenses attributable to such proper items of cost were reasonably and accurately determined. 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 the medicare provider reimbursement manual (PRM 15-1) 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~~] ICF/IID service.

**(2)** Costs of routine services: Allowable costs shall include all items of expense that providers incur to provide routine

services, known as operating costs. Operating costs include such things as:

**(a)** regular room;

**(b)** dietary and nursing services;

**(c)** medical and surgical supplies (including but not limited to syringes, catheters, ileostomy, and colostomy supplies);

**(d)** use of equipment and facilities;

**(e)** general services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas;

**(f)** items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans;

**(g)** items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, bandaids, laxatives and fecal softeners, aspirin, antacids, OTC ointments, and tongue depressors;

**(h)** items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen administration equipment, and other durable equipment;

**(i)** special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician;

**(j)** laundry services other than for personal clothing;

**(k)** oxygen for emergency use--the HCA 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:

**(i)** 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

**(ii)** the HCA will make payment directly to the medical equipment provider in accordance with procedures outlined in [~~medical assistance manual Section 754, medical supplies,~~] 8.324.5 NMAC, *Vision Appliances, Hearing Appliances, Durable Medical Equipment, Oxygen, Medical Supplies, Prosthetics and Orthotics* and subject to the limitations on rental payments contained in [~~that section~~] 8.324.5 NMAC.

**(l)** all services delivered in relation to active treatment, such as physical therapy, occupational therapy, speech therapy, psychology services, recreational therapy, etc.;

**(m)** managerial, administrative, professional and other services related to the providers operation and rendered in connection with patient care.

**(3)** Facility cost, for the purpose of specific limitations included in this plan, include only depreciation, lease costs, and long term interest.

**(a)** Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated life of the assets.

**(i)** The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.

**(ii)** Historical cost is the actual cost incurred in acquiring and preparing an asset for use.

**(iii)** Fair market value is the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American institute of real estate appraisers (MAI) and who is acceptable to the HCA

**(iv)** In determining the historical cost of assets where an on-going facility is purchased, the provisions of medicare provider reimbursement manual PRM 15-1 will apply.

**(v)** Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American hospital association useful lives guide.

**(b)** Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.

**(c)** Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

**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' cost reports.

**(3)** Return on equity capital.

**(4)** Other cost and expense items identified as unallowable in PRM 15-1.

**(5)** Interest paid on overpayments as per [~~MAD-702~~] 8.302.2 NMAC, *Billing for Medicaid Services*.

**(6)** Any civil monetary penalties levied in connection with licensure, certification, or fraud regulations.
[8.313.3.11 NMAC - Rp 8.313.3.11 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.12 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATES:** Prospective per diem rates will be established as follows and will be the lower of the amount calculated using the following formulas, or any applicable ceiling:

**A.** Base year:

**(1)** For implementation year one (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.

**(2)** Re-basing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as year one, year two, and year three. Since re-basing is done every three years, operating year four will again become year one.

**(3)** Costs incurred, reported, audited or desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year one will be used to re-base the prospective per diem rate. Re-basing costs in excess of one hundred and ten percent of the previous year's reported cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.

**B.** Inflation factor to recognize economic conditions and trends during the time period covered by the facility's prospective per diem rate. Pursuant to budget availability and at the HCA's discretion, an inflation factor may be used to recognize economic conditions and trends. A notice will be sent out every September informing each provider that:

**(1)** MBI will or will not be authorized for determining rates for the year; and

**(2)** the percentage increase if the MBI is authorized;

**(3)** if utilized, the index used to determine the inflation factor will be the center for medicare and medicaid services (CMS) market basket index (MBI);

**(4)** each provider's operating costs will be indexed to a mid-year point of February 28 for operating year 1;

**(5)** if utilized, the inflation factor will be the actual MBI for the previous calendar year.

**C.** Incentive to reduce increases in cost:

**(1)** As an incentive to reduce the increases in the administrative and general (A&G) and room and board (R&B) cost center, the HCA 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)] < $1.00

**(2)** Where:

A = allowable Incentive per diem

B = A&G/R&B ceiling per diem

C = allowable A&G/R&B per diem from the base year's cost report

**D.** Cost centers for rate calculation: For the purpose of rate calculation, costs will be grouped into four major cost centers. These are:

**(1)** direct patient care (DPC)

**(2)** administration and general (A&G)

**(3)** room and board (R&B)

**(4)** facility costs (FC)

**E.** Case-mix adjustment:

**(1)** In assuring the prospective reimbursement system addresses the needs of residents of [~~ICF-MR~~] ICF/IID facilities, a case mix adjustment factor will be incorporated into the reimbursement system. The case-mix index (CMI) will be used to adjust the reimbursement levels in the direct patient care cost center. The key objective of the CMI is to link reimbursement to the acuity level of residents in a facility. To accomplish this objective, the HCA utilizes level of care criteria which classify [~~ICF-MR~~] ICF/IID 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

**(2)** Using these level specific relative values, a provider specific base year CMI will be calculated. 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 x 1.077)+(B x .953)+(C x .768)]/N = CMI

**(3)** 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:

**(1)** A prospective per diem rate for each of the three levels of [~~ICF-MR~~] ICF/IID classification will be determined for each provider. Payment will be made based on the rate for the level of classification of the recipient.

**(2)** The provider's direct patient care (DPC) allowable cost will be divided by the provider's CMI to determine the cost at a value of 1.00 for the base year. The adjusted DPC is then multiplied by the relative value of the level of classification to determine the DPC component of the rate. To this, will be added the allowable A & G and R & B amount and the allowable facility cost. The formula for the rates will be as follows:

**(3)** The formula for year one is: (A1 x RV) + C1 + D + E = PR (year 1)

**(4)** The formula for year two is: [(A1 x RV) + C1) x (1 + MBI)] + D + E = PR (year 2)

**(5)** The formula for year three is: [(A2 x RV) + C2) x (1 + MBI)] + D + E = PR (year 3)

**(6)** 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.

**G.** Effective dates of prospective rates: Rates will be effective September 1 of each year for each facility.

**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 per diem plus;

**(3)** facility cost per diem as determined by using the medicare principles of reimbursement;

**(4)** 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 allowable and reasonable cost for the provider; a final prospective rate will be established at that time, and retroactive settlement will take place.

**I.** Changes of provider by sale of an existing facility: When a change of ownership occurs, the provider's prospective rate per diem will become the sum of:

**(1)** the patient care cost per diem for each level, established for the previous owner plus;

**(2)** the A&G and R&B per diem established for the previous owner; plus

**(3)** allowable facility costs determined by using the medicare principles of reimbursement.

**J.** Changes of ownership by lease of an existing facility: When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

**(1)** the patient care cost per diem for each level established for the previous owner; plus

**(2)** the A&G and R&B per diem established for the previous owner; plus

**(3)** the lower of allowable facility cost or the ceiling on lease cost as described by this plan.

**K.** Sale/leaseback of and existing facility: When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

[8.313.3.12 NMAC - Rp 8.313.3.12 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.13 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 one hundred ten percent of the median of allowable costs for the base year, indexed to 12/31 of the base year. The ceiling will then be indexed to the mid-point of year one and set. For years two and three, 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:

**(1)** No ceiling will be imposed on this cost center, except in relation to leases.

**(2)** 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~~] 12 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).

**(3)** The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective, and the reasonableness of such clauses will be determined by the inflation factor described in Subsection B of 8.313.3.12 NMAC of these regulations.

**(4)** 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 HCA the name of the appraiser, a copy of their certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the HCA.
[8.313.3.13 NMAC - Rp 8.313.3.13 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.16 CAREGIVERS CRIMINAL HISTORY SCREENING**: The MAD will reimburse providers for the medicaid portion of the billed amount that providers paid to the New Mexico [~~department of health (DOH)~~] health care authority. The following is the billing format.

[~~**A.** Each ICF-MR will pay DOH by check according to DOH regulations.~~

~~**B.** A copy of the check(s) that the ICF/IID sent to DOH will be submitted to medicaid for payment on a quarterly basis on a medicaid reimbursement voucher (available at MAD or at MAD's designee).~~]

**A.** Each ICF/IID will pay HCA via electronic payment using the authorized entity authorized by HCA.

**B.** A copy of the electronic receipt ICF/IID sent to the community based provider will be submitted to medicaid for payment on a quarterly basis on a medicaid reimbursement voucher (available at MAD or at MAD's designee).

**C.** Medicaid will only be responsible for the medicaid portion of the billed amount.

**D.** There will be a one-time charge to medicaid for fingerprinting equipment. Ongoing supplies, such as ink, rubber gloves, and other supplies, will be accounted for on the provider's cost report.
[8.313.3.16 NMAC - Rp 8.313.3.16 NMAC, 7/1/2024; A, 9/1/2026]

**8.313.3.17 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.

**B.** The filing of a request for reconsideration will not affect 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 HCA, 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~~] MAD 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~~] MAD no later than 30 days after the date of the transmittal letter.

**F.** The [~~medical assistance division~~] MAD 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~~] MAD 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~~] MAD director to the secretary, or their designee, within five days after the closing date for final submittals.

**H.** The secretary, or their designee, may secure all information and call on all expertise they believe necessary to decide the issues.

**I.** The secretary, or their designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to 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 changes to the original determination will be implemented pursuant to that decision.
[8.313.3.17 NMAC - Rp 8.313.3.17 NMAC, 7/1/2024; A, 9/1/2026]

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## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.324.7 NMAC, Sections 1, 8, 10, 12, 13, and 15, effective 9/1/2026.**

**8.324.7.1 ISSUING AGENCY:** New Mexico health care authority (HCA).
[8.324.7.1 NMAC - Rp, 8.324.7.1 NMAC, 1/1/2014; A, 7/1/2024; A, 9/1/2026]

**8.324.7.8 MISSION STATEMENT:** [~~To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.~~] We ensure that New Mexicans attain their highest level of health by providing whole-person, cost effective, accessible, and high-quality health

care and safety net services.
[8.324.7.8 NMAC - Rp, 8.324.7.8 NMAC, 1/1/2014; A, 9/1/2026]

**8.324.7.10 ELIGIBLE PROVIDERS:** Health care to a MAP eligible recipient is furnished by a variety of providers and provider groups. Reimbursement and billing for these services are administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. Providers must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the [~~HSD/ MAD~~] HCA/MAD website, on other program specific websites, and in hard copy format, information necessary to participate in health care programs administered by [~~HSD~~] HCA or its authorized agents, including program rules, billing instructions, utilization review (UR) instructions, and other pertinent material. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. Providers must contact [~~HSD~~] HCA, or its authorized agents, for answers to billing questions or any of these materials. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. The following providers are eligible to be reimbursed for providing transportation or transportation related services to MAP eligible recipients:

**A.** air ambulances certified by the state of New Mexico department of health (DOH), emergency medical services bureau;

**B.** ground ambulance services certified by the New Mexico public regulation commission (NMPRC) or by the appropriate state licensing body for out-of-state ground ambulance services, within those geographic regions in the state specifically authorized by the NMPRC;

**C.** [~~non-emergency transportation vendors (taxicab, vans and other vehicles) and certain bus services certified by the NMPRC, within those geographic regions in the state specifically authorized by the NMPRC~~] non-emergency transportation certified by the NMPRC, within those geographic regions in the state specifically authorized by the NMPRC:

**(1)** vendors (taxicab, vans and other vehicles);

**(2)** certain bus services; and

**D.** transportation network companies that have been issued a permit by the New Mexico department of transportation (DOT) that meets the requirements set forth in the Transportation Network Company Services Act. Transportation network companies' terms are defined as follows:

**(1) "transportation network company"** means a corporation, partnership, sole proprietorship or other entity that holds a permit issued pursuant to the Transportation Network Company Services Act and lawfully operating in New Mexico that uses a digital network, but which shall not be deemed to control, direct or manage the personal vehicles or transportation network company drivers that connect to its digital network except where agreed to by written contract, 65-7-2 NMSA (2016);

**(2) "digital network"** means an internet-supported application, software, program, website or system offered or utilized by a transportation network company that enables the prearrangement of transportation by passengers with transportation network company drivers.

[~~D.~~] **E.** long distance common carriers, that include buses, trains and airplanes;

[~~E.~~] **F.** certain carriers exempted or warranted by the NMPRC within those geographic regions in the state specifically authorized by the NMPRC;

[~~F.~~] **G.** lodging and meal providers; and

[~~G.~~] **H.** when services are billed to and paid by a MAD MAP coordinated services contractor authorized by [~~HSD~~] HCA, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.
[8.324.7.10 NMAC - Rp, 8.324.7.10 NMAC, 1/1/2014; A, 9/1/2026]

**8.324.7.12 COVERED SERVICES AND SERVICE LIMITATIONS:** MAD reimburses a transportation provider for transportation only when the transport is of a MAP eligible recipient and is subject to the following conditions.

**A. Free alternatives:** Alternative transportation services that can be provided free of charge include volunteers, relatives or transportation services provided by nursing facilities (NF) or other residential centers.

**B. Least costly alternatives:** MAD covers the most appropriate and least costly transportation alternatives suitable for the MAP eligible recipient's medical or behavioral health condition. If a MAP eligible recipient can use a private vehicle or public transportation, those alternatives must be used before a MAP eligible recipient can use more expensive transportation alternatives.

**C. Non-emergency transportation service:** MAD covers non-emergency transportation services for a MAP eligible recipient who has no primary transportation and who is unable to access a less costly form of public transportation except as described under non-covered services. See 8.324.7.13 NMAC.

**D. Long distance common carriers:** MAD covers long distance services furnished by a common carrier if a MAP eligible recipient must leave [~~his or her~~] their home community to receive medical or behavioral health services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through local county income support division (ISD) offices.

**E. Ground ambulance services:** MAD covers services provided by ground ambulances when:

**(1)** an emergency that requires ambulance service is certified by a physician or is documented in the provider's records as meeting emergency medical necessity criteria: terms are defined as follows:

**(a)** "emergency" is defined as a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part;

**(b)** "medical necessity" is established for ambulance services if the MAP eligible recipient's physical, or behavioral health condition is such that the use of any other method of transportation is contraindicated and would endanger the MAP eligible recipient's health.

**(2)** Scheduled, non-emergency ambulance services are ordered by a primary care provider (PCP) who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's physical, or behavioral health condition. MAD covers non-reusable items and oxygen required during transportation, if needed; coverage for these items is included in the base rate reimbursement for ground ambulance.

**F. Air ambulance services:** MAD covers services provided by air ambulances, including private airplanes, if an emergency exists and the PCP certifies the medical necessity for the service.

**(1)** An emergency that would require air over ground ambulance services is defined as a medical or behavioral health condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in one of the following:

**(a)** a MAP eligible recipient's death;

**(b)** placement of a MAP eligible recipient's health is in serious jeopardy (or with respect to a pregnant woman, the health of the woman or her unborn child);

**(c)** serious impairment of bodily functions; or

**(d)** serious dysfunction of any bodily organ or part.

**(2)** Coverage for the following is included in the base rate reimbursement for air ambulance:

**(a)** non-reusable items and oxygen required during transportation;

**(b)** professional attendants required during transportation;

**(c)** detention time or standby time; and

**(d)** use of equipment required during transportation.

**G. Lodging services:** MAD covers lodging services if a MAP eligible recipient is required to travel to receive medical services more than four hours one way and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15 days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the medical or behavioral health provider's statement of need. Authorization forms for direct payment by MAD to its lodging providers are available through local county ISD offices.

**H. Meal services:** MAD covers meals if a MAP eligible recipient is required to leave [~~his or her~~] their home community for eight hours or more to receive medical or behavioral health services. Authorization forms for direct payment to MAD meal providers by MAD are available through local county ISD offices.

**I. Coverage for attendants:** MAD covers transportation, meals and lodging for one attendant if the medical necessity for the attendant is certified in writing justified by the MAP eligible recipient's medical provider or the MAP eligible recipient who is receiving medical service is under 18 years of age. The attendant for a child under 18 years of age should be the parent or legal guardian. If the medical appointment is for an adult MAP eligible recipient, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the adult MAP eligible recipient.

**J. Coverage for medicaid home and community-based services waiver recipients:** Transportation of a medicaid waiver recipient to or from a provider of waiver service is only covered when the service is a physical therapy, occupational therapy, speech therapy or a behavioral health service.

[8.324.7.12 NMAC - Rp, 8.324.7.12 NMAC, 1/1/2014; A, 9/1/2026]

**8.324.7.13 NONCOVERED SERVICES:** Transportation services are subject to the same limitations

and coverage restrictions that exist for other MAD services. See [~~8.301.3~~] 8.310.2 NMAC. Payments for transportation for any non-covered service is subject to retroactive recoupment.

**A.** MAD does not pay to transport a MAP eligible recipient to a medical or behavioral health service or provider that is not covered under the MAD program.

**B.** A provider will not be eligible to seek reimbursement from a MAP eligible recipient if the provider fails to notify the MAP eligible recipient or [~~his or her~~] their authorized representative that the service is not covered by MAD. See 8.302.1 NMAC.

**C.** Transportation services will not be provided when other alternatives are available, such as mail delivery or free delivery. Retail pharmacies may mail, ship or deliver prescriptions to medicaid recipients consistent with applicable state and federal statutes and regulations.

**D.** MAD does not pay to transport a MAP eligible recipient to a pharmacy provider with the exception of justice-involved MAP eligible recipients who are released from incarceration at a correctional facility within the first seven days of release.

[8.324.7.13 NMAC - Rp, 8.324.7.13 NMAC, 1/1/2014; A, 9/1/2026]

**8.324.7.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:** All MAD services are subject to utilization review (UR) for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made or after payment is made. See [~~8.302.5~~] 8.310.2 NMAC. The provider must contact [~~HSD~~] HCA or its authorized agents to request UR instructions. It is the provider's responsibility to access these instructions or request hard copies to be provided, to understand the information, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a MAD fee-for-service coordinated services contractor, the provider must follow that contractor's instructions for authorization of services.

**A. Prior authorization:** Certain procedures or services may require prior authorization from MAD or its designee. Services for which prior authorization is received remain subject to UR at any time during the payment process.

**B. Referrals for travel outside the home community:**

**(1)** If a MAP eligible recipient must travel over [~~65~~] 120 miles from [~~his or her~~] their home community to receive medical or behavioral health care, the transportation provider must obtain and retain in its billing records written verification from the referring provider or the service provider containing the following:

**(a)** the medical, behavioral health or diagnostic service for which the MAP eligible recipient is being referred;

**(b)** the name of the out of community provider; and

**(c)** justification that the medical or behavioral health care is not available in the home community.

**(2)** Referrals and referral information must be obtained from a MAD provider. For continued out-of-community, non-emergency transportation, the required information must be obtained every [~~six~~] 12 months.

**C. Eligibility determination:** Prior authorization does not guarantee that individuals are eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and determine if the MAP eligible recipient has other health insurance.

[8.324.7.15 NMAC - Rp, 8.324.7.15 NMAC, 1/1/2014; A, 9/1/2026]

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## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.326.2 NMAC, Sections 1, 8, 10, 12, 14 and 16, effective 9/1/2026.**

**8.326.2.1 ISSUING AGENCY:** New Mexico health care authority (HCA).

[8.326.2.1 NMAC - Rp 8.326.2.1 NMAC, 7/1/2024; A, 9/1/2026]

**8.326.2.8 MISSION STATEMENT:** [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.326.2.8 NMAC - Rp 8.326.2.8 NMAC, 7/1/2024; A, 9/1/2026]

**8.326.2.10 ELIGIBLE PROVIDERS:**

**A.** Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are eligible to be reimbursed for providing case management services:

**(1)** state agencies in New Mexico providing case management services to individuals with developmental disabilities;

**(2)** Indian tribal governments and Indian health service clinics; and

**(3)** community-based agencies in New Mexico that do not furnish adult day habilitation, work related services, or adult residential services to individuals with developmental disabilities.

**B.** Agency qualification: Agencies must be

certified by the developmental disabilities division of the HCA and meet the MAD approved standards for agencies providing case management for adults who are developmentally disabled.

**(1)** Agencies must demonstrate knowledge of the community to be served, its populations and its resources, including methods for accessing those resources.

**(2)** Agencies must demonstrate direct experience in case management services and success in serving the target population.

**(3)** Agencies must have personnel management skills, including written policies and procedures that include recruitment, selection, retention and termination of case managers, job descriptions for case managers, grievance procedures, hours of work, holidays, vacations, leaves of absence, wage scales and benefits, conduct and other general rules.

**C.** Case manager qualifications: Case managers employed by case management agencies must possess the education, skills, abilities and experience to perform case management service for adults with developmental disabilities. At a minimum, case managers must meet one of the following qualifications:

**(1)** 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 skills development, such as psychology, sociology, speech, gerontology, education, counseling, social work, human development or any other study of services related field and one [~~(1)~~] year of experience working with individuals with developmental disabilities;

**(2)** licensed as a registered or licensed practical nurse with one year of experience working with individuals with developmental disabilities; or

**(3)** In the event that there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers:

**(a)** associate's degree and a minimum of three years of experience working with individuals with developmental disabilities; or

**(b)** high school graduation or general educational development (GED) test and a minimum of four [~~(4)~~] years of experience working with individuals with developmental disabilities.

**(4)** Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[8.326.2.10 NMAC - Rp 8.326.2.10 NMAC, 7/1/2024; A, 9/1/2026]

**8.326.2.12 ELIGIBLE RECIPIENTS:**

**A.** Case management services are available for eligible medicaid recipients that meet all of the following criteria:

**(1)** 21 years of age or older;

**(2)** resident of the state of New Mexico;

**(3)** meet the state definition of an individual with a developmental disability;

**(4)** placement on the list for developmental disability services by the community services team (CST) of the developmental disabilities division of the HCA;

**(5)** resides outside a medicaid certified intermediate care facility for [~~the mentally retarded (ICF-MR)~~] individuals with intellectual disabilities (ICF/IID); and

**(6)** not a participant in a home and community-based services waiver program.

**B.** Information on the individual is gathered by the CST and used to complete an assessment and assign an "urgency of need" priority. Recipients assigned a priority one are individuals who are in danger of becoming homeless or victims of abuse, if suitable placement services are not received. Recipients assigned a priority two are individuals whose condition will deteriorate without placement. Recipients assigned a priority three are individuals who could benefit from case management but whose present condition is acceptable.

[8.326.2.12 NMAC - Rp 8.326.2.12 NMAC, 7/1/2024; A, 9/1/2026]

**8.326.2.14 NONCOVERED SERVICES:** Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See [~~8.301.3 NMAC, General Noncovered Services~~] 8.310.2 NMAC, *General Benefit Description*. Medicaid does not cover the following specific activities:

**A.** services furnished to individuals who are not medicaid eligible or do not meet the definition of an eligible recipient for these case management services;

**B.** services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

**C.** formal educational or vocational services which relate to traditional academic subjects or job training;

**D.** outreach activities to contact potential recipients, except as described under covered services;

**E.** all administrative activities conducted after the initial 90 day referral by the CST;

**F.** institutional discharge planning which must be furnished by the institution prior to discharge;

**G.** services which are furnished under other categories, such as therapies, transportation or counseling;

**H.** services which are considered by MAD or its designee to

be excessive based on the condition of the recipient;

**I.** monitoring the quality of service provider agencies;

**J.** resource development; and

**K.** testifying before governmental bodies, such as city council meetings or legislative committees, even if on behalf of the recipient.

[8.326.2.14 NMAC - Rp 8.326.2.14 NMAC, 7/1/2024; A, 9/1/2026]

**8.326.2.16 PRIOR APPROVAL AND UTILIZATION REVIEW:** All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See [~~8.302.5 NMAC, Prior Approval and Utilization Review~~] 8.310.2 NMAC, *General Benefit Description*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

**A.** Prior approval: Certain procedures or services which are part of the recipients' plan of care can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

**B.** Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

**C.** Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, Reconsideration of Utilization Review Decisions.

[8.326.2.16 NMAC - Rp 8.326.2.16 NMAC, 7/1/2024; A, 9/1/2026]

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## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.370.3 NMAC, Sections 1, 10 and 14, effective 9/1/2026.**

**8.370.3.1 ISSUING AGENCY:** New Mexico health care authority (HCA), division of health improvement, health facility licensing and certification bureau.

[8.370.3.1 NMAC - Rp, 8.370.3.1 NMAC, 01/28/2025; A, 9/1/2026]

**8.370.3.10 LICENSURE FEE SCHEDULE:** Rates shall be charged, as indicated in the fee schedule shown in this section, upon initial and renewal application for an annual license and prior to issuance of a second temporary license. The fee for the first temporary license is included in the initial application fee. This rule applies to both initial and renewal of health facility licenses.

**A. Hospitals:** general hospitals, limited hospitals, children's psychiatric hospitals, special hospitals to include orthopedic, children's, psychiatric, alcohol & drug abuse treatment, rehabilitation, and other special hospital as identified;

| Facility Types: | Rate Per License | Term limit |
|---|---|---|
| Hospital bed rate | $12.00 per bed | Annually |

**B. Assisted living facilities:**

| Facility Types: | Rate Per License | Term limit |
|---|---|---|
| Assisted living base assessment rate | $300.00 | Annually |

**C. Long-term care facilities:**

| Facility Types: | Rate Per License |
|---|---|
| skilled nursing facilities | $12.00 per bed |
| intermediate care facilities | $12.00 per bed |
| intermediate care facilities for [~~mentally retarded~~] individuals with intellectual disabilities | $12.00 per bed |

**D. Outpatient health facilities:**

| Facility Types: | Rate Per License |
|---|---|
| Health facilities providing outpatient medical services | $300.00 |
| community mental health centers | $300.00 |
| free standing hospice | $300.00 |
| home health agency | $300.00 |
| diagnostic and treatment center | $300.00 |
| limited diagnostic and treatment center | $300.00 |

| | |
|---|---|
| rural health clinic | $300.00 |
| Infirmary | $300.00 |
| new or innovative clinic | $300.00 |
| ambulatory surgical center | $300.00 |

**E. Other health facilities:**

| **Facility Types:** | **Rate Per License** |
|---|---|
| Facilities providing services for end stage renal disease | $300.00 |
| services for end state renal disease | $300.00 |
| renal transplantation center | $300.00 |
| renal dialysis center | $300.00 |
| renal dialysis facility | $300.00 |
| self dialysis unit | $300.00 |
| special purpose renal dialysis facility | $300.00 |
| In home and inpatient hospice care | $300.00 |
| Home health agencies | $300.00 |
| Rural emergency hospital | $300.00 |
| Freestanding birth centers | $300.00 |
| Adult accredited residential treatment center | $600.00 bi-annually + $25 per bed |
| Boarding homes: | $300.00 |

**F. Adult Day Care:** Facilities providing adult day care and services for less than 24 hours a day for three or more clients in accordance with 8.370.20 NMAC

| **Facility Types:** | **Rate Per License** |
|---|---|
| Adult day care facilities | $300.00 |

[8.370.3.10 NMAC - Rp, 8.370.3.10 NMAC, 1/28/2025; A, 9/1/2026]

**8.370.3.14 RELATED REGULATIONS:** The following is a list of regulations regarding licensure of health facilities within the jurisdiction of the licensing authority.

**A.** Requirements for acute care, limited services and special hospitals, New Mexico health care authority, 8.370.12 NMAC.

**B.** Requirements for long term care facilities, New Mexico health care authority, 8.370.16 NMAC.

**C.** Requirements for facilities providing outpatient medical services and infirmaries, New Mexico health care authority, 8.370.18 NMAC.

**D.** Requirements for in-home and inpatient hospice care, New Mexico health care authority, 8.370.19 NMAC.

**E.** Requirements for adult day care facilities, New Mexico health care authority, 8.370.20 NMAC.

**F.** Requirements for intermediate care facilities for [~~the mentally retarded~~] individuals with intellectual disabilities, New Mexico health care authority, 8.371.2 NMAC.

**G.** Requirements for end stage renal disease facilities, New Mexico health care authority, 8.370.24 NMAC.

**H.** Requirements for assisted living facilities for Adults, New Mexico health care authority, 8.370.14 NMAC.

**I.** Requirements for home health agencies, New Mexico health care authority, 8.370.22 NMAC.

**J.** Requirements for rural emergency hospitals, New Mexico health care authority, 8.370.13 NMAC.

**K.** Requirements for boarding homes, New Mexico health care authority, 8.370.15 NMAC.

**L.** Requirements for clinical laboratory improvement amendments, 42 CFR, Part 493, New Mexico health care authority.

**M.** Requirements for community mental health centers, New Mexico health care authority, 8.321.6 NMAC.

**N.** Requirements for freestanding birth centers, New Mexico health care authority, 8.370.17 NMAC.

**O.** crisis triage centers, New Mexico health care authority, 8.321.11 NMAC.

[8.370.3.14 NMAC - Rp, 8.370.3.14 NMAC, 1/28/2025; A, 9/1/2026]

## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.370.4 NMAC, Sections 1, 7, 16 and 30, effective 9/1/2026.**

**8.370.4.1 ISSUING AGENCY:** New Mexico health care authority (HCA).
[8.370.4.1 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.370.4.7 DEFINITIONS:** For purposes of these regulations the following shall apply.

~~**[A. "Abuse"** means any act or failure to act performed intentionally, knowingly or recklessly that causes or is likely to cause harm to a resident, including:~~

~~**(1)** physical contact that harms or is likely to harm a resident of a health facility;~~

~~**(2)** inappropriate use of a physical restraint, isolation, or medication that harms or is likely to harm a resident;~~

~~**(3)** inappropriate use of a physical or chemical restraint, medication, or isolation as punishment or in conflict with a physician's order;~~

~~**(4)** medically inappropriate conduct that causes or is likely to cause physical harm to a resident;~~

~~**(5)** medically inappropriate conduct that causes or is likely to cause great psychological harm to a resident;~~

~~**(6)** an unlawful act, a threat or menacing conduct directed toward a resident that results and might reasonably be expected to result in fear or emotional or mental distress to a resident.~~

~~**B. "Exploitation"** of a resident consists of the act or process, performed intentionally, knowingly, or recklessly, of using a resident's property for another person's profit, advantage or benefit without legal entitlement to do so.~~

~~**C. "Serious physical harm"** means physical harm of a type that causes a temporary or permanent physical loss of a bodily member or organ or functional loss of a bodily member or organ or of a major life activity.~~

~~**D. "Serious psychological harm"** means psychological harm that causes a temporary or permanent mental or emotional incapacitation or that causes an obvious behavioral change or obvious physical symptoms or that requires psychological or psychiatric treatment or care.~~

~~**E. "Health facility"** means any health care entity identified in the Public Health Act which requires state licensure in order to provide health services.~~

~~**F. "Intermediate sanction"** means a measure imposed on a facility for a violation(s) of applicable licensing laws and regulations other than license revocation, suspension, denial of renewal of license or loss of certification.~~

~~**G. "Licensing authority"** means the New Mexico health care authority.~~

~~**H. "Neglect"** means subject to the resident's right to refuse treatment and subject to the caregiver's right to exercise sound medical discretion, the grossly negligent:~~

~~**(1)** failure to provide any treatment, service, care, medication or item that is necessary to maintain the health or safety of a resident;~~

~~**(2)** failure to take any reasonable precaution that is necessary to prevent damage to the health or safety of a resident;~~

~~**(3)** failure to carry out a duty to supervise properly or control the provision of any treatment, care, good, service or medication necessary to maintain the health or safety of a resident.~~

~~**I. "Class A deficiency"** means:~~

~~**(1)** any abuse or neglect of a patient, resident, or client by a facility employee or for which the facility is responsible which results in death, or serious physical or psychological harm; or~~

~~**(2)** any exploitation of a patient, resident, or client by a facility employee or for which the facility is responsible in which the value of the property exceeds $1,500; or~~

~~**(3)** a violation or group of violations of applicable regulations, which results in death, serious physical harm, or serious psychological harm to a patient, resident, or client.~~

~~**J. "Class B deficiency"** means:~~

~~**(1)** any abuse or neglect of a patient, resident, or client by a facility employee or for which the facility is responsible; or~~

~~**(2)** any exploitation of a patient, resident, or client by a facility employee or for which the facility is responsible in which the value of the property exceeds $100, but is less than $1,500; or~~

~~**(3)** a violation or group of violations of applicable regulations which present a potential risk of injury or harm to any patient, resident or client.~~

~~**K. "Class C deficiency"** means:~~

~~**(1)** a violation or a group of violations of applicable regulations as cited by surveyors from the licensing authority which have the potential to cause injury or harm to any patient, resident or client if the violation is not corrected; or~~

~~**(2)** any exploitation of a patient, resident, or client by a facility employee in which the value of the property was less than $100.~~]

**A. Definitions beginning with "A": "Abuse"** means any act or failure to act performed intentionally, knowingly or recklessly that causes or is likely to cause harm to a resident, including:

**(1)** physical contact that harms or is likely to harm a resident of a health facility;

**(2)** inappropriate use of a physical restraint, isolation, or medication that harms or is likely to harm a resident;

**(3)** inappropriate use of a physical or chemical restraint, medication, or isolation as punishment or in conflict with a physician's order;

**(4)** medically inappropriate conduct that causes or is likely to cause physical harm to a resident;

**(5)** medically inappropriate conduct that causes or is likely to cause great psychological harm to a resident;

**(6)** an unlawful act, a threat or menacing conduct directed toward a resident that results and might reasonably be expected to result in fear or emotional or mental distress to a resident.

**B. Definitions beginning with "B": [RESERVED]**

**C. Definitions beginning with "C":**

**(1) "Class A deficiency"** means:

**(a)** any abuse or neglect of a patient, resident, or client by a facility employee or for which the facility is responsible which results in death, or serious physical or psychological harm; or

**(b)** any exploitation of a patient, resident, or client by a facility employee or for which the facility is responsible in which the value of the property exceeds $1,500; or

**(c)** a violation or group of violations of applicable regulations, which results in death, serious physical harm, or serious psychological harm to a patient, resident, or client.

**(2) "Class B deficiency"** means:

**(a)** any abuse or neglect of a patient, resident, or client by a facility employee or for which the facility is responsible; or

**(b)** any exploitation of a patient, resident, or client by a facility employee or for which the facility is responsible in which the value of the property exceeds $100, but is less than $1,500; or

**(c)** a violation or group of violations of applicable regulations which present a potential risk of injury or harm to any patient, resident or client.

**(3) "Class C deficiency"** means:

**(a)** a violation or a group of violations of applicable regulations as cited by surveyors from the licensing authority which have the potential to cause injury or harm to any patient, resident or client if the violation is not corrected; or

**(b)** any exploitation of a patient, resident, or client by a facility employee in which the value of the property was less than $100.

**D. Definitions beginning with "D": [RESERVED]**

**E. Definitions beginning with "E": "Exploitation"** of a resident consists of the act or process, performed intentionally, knowingly, or recklessly, of using a resident's property for another person's profit, advantage or benefit without legal entitlement to do so.

**F. Definitions beginning with "F": [RESERVED]**

**G. Definitions beginning with "G": [RESERVED]**

**H. Definitions beginning with "H": "Health facility"** means any health care entity identified in the Public Health Act which requires state licensure in order to provide health services.

**I. Definitions beginning with "I": "Intermediate sanction"** means a measure imposed on a facility for a violation(s) of applicable licensing laws and regulations other than license revocation, suspension, denial of renewal of license or loss of certification.

**J. Definitions beginning with "J": [RESERVED]**

**K. Definitions beginning with "K": [RESERVED]**

**L. Definitions beginning with "L": "Licensing authority"** means the New Mexico health care authority.

**M. Definitions beginning with "M": [RESERVED]**

**N. Definitions beginning with "N": "Neglect"** means subject to the resident's right to refuse treatment and subject to the caregiver's right to exercise sound medical discretion, the grossly negligent:

**(1)** failure to provide any treatment, service, care, medication or item that is necessary to maintain the health or safety of a resident;

**(2)** failure to take any reasonable precaution that is necessary to prevent damage to the health or safety of a resident;

**(3)** failure to carry out a duty to supervise properly or control the provision of any treatment, care, good, service or medication necessary to maintain the health or safety of a resident.

**O. Definitions beginning with "O": [RESERVED]**

**P. Definitions beginning with "P": [RESERVED]**

**Q. Definitions beginning with "Q": [RESERVED]**

**R. Definitions beginning with "R": [RESERVED]**

**S. Definitions beginning with "S":**

**(1) "Serious physical harm"** means physical harm of a type that causes a temporary or permanent physical loss of a bodily member or organ or functional loss of a bodily member or organ or of a major life activity.

**(2) "Serious psychological harm"** means psychological harm that causes a temporary or permanent mental or emotional incapacitation or that causes an obvious behavioral change or obvious physical symptoms or that requires psychological or psychiatric treatment or care.

**T. Definitions beginning with "T": [RESERVED]**

**U. Definitions beginning with "U": [RESERVED]**

**V. Definitions beginning with "V": [RESERVED]**

**W. Definitions beginning with "W":**

**[RESERVED]**

**X. Definitions beginning with "X": [RESERVED]**

**Y. Definitions beginning with "Y": [RESERVED]**

**Z. Definitions beginning with "Z": [RESERVED]**

[8.370.4.7 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.370.4.16 LICENSED CAPACITY AND FACILITY PENALTY RATES:**

**A. Licensed capacity:** For purposes of calculating the amount of civil monetary penalties, the facility's licensed capacity is determined by one of the following two methods, depending on the type of facility:

**(1)** For a facility having a capacity stated on its license, that capacity amount is employed in calculating the daily civil monetary penalty imposed by the licensing authority.

**(2)** For facilities not having a capacity reflected on the license, the licensed capacity will be based on the average number of patients or clients receiving services from the facility each day for the five working days preceding the day deficiencies were noted during the survey or investigation by the licensing authority.

**B. Facility penalty rates:** For purposes of calculation of the amount of civil monetary penalties the following penalty rates for facilities are as listed below:

TYPE OF FACILITY PENALTY RATE

**(1)** Adult residential facilities:

**(a)** adult residential shelter care home $10.00

**(b)** community residential facility for developmentally disabled individuals $10.00

**(c)** residential treatment home $10.00

**(d)** boarding home $10.00

**(e)** halfway home $10.00

**(f)** new or innovative programs $10.00

**(2)** Adult day care facilities:

**(a)** adult day care center $10.00

**(b)** adult day care home $10.00

**(c)** new or innovative programs $10.00

**(3)** General and special hospitals:

**(a)** rehabilitation hospital $10.00

**(b)** general hospital $10.00

**(c)** psychiatric hospital $10.00

**(d)** specialty hospitals $10.00

**(e)** rural primary care hospital $10.00

**(4)** Long term care facilities:

**(a)** intermediate care facility (ICF) $10.00

**(b)** medicaid certified nursing facilities (NF) $10.00

**(c)** skilled nursing facility (SNF) $10.00

**(d)** intermediate care facility for [~~the mentally retarded (ICF/MR)~~] individuals with intellectual disabilities (ICF/IID) $10.00

**(5)** Facilities providing outpatient medical services and infirmaries:

**(a)** ambulatory surgical center $65.00

**(b)** diagnostic and treatment center $10.00

**(c)** limited diagnostic and treatment center $10.00

**(d)** rural health clinic $10.00

**(e)** infirmary $10.00

**(f)** new or innovative clinic $10.00

**(6)** Other facilities:

**(a)** home health agency $10.00

**(b)** end stage renal disease $65.00

**(c)** hospice $10.00

[8.370.4.16 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.370.4.30 RELATED REGULATION AND CODES:** Health facilities subject to these regulations are also subject to other regulations, codes and standards as the same may from time to time be amended as follows:

**A.** Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

**B.** Requirements for long term care facilities, New Mexico health care authority, 8.370.16 NMAC.

**C.** Requirements for general and special hospitals, New Mexico health care authority, 8.370.12 NMAC.

**D.** Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

**E.** Requirements for adult day care facilities, New Mexico health care authority, 8.370.20 NMAC.

**F.** Requirements for adult residential care facilities, New Mexico health care authority, 8.370.14 NMAC.

**G.** Requirements for inhome and inpatient hospice care, New Mexico health care authority, 8.370.19 NMAC.

**H.** Requirements for home health agencies, New Mexico health care authority, 8.370.24 NMAC.

**I.** Requirements for facilities providing outpatient medical services and infirmaries, New Mexico health care authority, 8.370.18 NMAC.

**J.** Requirements for intermediate care facilities for [~~the mentally retarded~~] individuals with intellectual disabilities, New Mexico health care authority, 8.370.22 NMAC.

**K.** Requirements for end stage renal disease facilities, New Mexico health care authority, 8.370.26 NMAC.

[8.370.4.30 NMAC - N, 7/1/2024; A, 9/1/2026]

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## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.370.9 NMAC, Sections 1, 2 and 7, effective 9/1/2026.**

**8.370.9.1 ISSUING AGENCY:** New Mexico health care authority (HCA).
[8.370.9.1 NMAC - N, 07/01/2024; A, 9/1/2026]

**8.370.9.2 SCOPE:** This rule is applicable to persons, organizations or legal entities to include each: adult day care center, adult day care home, adult assisted living facility, ambulatory surgical center, diagnostic and treatment center, end stage renal disease facility, general, acute, special and limited service hospitals, home health agency, hospice facility, hospital infirmary, intermediate care facility for [~~the mentally retarded or the intellectually and developmentally disabled~~] individuals with intellectual disabilities, limited diagnostic and treatment center, nursing facility, skilled nursing facility, and rural health clinic.
[8.370.9.2 NMAC - N, 07/01/2024; A, 9/1/2026]

**8.370.9.7 DEFINITIONS**:
[~~**A. "Abuse"** means:~~
~~**(1)** knowingly, intentionally, and without justifiable cause inflicting physical pain, injury or mental anguish;~~
~~**(2)** the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of a person;~~
~~**(3)** sexual abuse, including criminal sexual contact, incest, and criminal sexual penetration; or~~
~~**(4)** verbal abuse, including profane, threatening, derogatory, or demeaning language, spoken or conveyed with the intent to cause mental anguish.~~
~~**B. "Bureau"** means the health care authority, division of health improvement, health facility licensing and certification bureau.~~
~~**C. "Case manager"** means the staff person designated to coordinate and monitor the individual service plan for persons receiving services.~~
~~**D. "Complaint"** means any report, assertion, or allegation of abuse, neglect, or exploitation of, or injuries of unknown origin to, a consumer made by a reporter to the incident management system, and includes any reportable incident that a licensed health care facility is required to report under applicable law.~~
~~**E. "CMS"** means the centers for medicare and medicaid services.~~
~~**F. "Consumer"** means any person who engages the professional services of a medical or other health professional on an inpatient or outpatient basis, or person requesting services from a hospital.~~
~~**G. "Division"** means the health care authority, division of health improvement.~~
~~**H. "Employee"** means:~~
~~**(1)** any person whose employment or contractual service with a licensed health care facility which includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that licensed health care facility; or~~
~~**(2)** any compensated persons such as employees, contractors and employees of contractors; or guardianship service providers or case management entities that provide services to people with developmental disabilities; or administrators or operators of facilities who are routinely on site.~~
~~**I. "Exploitation"** means an unjust or improper use of a person's money or property for another person's profit or advantage, financial or otherwise.~~
~~**J. "Immediate access"** means physical or in person direct and unobstructed access, to electronic or other access needed by employees, consumers, family members or legal guardian to the licensed health care facility's incident management reporting procedures or access to the division's incident report form.~~
~~**K. "Immediate reporting"** means reporting that is done as soon as practicable and no later than 24 hours from knowledge of the incident.~~
~~**L. "Immediate jeopardy"** means a provider's noncompliance with one or more requirements of medicaid or medicare participation, which causes or is likely to cause, serious injury, harm, impairment, or death to a consumer.~~
~~**M. "Incident"** means any known, alleged or suspected event of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.~~
~~**N. "Incident management system"** means the written policies and procedures adopted or developed by the licensed health facility for reporting abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.~~
~~**O. "Incident report**

~~**form"** means the reporting format issued by the division for the reporting of incidents or complaints.~~

~~**P. "ISP"** means a consumer's individual service plan.~~

~~**Q. "Licensed health care facilities"** means any organization licensed by the authority for the following services: adult day care center, assisted living facility, ambulatory surgical center, diagnostic and treatment center, end stage renal disease facility, general, acute, special and limited service hospitals, home health agency, hospice facility, hospital infirmary, intermediate care facility for the mentally retarded or intellectually and developmentally disabled, limited diagnostic and treatment center, nursing facility, skilled nursing facility, rural health clinic.~~

~~**R. "Mental anguish"** means a relatively high degree of mental pain and distress that is more than mere disappointment, anger, resentment or embarrassment, although it may include all of these, and is objectively manifested by the recipient of care or services by significant behavioral or emotional changes or physical symptoms.~~

~~**S. "Neglect"** means the failure of the caretaker to provide basic needs of a person, such as clothing, food, shelter, supervision and care for the physical and mental health of that person. Neglect causes, or is likely to cause, harm to a person.~~

~~**T. "Quality assurance"** means a systematic approach to the continuous study and improvement of the efficiency and efficacy of organizational, administrative and clinical practices in meeting the needs of persons served as well as achieving the licensed health care facility's mission, values and goals.~~

~~**U. "Quality improvement system"** means the adopted or developed licensed health care facility's policies and procedures for reviewing and documenting all alleged incidents of abuse, neglect, exploitation, injuries of unknown origin, or other reportable incidents for the continuous study and improvement of the efficiency and efficacy of organizational, administrative and preventative practices in employee training and reporting.~~

~~**V. "Reportable incident"** means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation.~~

~~**W. "Reporter"** means any person who or any entity that reports possible abuse, neglect or exploitation to the division.~~

~~**X. "Restraints"** means use of a mechanical device, or chemical restraints imposed, for the purposes of discipline or convenience, to physically restrict a consumer's freedom of movement, performance of physical activity, or normal access to his body.~~

~~**Y. "Revocation"** means a type of sanction making a license null and void through its cancellation.~~

~~**Z. "Sanction"** means a measure imposed by the authority on a licensed program, pursuant to these requirements, in response to a finding of deficiency, with the intent of obtaining increased compliance with these requirements.~~

~~**AA. "Substantiated"** means the verification of a complaint based upon a preponderance of reliable evidence obtained from an appropriate investigation of a complaint of abuse, neglect, or exploitation.~~

~~**BB. "Suspension"** means a temporary cancellation of a license pending an appeal, hearing or correction of the deficiency. During a suspension the provider's medicare or medicaid agreement is not in effect.~~

~~**CC. "Training curriculum"** means the instruction manual or pamphlet adopted or developed by the licensed health facility containing policies and procedures for reporting abuse, neglect, misappropriation of consumers' property or other reportable incidents.~~

~~**DD. "Unsubstantiated"** means that the complaint or incident could not be verified based upon a preponderance of reliable evidence obtained from an appropriate investigation of a complaint of abuse, neglect, or exploitation.~~

~~**EE. "Volunteer"** means any person who works without compensation for a licensed health care facility whose services includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that licensed health care facility.~~]

**A. Definitions beginning with "A": "Abuse"** means:

**(1)** knowingly, intentionally, and without justifiable cause inflicting physical pain, injury or mental anguish;

**(2)** the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of a person;

**(3)** sexual abuse, including criminal sexual contact, incest, and criminal sexual penetration; or

**(4)** verbal abuse, including profane, threatening, derogatory, or demeaning language, spoken or conveyed with the intent to cause mental anguish.

**B. Definitions beginning with "B": "Bureau"** means the health care authority, division of health improvement, health facility licensing and certification bureau.

**C. Definitions beginning with "C":**

**(1) "Case manager"** means the staff person designated to coordinate and monitor the individual service plan for persons receiving services.

**(2) "CMS"** means the centers for medicare and medicaid services.

**(3) "Complaint"** means any report,

assertion, or allegation of abuse, neglect, or exploitation of, or injuries of unknown origin to, a consumer made by a reporter to the incident management system, and includes any reportable incident that a licensed health care facility is required to report under applicable law.

**(4) "Consumer"** means any person who engages the professional services of a medical or other health professional on an inpatient or outpatient basis, or person requesting services from a hospital.

**D. Definitions beginning with "D": "Division"** means the health care authority, division of health improvement.

**E. Definitions beginning with "E":**

**(1) "Employee"** means:

**(a)** any person whose employment or contractual service with a licensed health care facility which includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that licensed health care facility; or

**(b)** any compensated persons such as employees, contractors and employees of contractors; or guardianship service providers or case management entities that provide services to people with developmental disabilities; or administrators or operators of facilities who are routinely on site.

**(2) "Exploitation"** means an unjust or improper use of a person's money or property for another person's profit or advantage, financial or otherwise.

**F. Definitions beginning with "F": [RESERVED]**

**G. Definitions beginning with "G": [RESERVED]**

**H. Definitions beginning with "H": [RESERVED]**

**I. Definitions beginning with "I":**

**(1) "Immediate access"** means physical or in person direct and unobstructed access, to electronic or other access needed by employees, consumers, family members or legal guardian to the licensed health care facility's incident management reporting procedures or access to the division's incident report form.

**(2) "Immediate jeopardy"** means a provider's noncompliance with one or more requirements of medicaid or medicare participation, which causes or is likely to cause, serious injury, harm, impairment, or death to a consumer.

**(3) "Immediate reporting"** means reporting that is done as soon as practicable and no later than 24 hours from knowledge of the incident.

**(4) "Incident"** means any known, alleged or suspected event of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.

**(5) "Incident management system"** means the written policies and procedures adopted or developed by the licensed health facility for reporting abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.

**(6) "Incident report form"** means the reporting format issued by the division for the reporting of incidents or complaints.

**(7) "ISP"** means a consumer's individual service plan.

**J. Definitions beginning with "J": [RESERVED]**

**K. Definitions beginning with "K": [RESERVED]**

**L. Definitions beginning with "L": "Licensed health care facilities"** means any organization licensed by the authority for the following services: adult day care center, assisted living facility, ambulatory surgical center, diagnostic and treatment center, end stage renal disease facility, general, acute, special and limited service hospitals, home health agency, hospice facility, hospital infirmary, intermediate care facility for individuals with intellectual disabilities, limited diagnostic and treatment center, nursing facility, skilled nursing facility, rural health clinic.

**M. Definitions beginning with "M": "Mental anguish"** means a relatively high degree of mental pain and distress that is more than mere disappointment, anger, resentment or embarrassment, although it may include all of these, and is objectively manifested by the recipient of care or services by significant behavioral or emotional changes or physical symptoms.

**N. Definitions beginning with "N": "Neglect"** means the failure of the caretaker to provide basic needs of a person, such as clothing, food, shelter, supervision and care for the physical and mental health of that person. Neglect causes, or is likely to cause, harm to a person.

**O. Definitions beginning with "O": [RESERVED]**

**P. Definitions beginning with "P": [RESERVED]**

**Q. Definitions beginning with "Q":**

**(1) "Quality assurance"** means a systematic approach to the continuous study and improvement of the efficiency and efficacy of organizational, administrative and clinical practices in meeting the needs of persons served as well as achieving the licensed health care facility's mission, values and goals.

**(2) "Quality improvement system"** means the adopted or developed licensed health care facility's policies and procedures for reviewing and documenting all alleged incidents of abuse, neglect, exploitation, injuries of unknown origin, or other reportable incidents for the continuous study and improvement of the efficiency and efficacy of organizational, administrative and preventative practices in employee training and reporting.

**R. Definitions beginning with "R":**

**(1) "Reportable incident"** means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected

death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation.

**(2)** **"Reporter"** means any person who or any entity that reports possible abuse, neglect or exploitation to the division.

**(3)** **"Restraints"** means use of a mechanical device, or chemical restraints imposed, for the purposes of discipline or convenience, to physically restrict a consumer's freedom of movement, performance of physical activity, or normal access to his body.

**(4)** **"Revocation"** means a type of sanction making a license null and void through its cancellation.

**S. Definitions beginning with "S":**

**(1)** **"Sanction"** means a measure imposed by the authority on a licensed program, pursuant to these requirements, in response to a finding of deficiency, with the intent of obtaining increased compliance with these requirements.

**(2)** **"Substantiated"** means the verification of a complaint based upon a preponderance of reliable evidence obtained from an appropriate investigation of a complaint of abuse, neglect, or exploitation.

**(3)** **"Suspension"** means a temporary cancellation of a license pending an appeal, hearing or correction of the deficiency. During a suspension the provider's medicare or medicaid agreement is not in effect.

**T. Definitions beginning with "T": "Training curriculum"** means the instruction manual or pamphlet adopted or developed by the licensed health facility containing policies and procedures for reporting abuse, neglect, misappropriation of consumers' property or other reportable incidents.

**U. Definitions beginning with "U": "Unsubstantiated"** means that the complaint or incident could not be verified based upon a preponderance of reliable evidence obtained from an appropriate investigation of a complaint of abuse, neglect, or exploitation.

**V. Definitions beginning with "V": "Volunteer"** means any person who works without compensation for a licensed health care facility whose services includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that licensed health care facility.

**W. Definitions beginning with "W": [RESERVED]**

**X. Definitions beginning with "X": [RESERVED]**

**Y. Definitions beginning with "Y": [RESERVED]**

**Z. Definitions beginning with "Z": [RESERVED]**

[8.370.9.7 NMAC - N, 07/01/2024; A, 9/1/2026]

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## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.370.16 NMAC, Sections 1, 7, 35 and 51, effective 9/1/2026.**

**8.370.16.1 ISSUING AGENCY:** New Mexico health care authority (HCA).

[8.370.16.1 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.370.16.7 DEFINITIONS:** For purposes of these regulations the following shall apply:

**A. Definitions beginning with "A":**

**(1)** **"Abuse"** means any act or failure to act performed intentionally, knowingly, or recklessly that causes or is likely to cause harm to a resident, including but not limited to:

**(a)** Physical contact that harms or is likely to harm a resident of a care facility.

**(b)** Inappropriate use of physical restraint, isolation, or medication that harms or is likely to harm a resident.

**(c)** Inappropriate use of a physical or chemical restraint, medication or isolation as punishment or in conflict with a physician's order.

**(d)** Medically inappropriate conduct that causes or is likely to cause physical harm to a resident.

**(e)** Medically inappropriate conduct that causes or is likely to cause great psychological harm to a resident.

**(f)** An unlawful act, a threat or menacing conduct directed toward a resident that results and might reasonably be expected to result in fear or emotional or mental distress to a resident.

**(2)** **"Ambulatory"** means able to walk without assistance.

**(3)** **"Applicant"** means the individual who, or organization which, applies for a license. If the applicant is an organization, then the individual signing the application on behalf of the organization, must have authority from the organization. The applicant must be the owner.

**B. Definitions beginning with "B": [RESERVED]**

**C. Definitions beginning with "C": [RESERVED]**

**D. Definitions beginning with "D":**

**(1)** **"Developmental disability"** means [~~mental retardation~~] intellectual disability or a related condition, such as cerebral palsy, epilepsy or autism, but excluding mental illness and infirmities of aging, which is:

**(a)** manifested before the individual reaches age 22;

**(b)** likely to continue indefinitely; and

**(c)** results in substantial functional limitations in three or more of the

following areas of major life activity:

**(i)** self-care;

**(ii)** understanding and use of language;

**(iii)** learning;

**(iv)** mobility;

**(v)** self-direction;

**(vi)** capacity for independent living; and

**(vii)** economic self-sufficiency.

**(2) "Dietitian"** means a person who is eligible for registration as a dietitian by the commission on dietetic registration of the American dietetic association under its requirements in effect on January 17, 1982.

**(4) "Direct supervision"** means supervision of an assistant by a supervisor who is present in the same building as the assistant while the assistant is performing the supervised function.

**E. Definitions beginning with "E": "Exploitation"** of a patient/client/resident consists of the act or process, performed intentionally, knowingly, or recklessly, of using a patient/client's property, including any form of property, for another persons profit, advantage or benefit.

**(1) Exploitation** includes but is not limited to:

**(a)** manipulating the patient/client resident by whatever mechanism to give money or property to any facility staff or management member;

**(b)** misappropriation or misuse of monies belonging to a resident or the unauthorized sale, or transfer or use of a patient/client/residents property;

**(c)** loans of any kind from a patient/client/resident to family, operator or families of staff or operator;

**(d)** accepting monetary or other gifts from a patient /client/resident or their family with a value in excess of $25 and not to exceed a total value of $300 in one year.

**(e)** All gifts received by facility operators, their families or staff of the facility must be documented and acknowledged by person giving the gift and the recipient.

**(2) Exception:** Testamentary gifts, such as wills, are not, per se, considered financial exploitation.

**F. Definitions beginning with "F":**

**(1) "Facility"** means a nursing home subject to the requirements of these regulations.

**(2) "Full-time"** means at least an average of 37.5 hours each week devoted to facility business.

**G. Definitions beginning with "G": [RESERVED]**

**H. Definitions beginning with "H": [RESERVED]**

**I. Definitions beginning with "I":**

**(1) "Intermediate care facility"** means a nursing home, which is licensed by the authority as an intermediate care facility to provide intermediate nursing care.

**(2) "Intermediate nursing care"** means a basic care consisting of physical, emotional, social and other rehabilitative services under periodic medical supervision. This nursing care requires the skill of a licensed nurse for observation and recording of reactions and symptoms, and for supervision of nursing care. Most of the residents have long-term illnesses or disabilities which may have reached a relatively stable plateau. Other residents whose conditions are stabilized may need medical and nursing services to maintain stability. Essential supportive consultant services are provided in accordance with these regulations.

**J. Definitions beginning with "J": [RESERVED]**

**K. Definitions beginning with "K": [RESERVED]**

**L. Definitions beginning with "L":**

**(1) "Licensed practical nurse"** means a person licensed as a licensed practical nurse under Section 61-3-1 through Section 61-3-30 NMSA 1978, Nursing Practice Act.

**(2) "Licensee"** means the person(s) who, or organization which, has an ownership, leasehold, or similar interest in the long term care facility and in whose name a license has been issued and who is legally responsible for compliance with these regulations.

**M. Definitions beginning with "M": "Mobile non-ambulatory"** means unable to walk without assistance, but able to move from place to place with the use of a device such as a walker, crutches, a wheelchair or a wheeled platform.

**N. Definitions beginning with "N":**

**(1) "Non-ambulatory"** means unable to walk without assistance.

**(2) "Non-mobile"** means unable to move from place to place.

**(3) "Nurse"** means registered nurse or licensed practical nurse.

**(4) "Nurse practitioner (certified)"** means a registered professional nurse who meets the requirements for licensure as established under Sections 61-3-1 through 61-3-30 NMSA 1978, Nursing Practice Act.

**O. Definitions beginning with "O": [RESERVED]**

**P. Definitions beginning with "P":**

**(1) "Personal care"** means personal assistance, supervision and a suitable activities program. In addition:

**(a)** the services provided are chiefly characterized by the fact that they can be provided by personnel other than those trained in medical or allied fields. The services are directed toward personal assistance, supervision, and protection;

**(b)** the medical service emphasizes a preventive approach of periodic

medical supervision by the resident's physician as part of a formal medical program that will provide required consultation services and also cover emergencies; and

**(c)** the dietary needs of residents are met by the provision of adequate general diet or by therapeutic, medically prescribed diets.

**(2)** **"Pharmacist"** means a person registered as a pharmacist under Section 61-11-1 NMSA 1978, the Pharmacy Act.

**(3)** **"Physical therapist"** means a person licensed to practice physical therapy under Sections 61-12D-1 to Section 61-12D-19 NMSA 1978, the Physical Therapy Act.

**(4)** **"Physician"** means a person licensed to practice medicine or osteopathy as defined by Section 61-6-1 NMSA 1978, the Medical Practice Act, and Sections 61-10-1 through 61-10-21 NMSA 1978, the Osteopathic Medicine Act.

**(5)** **"Physician's extender"** means a person who is a physician's assistant or a nurse practitioner acting under the general supervision and direction of a physician.

**(6)** **"Physician's assistant"** means a person licensed under Section 61-6-7 through 61-6-10 NMSA 1978, the Physician Assistant Act, to perform as a physician's assistant.

**(7)** **"Practitioner"** means a physician, dentist or podiatrist or other person permitted by New Mexico law to distribute, dispense and administer a controlled substance in the course of professional practice.

**Q. Definitions beginning with "Q": [RESERVED]**

**R. Definitions beginning with "R":**

**(1)** **"Registered nurse"** means a person who holds a certificate of registration as a registered nurse under Section 61-3-1 to 61-3-30 NMSA 1978, the Nursing Practice Act.

**(2)** **"Resident"** means a person cared for or treated in any facility on a 24-hour basis irrespective of how the person has been admitted to the facility.

**S. Definitions beginning with "S":**

**(1)** **"Skilled nursing facility"** means a nursing home which is licensed by the authority to provide skilled nursing services.

**(2)** **"Skilled nursing care"** means those services furnished pursuant to a physician's orders which:

**(a)** require the skills of professional personnel such as registered or licensed practical nurses; and

**(b)** are provided either directly by or under the supervision of these personnel;

**(c)** in determining whether a service is skilled nursing care, the following criteria shall be used:

**(i)** the service would constitute a skilled service where the inherent complexity of a service prescribed for a resident is such that it can be safely and effectively performed only by or under the supervision of professional personnel;

**(ii)** the restoration potential of a resident is not the deciding factor in determining whether a service is to be considered skilled or unskilled. Even where full recovery or medical improvement is not possible, skilled care may be needed to prevent, to the extent possible, deterioration of the condition or to sustain current capacities; and

**(iii)** a service that is generally unskilled would be considered skilled where, because of special medical complications, its performance or supervision or the observation of the resident necessitates the use of skilled nursing personnel.

**(3)** **"Specialized consultation"** means the provision of professional or technical advice, such as systems analysis, crisis resolution or in-service training, to assist the facility in maximizing service outcomes.

**(4)** **"Supervision"** means at least intermittent face-to-face contact between supervisor and assistant, with the supervisor instructing and overseeing the assistant, but does not require the continuous presence of the supervisor in the same building as the assistant.

**T. Definitions beginning with "T": "Tour of duty"** means a portion of the day during which a shift of resident care personnel are on duty.

**U. Definitions beginning with "U": "Unit dose drug delivery system"** means a system for the distribution of medications in which single doses of medications are individually packaged and sealed for distribution to residents.

**V. Definitions beginning with "V": "Variance"** means an act on the part of the licensing authority to refrain from pressing or enforcing compliance with a portion or portions of these regulations for an unspecified period of time where the granting of a variance will not create a danger to the health, safety, or welfare of residents or staff of a long term care facility, and is at the sole discretion of the licensing authority.

**W. Definitions beginning with "W": "Waive/waivers"** means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health, safety, or welfare of residents and staff are not in danger. Waivers are issued at the sole discretion of the licensing.

**X. Definitions beginning with "X": [RESERVED]**

**Y. Definitions beginning with "Y": [RESERVED]**

**Z. Definitions beginning with "Z": [RESERVED]**

[8.370.16.7 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.370.16.35 OTHER LIMITATIONS ON ADMISSION:**

**A.** Persons requiring unavailable services: Persons who require services which the facility does not provide or make available shall not be admitted or retained.

**B.** Communicable diseases:

**(1)** Restriction: No person suspected of having a disease in a communicable state shall be admitted or retained unless the facility has the means to manage the condition.

**(2)** Isolation techniques: Persons suspected of having a disease in a communicable state shall be managed according to isolation techniques for use in hospitals, published by the U.S. department of health and human services, public health services, center for disease control, or with comparable methods as developed by facility policies.

**(3)** Reportable diseases: Suspected diseases reportable by law shall be reported to the local public health agency and the division of health, bureau of community health and prevention within time frames specified by these agencies.

**C.** Destructive residents: Residents who are known to be destructive of property, self-destructive, disturbing or abusive to other residents, or suicide, shall not be admitted or retained, unless the facility has and uses sufficient resources to appropriately manage and care for them.

**D.** Developmental disabilities: No person who has a primary diagnosis of developmental disability may be admitted to a facility unless the facility is certified as in intermediate care facility for [~~the mentally retarded~~] individuals with intellectual disabilities, except that a person who has a developmental disability and who requires skilled nursing care services may be admitted to a skilled nursing facility if approved for such level of care by the state developmental disability authority.

**E.** Mental illness: No person with a primary diagnosis of mental illness may be admitted to long term care facilities except that a person who has a diagnosis of mental illness and who requires skilled nursing care services may be admitted to a long term care facility if approved for such level of care by-the state mental illness authority.

**F.** Admission seven days a week: With prior approval, facilities shall take reasonable steps to admit residents seven days a week. [8.370.16.35 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.370.16.51 NURSING STAFF:** In addition to the requirements of 8.370.16.50 NMAC, the following conditions shall be met:

**A.** Assignments: There shall be sufficient nursing service personnel assigned to care for the specific needs of each resident on each tour of duty. Those personnel shall be briefed on the condition and appropriate care of each resident prior to beginning hands-on care of residents.

**B.** Relief personnel: Facilities shall obtain qualified relief personnel.

**C.** Records, weekly schedules: Weekly time schedules shall be planned at least one week in advance, shall be posted and dated, shall indicate the names and classifications of nursing personnel and relief personnel assigned on each nursing unit for each tour of duty, and shall be updated as changes occur.

**D.** Staff meetings: Meetings shall be held at least quarterly for the nursing personnel to brief them on new developments, raise issues relevant to the service, and for such other purposes as are pertinent.

**E.** [~~Twenty-four (24)~~] 24 hour coverage: All facilities shall have at least one nursing staff person on duty at all times.

**F.** Staffing patterns: The assignment of the nursing personnel required by this subsection to each tour of duty shall be sufficient to meet each resident's needs and implement each resident's comprehensive care plan.

**(1)** Nursing department personnel means, the director of nursing, the assistant director of nursing, nursing department directors, licensed nursing personnel, certified nursing assistants, nursing assistants who have completed 16 hours or more of orientation and demonstrated competency and restorative nursing assistants.

**(2)** The director of nursing, the assistant director of nursing, and nursing department directors may be counted towards the minimum staffing requirements only for the time spent on the shift providing direct resident care services.

**(a)** A skilled nursing facility or facility that offers intermediate and skilled nursing shall maintain a nursing department minimum staffing level of two and a half hours per patient day calculated on a seven day average.

**(b)** An intermediate care facility shall maintain a nursing department minimum staffing level of two and three-tenths (2.3) hours per patient day calculated on a seven day average.

**(c)** Within one hour of shift change, facilities shall post the number of nursing personnel on duty in a conspicuous and consistent location for public review. Shifts are informally defined as the day shift, evening shift, and night shift. Employees working variations of these shifts shall be included within the shift count where a majority of the hours fall. Example: For a facility with 100 patients, two and three-tenths (2.3) hours per patient day averages one nursing department employee on duty for approximately every 10 to 11 patients. For a facility with 100 patients, two and five tenths (2.5) hours per patient day averages one nursing department employee for every nine to 10 patients. These are daily averages that will vary from shift to shift so that actual staffing

might approximate:

| | |
|---|---|
| 2.3 Hours per patient day | |
| 2.5 Hours per patient day | |
| Day Shift | One staff for eight patients |
| | One staff for seven patients |
| Evening Shift | One staff for 10 patients |
| | One staff for 10 patients |
| Night Shift | One staff for 13 patients |
| | One staff for 12 patients |

[8.370.16.51 NMAC - N, 7/1/2024; A, 9/1/2026]

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## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.371.2 NMAC, Sections 1, 2, 6-9, 11, 12, 15, 20, 21, 26, 28, 33, 37, 62, 69, 78, 91 and 96, effective 9/1/2026.**

**8.371.2.1 ISSUING AGENCY:** New Mexico health care authority (HCA).
[8.371.2.1 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.2 SCOPE:** These regulations apply to any facility providing services as outlined by these regulations and any facility which by federal regulation must be licensed by the state of New Mexico to obtain or maintain full or partial permanent or temporary federal funding as an intermediate care facility for [~~the mentally retarded (ICF/MR)~~] individuals with intellectual disabilities (ICF/IID). All facilities licensed after the effective date of these regulations shall be limited to a capacity of no greater than four clients, except as provided herein in Subsection C of 8.371.2.21 NMAC.
[8.371.2.2 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.6 OBJECTIVE:** The purpose of these regulations is to:

**A.** Establish professional minimum standards for [~~ICF/MR~~] ICF/IID facilities in the state of New Mexico which were formerly licensed under regulations governing long term care facilities.

**B.** Monitor [~~ICF/MR~~] ICF/IID facilities with these regulations through surveys to identify any areas which could be dangerous or harmful to the clients or staff.

**C.** Encourage the maintenance of [~~ICF/MR~~] ICF/IID facilities that provide quality services which maintain or improve the health and quality of life to the clients.

**D.** Expand the availability of [~~ICF/MR~~] ICF/IID programs to assure timely placement for persons who need residential services.

**E.** Assure integrated active treatment programs, homelike living arrangements, and consumer protections for [~~ICF/MR~~] ICF/IID clients.

**F.** Promote access and availability statewide.

**G.** Recognize specialized [~~ICF/MR~~] ICF/IID programs to serve individuals with intense needs.
[8.371.2.6 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.7 GENERAL DEFINITIONS:** For purposes of these regulations the following shall apply:

[~~**A. "Active treatment"** means the consistent, aggressive, accountable, and continuous application of competent interactions between caregivers and persons with developmental disabilities whom they serve in structured and unstructured settings alike, directed toward each individual's developmental progress through the life cycle.~~

~~**B. "Applicant"** means the individual who, or organization which, applies for a license. If the applicant is an organization, then the individual signing the application on behalf of the organization, must have authority from the organization. The applicant must be the owner.~~

~~**C. "Client"** means an individual living in and receiving services from an ICF/MR licensed pursuant to these regulations.~~

~~**D. "Community supports"** means community services such as recreational activities, social clubs, religious services, employment services, and transportation, as well as other supportive services that are available to the general population and not designated to serve only persons with disabilities.~~

~~**E. "Dietitian"** means a person eligible or required to be licensed under the New Mexico Nutrition and Dietetics Practice Act, Sections 61-7A-1 through 61-7A-15 NMSA 1978, effective July 1, 1989.~~

~~**F. "Facility"** means a building or buildings in which clients live and ICF/MR services are provided and is licensed or required to be licensed pursuant to these regulations.~~

~~**G. "Governing body"** means the governing authority of a facility which has the ultimate responsibility for all planning, direction, control and management of the activities and functions of a facility licensed pursuant to these regulations.~~

~~**H. "ICF/MR"** means an intermediate care facility that provides food, shelter, health or rehabilitative and active treatment for the mentally retarded or persons with related conditions.~~

~~**I. "License"** means the document issued by the licensing authority pursuant to these regulations granting the legal right to operate for a specified period of time, not to exceed one year.~~

~~**J. "Licensee"** means the person(s) who, or organization which, has an ownership, leasehold or similar interest in the ICF/MR facility and in whose name a license has been issued and who is legally responsible for compliance with these regulations.~~

~~**K. "Licensing authority"** means the New Mexico health care authority.~~

~~**L. "NMSA"** means the New Mexico Statutes Annotated 1978 compilation and all the revisions and compilations thereof.~~

~~**M. "Nurse"** is an~~

~~individual who is currently licensed/ registered in the state of New Mexico.~~

~~**N. "Occupational therapist"** is an individual who is eligible for certification by the American occupational therapy association or another comparable body.~~

~~**O. "Physical therapist"** is an individual who is eligible for certification as a physical therapist by the American physical therapy association or another comparable body.~~

~~**P. "Plan of correction"** means the plan submitted by the licensee or representative of the licensee addressing how and when deficiencies identified at time of a survey will be corrected.~~

~~**Q. "Policy"** means a statement of principle that guides and determines present and future decisions and actions.~~

~~**R. "Premises"** means all parts of buildings, grounds, and equipment of a facility.~~

~~**S. "Procedure"** means the action(s) that must be taken in order to implement a policy.~~

~~**T. "Psychologist"** is an individual who has at least a master's degree in psychology from an accredited school.~~

~~**U. "Social worker"** means a person required to be licensed under the Social Work Practice Act Sections 61-31-1 through 61-31-25 NMSA 1978.~~

~~**V. "Speech language pathologist or audiologist"** is an individual who is eligible for a certificate of clinical competence in speech-language pathology or audiology granted by the American speech-language hearing association or another comparable body or who meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.~~

~~**W. "U/L approved"** means approved for safety by the national underwriters laboratory.~~

~~**X. "Training and habilitation services"** means the training and services which are provided to a client intended to aid the intellectual, sensorimotor, and emotional development of that client.~~

~~**Y. "Variance"** means an act on the part of the licensing authority to refrain from pressing or enforcing compliance with a portion or portions of these regulations for an unspecified period of time where the granting of a variance will not create a danger to the health, safety, or welfare of clients or staff of a facility, and is at the sole discretion of the licensing authority.~~

~~**Z. "Waive/waiver"** means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health, safety, or welfare of the clients and staff are not in danger. Waivers are issued at the sole discretion of the licensing authority.~~]

**A. Terms beginning with the letter "A":**

**(1) "Active treatment"** means the consistent, aggressive, accountable, and continuous application of competent interactions between caregivers and persons with developmental disabilities whom they serve in structured and unstructured settings alike, directed toward each individual's developmental progress through the life cycle.

**(2) "Applicant"** means the individual who, or organization which, applies for a license. If the applicant is an organization, then the individual signing the application on behalf of the organization, must have authority from the organization. The applicant must be the owner.

**B. Terms beginning with the letter "B": [RESERVED]**

**C. Terms beginning with the letter "C":**

**(1) "Client"** means an individual living in and receiving services from an ICF/IID licensed pursuant to these regulations.

**(2) "Community supports"** means community services such as recreational activities, social clubs, religious services, employment services, and transportation, as well as other supportive services that are available to the general population and not designated to serve only persons with disabilities.

**D. Terms beginning with the letter "D": "Dietitian"** means a person eligible or required to be licensed under the New Mexico Nutrition and Dietetics Practice Act, Sections 61-7A-1 through 61-7A-15 NMSA 1978, effective July 1, 1989.

**E. Terms beginning with the letter "E": [RESERVED]**

**F. Terms beginning with the letter "F": "Facility"** means a building or buildings in which clients live and ICF/IID services are provided and is licensed or required to be licensed pursuant to these regulations.

**G. Terms beginning with the letter "G": "Governing body"** means the governing authority of a facility which has the ultimate responsibility for all planning, direction, control and management of the activities and functions of a facility licensed pursuant to these regulations.

**H. Terms beginning with the letter "H": [RESERVED]**

**I. Terms beginning with the letter "I": "ICF/IID"** means an intermediate care facility that provides food, shelter, health or rehabilitative and active treatment for individuals with intellectual disabilities or persons with related conditions.

**J. Terms beginning with the letter "J": [RESERVED]**

**K. Terms beginning with the letter "K": [RESERVED]**

**L. Terms beginning with the letter "L":**

**(1) "License"** means the document issued by the licensing authority pursuant to these regulations granting the legal right to operate for a specified period of time, not to exceed one year.

**(2) "Licensee"** means the person(s) who, or organization which, has an ownership, leasehold or similar interest in the ICF/IID facility and in whose name a license has been issued and who is legally responsible for

compliance with these regulations.

**(3) "Licensing authority"** means the New Mexico health care authority.

**M. Terms beginning with the letter "M": [RESERVED]**

**N. Terms beginning with the letter "N":**

**(1) "NMSA"** means the New Mexico Statutes Annotated 1978 compilation and all the revisions and compilations thereof.

**(2) "Nurse"** is an individual who is currently licensed/registered in the state of New Mexico.

**O. Terms beginning with the letter "O": "Occupational therapist"** is an individual who is eligible for certification by the American occupational therapy association or another comparable body.

**P. Terms beginning with the letter "P":**

**(1) "Physical therapist"** is an individual who is eligible for certification as a physical therapist by the American physical therapy association or another comparable body.

**(2) "Plan of correction"** means the plan submitted by the licensee or representative of the licensee addressing how and when deficiencies identified at time of a survey will be corrected.

**(3) "Policy"** means a statement of principle that guides and determines present and future decisions and actions.

**(4) "Premises"** means all parts of buildings, grounds, and equipment of a facility.

**(5) "Procedure"** means the action(s) that must be taken in order to implement a policy.

**(6) "Psychologist"** is an individual who has at least a master's degree in psychology from an accredited school.

**Q. Terms beginning with the letter "Q": [RESERVED]**

**R. Terms beginning with the letter "R": [RESERVED]**

**S. Terms beginning with the letter "S":**

**(1) "Social worker"** means a person required to be licensed under the Social Work Practice Act Sections 61-31-1 through 61-31-25 NMSA 1978.

**(2) "Speech language pathologist or audiologist"** is an individual who is eligible for a certificate of clinical competence in speech-language pathology or audiology granted by the American speech-language hearing association or another comparable body or who meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

**T. Terms beginning with the letter "T": "Training and habilitation services"** means the training and services which are provided to a client intended to aid the intellectual, sensorimotor, and emotional development of that client.

**U. Terms beginning with the letter "U": "U/L approved"** means approved for safety by the national underwriters laboratory.

**V. Terms beginning with the letter "V": "Variance"** means an act on the part of the licensing authority to refrain from pressing or enforcing compliance with a portion or portions of these regulations for an unspecified period of time where the granting of a variance will not create a danger to the health, safety, or welfare of clients or staff of a facility, and is at the sole discretion of the licensing authority.

**W. Terms beginning with the letter "W": "Waive/ waiver"** means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health, safety, or welfare of the clients and staff are not in danger. Waivers are issued at the sole discretion of the licensing authority.

**X. Terms beginning with the letter "X": [RESERVED]**

**Y. Terms beginning with the letter "Y": [RESERVED]**

**Z. Terms beginning with the letter "Z": [RESERVED]**

[8.371.2.7 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.8 STANDARD OF COMPLIANCE:** The degree of compliance required throughout these regulations is designated by the use of the words "shall" or "must" or "may". "Shall" or "must" means mandatory. "May" means permissive. The use of the words "adequate", "proper", and other similar words means the degree of compliance that is generally accepted throughout the professional field by those who provide [~~ICF/MR~~] ICF/IID services to the public in facilities governed by these regulations.

[8.371.2.8 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.9 [~~ICF/MR~~] ICF/IID FACILITY AND SCOPE OF SERVICES PROVIDED:** The [~~ICF/MR~~] ICF/IID provides active treatment in the least restrictive setting and includes all needed services for [~~mentally retarded individuals~~] individuals with intellectual disabilities or persons with related conditions whose mental or physical condition require services on a regular basis that are above the level of a residential or room and board setting and can only be provided in a facility which is equipped and staffed to provide the appropriate services.

[8.371.2.9 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.11 INITIAL LICENSURE PROCEDURES:** The following procedures must be followed by the applicant for initial licensure of an [~~ICF/MR~~] ICF/IID facility.

**A.** Initial phase: These regulations should be thoroughly understood by the applicant and used as a reference for design of a new building or renovation or addition to an existing building for licensure as an [~~ICF/MR~~] ICF/IID facility pursuant to these regulations. Prior to starting construction, renovations,

or additions to an existing building the applicant of the proposed facility shall:

**(1)** advise the licensing authority of intention to open a [~~ICF/MR~~] ICF/IID facility pursuant to these regulations;

**(2)** submit a complete set of construction documents (blueprints) for the total building;

**(3)** blueprints will be reviewed by the licensing authority for compliance with current licensing regulations, building and fire codes;

**(4)** if blue prints or plans are approved the licensing authority will advise the applicant that construction may begin.

**B.** Construction phase: During the construction of a new building or renovations or additions to an existing building, the applicant must coordinate with the licensing authority and submit any changes to the blueprints or plans for approval before making such changes.

**C.** Licensing phase: Prior to completion of construction, renovation or addition to an existing building the applicant will submit to the licensing authority the following:

**(1)** Application form:

**(a)** will be provided by the licensing authority;

**(b)** all information requested on the application must be provided;

**(c)** will be printed or typed;

**(d)** will be dated and signed;

**(e)** will be notarized.

**(2)** Fees: All applications for licensure must be accompanied by the required fee.

**(a)** Fees must be in the form of a certified check, money order, personal or business check made payable to the state of New Mexico.

**(b)** Fees are non-refundable.

**(3)** Zoning and building approval:

**(a)** All initial applications must be accompanied with written zoning approval from the appropriate authority (city, county, or municipality).

**(b)** All initial applications must be accompanied with written building approval (certificate of occupancy) from the appropriate authority (city, county, or municipality).

**(4)** Fire authority approval: All initial applications must be accompanied with written approval of the fire authority having jurisdiction.

**(5)** New Mexico environment department approval: All initial applications must be accompanied by written approval of the environmental improvement division for the following:

**(a)** private water supply, if applicable;

**(b)** private waste or sewage disposal, if applicable;

**(c)** kitchen approval.

**(d)** Exception: Facilities utilizing the kitchen as a training site for clients to develop personal skills in meal planning and preparation may be exempt from this requirement if the New Mexico environment department waives the requirement and a letter of exemption is on file in the facility.

**(6)** Copy of appropriate drug permit issued by the state board of pharmacy.

**(7)** Initial survey: Upon receipt of a properly completed application with all supporting documentation as outlined above an initial survey of the proposed facility shall be scheduled by the licensing authority.

**(8)** Issuance of license: Upon completion of the initial survey and determination that the facility is in compliance with these regulations the licensing authority shall issue a license.

[8.371.2.11 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.12 LICENSES:**

**A.** Annual license: An annual license is issued for a one year period to an [~~ICF/MR~~] ICF/IID facility which has met all requirements of these regulations.

**B.** Temporary license: The licensing authority may, at its sole discretion, issue a temporary license prior to the initial survey or when the licensing authority finds partial compliance with these regulations.

**(1)** A temporary license shall cover a period of time, not to exceed 120 days, during which the facility must correct all specified deficiencies.

**(2)** In accordance with Subsection D of Section 24-1-5 NMSA 1978, no more than two consecutive temporary licenses shall be issued.

**C.** Amended license: A licensee must apply to the licensing authority for an amended license when there is a change of administrator/director, or when there is a change of name for the facility

**(1)** Application must be on a form provided by the licensing authority.

**(2)** Application must be accompanied by the required fee for amended license.

**(3)** Application must be submitted within 10 working days of the change.

[8.371.2.12 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.15 NON-TRANSFERABLE RESTRICTION ON LICENSE:** A license shall not be transferred by assignment or otherwise to other persons or locations. The license shall be void and must be returned to the licensing authority when any one of the following situations occur:

**A.** ownership of the facility changes;

**B.** the facility changes location;

**C.** licensee of the facility changes;

**D.** The facility discontinues operation.

**E.** A facility wishing to continue operation as a licensed [~~ICF/MR~~] ICF/IID facility under circumstances found in Subsections A through D above must submit an application for initial licensure in accordance with Section 11 of these regulations at least 30 days prior to the anticipated change.
[8.371.2.15 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.20 CURRENTLY LICENSED FACILITIES:** Any facility currently licensed on the date these regulations are promulgated and which provides the services prescribed under these regulations, but which fails to meet all building requirements may continue to be licensed as an [~~ICF/MR~~] ICF/IID.

**A.** Variance may be granted for those building requirements the facility cannot meet provided the variances granted will not create a hazard to the health, safety and welfare of the clients and staff, and;

**B.** The building requirements for which variances are granted cannot be corrected without an unreasonable expense to the facility, and

**C.** Variances granted will be recorded and made a permanent part of the facility file.

**D.** Facilities currently licensed for more than four clients may not increase their capacity.
[8.371.2.20 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.21 NEW FACILITY:** A new facility may be opened in an existing building or a newly constructed building.

**A.** If opened in an existing building a variance may be granted for those building requirements the facility cannot meet under the same criteria outlined in Subsections A, B and C of 8.371.2.20 NMAC, if not in conflict with existing building and fire codes. This is at the sole discretion of the licensing authority.

**B.** A new facility opened in a newly constructed building must meet all requirements of these regulations.

**C.** A new facility may not be licensed for more than four clients. Exception: [~~ICF/MR~~] ICF/IID facilities may be licensed for a maximum capacity of six clients based upon a written plan that must be submitted to the licensing authority prior to the facility's licensure. Approval of the plan is in the discretion of the licensing authority. The plan must demonstrate the following:

**(1)** The anticipated facility service benefits to the client population.

**(2)** How the facility's services will promote, independence, active treatment and community supports.

**(3)** How the facility's services will address the needs and protections of the proposed clients.
[8.371.2.21 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.26 REPORTS AND RECORDS REQUIRED TO BE ON FILE IN THE FACILITY:** Each facility licensed pursuant to these regulations must keep the following reports and records on file and make them available for review upon request of the licensing authority.

**A.** a copy of the latest fire inspection report by the fire authority having jurisdiction;

**B.** a copy of the last survey conducted by the licensing authority and variances granted;

**C.** record of fire and emergency evacuation drills conducted by the facility;

**D.** licensing regulations: a copy of these regulations: Requirements for intermediate care facilities for [~~the Mentally Retarded~~] individuals with intellectual disabilities, New Mexico health care authority, 8.371.2 NMAC;

**E.** health certificates of staff;

**F.** a copy of the current license, registration or certificate, of each staff member for which a license, registration, or certification is required by the state of New Mexico;

**G.** valid drug permit as required by the state board of pharmacy;

**H.** latest inspection by the state board of pharmacy;

**I.** New Mexico environment department approval of private water system, if applicable;

**J.** New Mexico environment department approval of private waste or sewage disposal, if applicable;

**K.** New Mexico environment department approval of the kitchen. NOTE: An approval of kitchen is not required if preparing meals is part of the training program of the clients of the facility and the facility has a letter of exemption on file from the New Mexico environment department;

**L.** documentation of fire equipment and fire systems inspections;

**M.** reports of client abuse and incidents involving clients.
[8.371.2.26 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.28 PHILOSOPHY, OBJECTIVES AND GOALS:** Each facility licensed pursuant to these regulations must have a written outline of the philosophy, objectives, and goals it is striving to achieve that includes, at least:

**A.** the facility's role in the state comprehensive program for [~~the mentally retarded~~] individuals with intellectual disabilities;

**B.** the facility's goals for its clients to include but not limited to: an integrated active treatment program, homelike living environments and consumer protections;

**C.** the facility's concept of its relationship to the parents or legal guardians of its residents;

**D.** the facility's outline of the above must be available for distribution to staff, consumer representatives, and the interested public;

**E.** the facility's promotion of informed decision making by the consumer;

**F.** the facilities policies on utilization of community supports and how clients will be involved in the community.

[8.371.2.28 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.33 AGREEMENTS WITH OUTSIDE RESOURCES:** If the [~~ICF/MR~~] ICF/IID does not employ a qualified professional to furnish a required service, it must have in effect a written agreement with a qualified professional outside the [~~ICF/MR~~] ICF/IID to furnish the required service. The agreement must:

**A.** contain the responsibilities, functions, objectives, and other items agreed to by the [~~ICF/MR~~] ICF/IID and the qualified professional;

**B.** be signed by the administrator or their representative and by the qualified professional;

**C.** the facility must assure that outside providers meet all appropriate state and federal requirements, and the quality of services meet the needs of the individual.

[8.371.2.33 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.37 BUILDING(S), GROUNDS, AND SAFETY REQUIREMENTS:**

**A.** Those programs which are located in a building which is licensed as a long term care facility or hospital must meet all the building requirements for that type facility as outlined in the following regulations:

**(1)** Requirements for General and Special Hospitals, New Mexico health care authority, 8.370.12 NMAC.

**(2)** Requirements for Long Term Care Facilities, New Mexico health care authority, 8.370.16 NMAC.

**(3)** Copies of these regulations may be requested from the licensing authority.

**B. Capacity of building(s):** All building requirements contained in these regulations are based on a maximum capacity of 15 clients. All facilities requesting licensure for more than 15 clients will have additional requirements according to the applicable building and fire codes. Due to the complexities of the building and fire codes these additional requirements will be outlined by the appropriate building and fire authorities, and by the licensing authority through plan review and on site surveys during the licensing process. Maximum capacity for any facility licensed after the effective date of revisions to these regulations is four clients. Exception: [~~ICF/MR~~] ICF/IID facilities may be licensed for a maximum capacity of six clients based upon a written plan that must be approved by the licensing authority prior to the facility's licensure. The plan must demonstrate the following:

**(1)** the anticipated facility service benefits to the client population;

**(2)** how the facility's services will promote, independence, active treatment and community supports;

**(3)** how the facility's services will address the needs and protections of the proposed clients.

**C.** Number of stories: All building requirements contained in these regulations are based on buildings of one story,which do not house clients above or below ground level. Buildings which are multi-storied or house clients below ground level shall have additional requirements which vary due to the complexities of the building and fire codes. These additional requirements will be outlined by the appropriate building and fire authorities and by the licensing authority through plan review and on-site surveys during the licensing process.

**D.** Additional requirements: A facility applying for licensure pursuant to these regulations may have additional requirements not contained herein. The complexity of building and fire codes and requirements of city, county, or municipal governments may require these additional requirements. Any additional requirement will be outlined by the appropriate building and fire authorities, and by the licensing authority through plan review, consultation and on-site surveys during the licensing process.

**E.** Access to the handicapped: All facilities licensed pursuant to these regulations must be accessible to and usable by handicapped employees, visitors and clients.

**F.** Prohibition on mobile homes: Trailers and mobile homes must not be used as any part of a facility in which services and care are given to clients.

**G.** Extent of a facility: All buildings on the premises providing client care and services shall be considered part of the facility and must meet all requirements of these regulations.

**H.** Individual living units may not be located within 150 feet of each other.

[8.371.2.37 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.62 QUALIFIED [~~MENTAL RETARDATION~~] INTELLECTUAL DISABILITY PROFESSIONAL:** Each facility licensed pursuant to these regulations must have a qualified [~~mental retardation~~] intellectual disability professional. A qualified [~~mental retardation~~] intellectual disability professional is a person who has specialized training or one year of experience in treating or working with [~~the mentally retarded~~] indivudals with intellectual disabilities and is one of the following:

**A.** a psychologist with a masters degree from an accredited program;

**B.** a licensed doctor of medicine or osteopathy;

**C.** an educator with a degree in education from an accredited program;

**D.** a social worker with a bachelors degree in:

**(1)** social work from an accredited program; or

**(2)** a field other than social work and at least three years of social work experience under the supervision of a qualified social worker.

**E.** a physical or occupational therapist who meets all criteria of the state or federal government as a physical or occupational therapist.

**F.** a speech pathologist or audiologist who meets all criteria of the state or federal government as a speech pathologist or audiologist.

**G.** a registered nurse licensed in the state of New Mexico.

**H.** a therapeutic recreation specialist who:

**(1)** is a graduate of an accredited program; or

**(2)** meets all criteria of the state or federal government as a therapeutic recreation specialist;

**I.** a rehabilitation counselor who is certified by the committee on rehabilitation counselor certification.

**J.** a human services professional who has at least a bachelor's degree in a human services field (including but not limited to sociology, special education, rehabilitation counseling, or psychology).

[8.371.2.62 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.69 STAFF/CLIENT RATIOS:** For each facility regardless of organization or design must have, as a minimum, overall staff/client ratios (allowing for a five day work week plus holiday, vacation and sick time) as shown below:

**A.** Those facilities serving children under the age of six years, severely and profoundly [~~retarded~~] intellectually disabled, severely physically handicapped, or client's who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the overall ratio is one staff member to three point two (3.2) clients.

**B.** Those facilities serving moderately [~~retarded~~] intellectually disabled clients requiring habit training, the overall ratio is one staff member to four clients.

**C.** Those facilities serving clients in vocational training programs and adults who work in sheltered employment situation, the overall ratio is one staff member to six point four (6.4) clients.

[8.371.2.69 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.78 BEHAVIOR MODIFICATION PROGRAMS:**

**A.** "Aversive stimuli": things or events that a client finds unpleasant or painful that are used to immediately discourage undesired behavior may be used by the facility as a means of behavior modification.

**B.** "Time out": a procedure designed to improve a client's behavior by removing positive reinforcement when their behavior is undesirable may be used by the facility as a means of behavior modification.

**C.** Behavior modification programs involving the use of aversive stimuli or time out must be:

**(1)** reviewed and approved by the facility's human rights committee and the qualified [~~mental retardation~~] intellectual disability professional;

**(2)** conducted only with the consent of the affected client's parents or legal guardian;

**(3)** described in written plans that are kept on file in the facility;

**(4)** a physical restraint used as a time-out device shall be applied only during behavior modification exercises and only in the presence of the trainer.

**(5)** time-out devices and aversive stimuli may not be used for longer than one hour for time-out purposes involving removal from a situation, and then only during the behavior modification program and only under the supervision of the trainer.

[8.371.2.78 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.91 SOCIAL SERVICES:** The facility must provide, as part of an inter-disciplinary set of services, social services to each client directed toward:

**A.** maximizing the social functioning of each client;

**B.** enhancing the coping capacity of each client's family;

**C.** asserting and safeguarding the human and civil rights of [~~the retarded~~] individuals with intellectual disabilities and their families;

**D.** fostering the human dignity and personal worth of each client;

**E.** the development of the discharge plan;

**F.** the referral to appropriate community resources.

[8.371.2.91 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.2.96 RELATED REGULATIONS AND CODES:** [~~ICF/MR~~] ICF/IID facilities subject to these regulations are also subject to other regulations, codes and standards as the same may from time to time be amended as follows:

**A.** Health facility licensure fees and procedures, New Mexico health care authority, 8.370.3 NMAC.

**B.** Health facility sanctions and civil monetary penalties, 8.370.4 NMAC.

**C.** Adjudicatory hearings, New Mexico health care authority, 8.370.2 NMAC.

**D.** Caregivers criminal history screening requirements, New Mexico health care authority, 8.370.5 NMAC.

[8.371.2.96 NMAC - N, 7/1/2024; A, 9/1/2026]

## HEALTH CARE AUTHORITY
### MEDICAL ASSISTANCE DIVISION

**This is an amendment to 8.371.9 NMAC, Sections 1, 2 and 6-11, effective 9/1/2026.**

**8.371.9.1 ISSUING AGENCY:** New Mexico health care authority (HCA).
[8.371.9.1 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.9.2 SCOPE:**

**A.** These regulations provide a systematic process for admission of persons requesting services from an intermediate care facility for [~~the mentally retarded (ICF/MR)~~] individuals with intellectual disabilities (ICF/IID); the transfer between [~~ICF/MR~~] ICF/IID facilities of persons previously determined eligible; and the discharge of persons residing in an [~~ICF/MR~~] ICF/IID.

**B.** These regulations apply to persons who request admission to an [~~ICF/MR~~] ICF/IID and who reside in the community; in a nursing facility; in a hospital; or, in an [~~ICF/MR~~] ICF/IID. In addition, these regulations apply to any [~~ICF/MR~~] ICF/IID in the state of New Mexico that is licensed under health care authority regulations governing long term care facilities.

**C.** These regulations are limited to the admission, transfer and discharge of persons receiving support and services funded in whole or in part by state funds or for whom services can reasonably be expected to be funded in whole or in part with state funds within six months of admission into an [~~ICF/MR~~] ICF/IID.
[8.371.9.2 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.9.6 OBJECTIVE:** The purpose of these regulations is to:

**A.** establish the process for the admission of any and all persons requesting admission to an [~~ICF/MR~~] ICF/IID, to be transferred between [~~ICF/MR~~] ICF/IID facilities, or to be discharged from an [~~ICF/MR~~] ICF/IID;

**B.** establish admission, transfer and discharge procedures for [~~ICF/MR~~] ICF/IID facilities licensed and located in the state of New Mexico consistent with the Developmental Disabilities Act, Section 28-16A-15 NMSA 1978;
[8.371.9.6 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.9.7 DEFINITIONS:**

[~~**A. "Discharge"** means the termination of services for a person previously admitted into an ICF/MR and the discharging facility ceases to be legally responsible for the care of the person.~~

~~**B. "Eligible central registry person"** means a person who has requested admission to an ICF/MR, or discharge from an ICF/MR and transfer to a community-based HCA funded program, and who is determined by the HCA to meet pre-admission screening criteria for ICF/MR and home/community-based developmental disabilities services.~~

~~**C. "ICF/MR"** means an intermediate care facility that provides food, shelter, health or rehabilitative and active treatment for persons with mental retardation or related conditions, and that has a current license issued by the HCA.~~

~~**D. "New admission"** means a person requesting an ICF/MR admission for the first time and does not otherwise qualify as a re-admission. New admissions are subject to pre-admission screening.~~

~~**E. "NMSA"** means the New Mexico Statutes Annotated 1978 compilation and all the revisions and compilations thereof.~~

~~**F. "Pre-admission screening"** means the evaluation process of the health care authority to determine a person's choice between ICF/MR and community based services, and whether the person has a developmental disability as described in the *American association on mental retardation's manual on classification in mental retardation (1996)* or a related condition as defined by 42 CFR 435.1009.~~

~~**G. "Readmission"** means a person re-admitted to an ICF/MR from another type of institution to which they were transferred for the purpose of receiving acute, psychiatric care or rehabilitation following a temporary, acute care episode. A readmission is not subject to pre-admission screening.~~

~~**H. "Transfer"** means movement of an individual from one ICF/MR to another ICF/MR, with or without an intervening hospital stay. A transfer is not subject to pre-admission screening.~~

~~**I. "State medicaid agency"** means the health care authority.~~

~~**J. "Central registry"** means a registry of persons who are requesting or receiving services established by the HCA in accordance with Section 28-16A-15 NMSA 1978.~~]

**A. Definitions beginning with "A": [RESERVED]**

**B. Definitions beginning with "B": [RESERVED]**

**C. Definitions beginning with "C": "Central registry"** means a registry of persons who are requesting or receiving services established by the HCA in accordance with Section 28-16A-15 NMSA 1978.

**D. Definitions beginning with "D": "Discharge"** means the termination of services for a person previously admitted into an ICF/IID and the discharging facility ceases to be legally responsible for the care of the person.

**E. Definitions beginning with "E": "Eligible central registry person"** means a person who has requested admission to an ICF/IID, or discharge from an ICF/IID and transfer to a community-based HCA funded program, and who is determined by the HCA to meet pre-admission screening criteria for ICF/IID and home/community-based developmental disabilities services.

**F. Definitions beginning with "F": [RESERVED]**

**G. Definitions beginning with "G": [RESERVED]**

**H. Definitions**

**beginning with "H": [RESERVED]**

**I. Definitions beginning with "I": "ICF/IID"** means an intermediate care facility that provides food, shelter, health or rehabilitative and active treatment for persons with intellectual disabilities or related conditions, and that has a current license issued by the HCA.

**J. Definitions beginning with "J": [RESERVED]**

**K. Definitions beginning with "K": [RESERVED]**

**L. Definitions beginning with "L": [RESERVED]**

**M. Definitions beginning with "M": [RESERVED]**

**N. Definitions beginning with "N":**

**(1) "New admission"** means a person requesting an ICF/IID admission for the first time and does not otherwise qualify as a re-admission. New admissions are subject to pre-admission screening.

**(2) "NMSA"** means the New Mexico Statutes Annotated 1978 compilation and all the revisions and compilations thereof.

**O. Definitions beginning with "O": [RESERVED]**

**P. Definitions beginning with "P": "Pre-admission screening"** means the evaluation process of the health care authority to determine a person's choice between ICF/IID and community based services, and whether the person has a developmental disability as described in the *American Association on Intellectual Disability: Definition, Diagnosis, Classification, and Systems of Supports (12th edition, published in 2021)*, or a related condition as defined by 42 CFR 435.1009.

**Q. Definitions beginning with "Q": [RESERVED]**

**R. Definitions beginning with "R": "Readmission"** means a person re-admitted to an ICF/IID from another type of institution to which they were transferred for the purpose of receiving acute, psychiatric care or rehabilitation following a temporary, acute care episode. A readmission is not subject to pre-admission screening.

**S. Definitions beginning with "S": "State medicaid agency"** means the health care authority.

**T. Definitions beginning with "T": "Transfer"** means movement of an individual from one ICF/IID to another ICF/IID, with or without an intervening hospital stay. A transfer is not subject to pre-admission screening.

**U. Definitions beginning with "U": [RESERVED]**

**V. Definitions beginning with "V": [RESERVED]**

**W. Definitions beginning with "W": [RESERVED]**

**X. Definitions beginning with "X": [RESERVED]**

**Y. Definitions beginning with "Y": [RESERVED]**

**Z. Definitions beginning with "Z": [RESERVED]**

[8.371.9.7 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.9.8 ADMISSION:**

**A.** No person shall be admitted into an [~~ICF/MR~~] ICF/IID unless the person has been pre-screened and referred to an [~~ICF/MR~~] ICF/IID by the health care authority central registry.

**B.** Consistent with the provisions of 42 CFR 431.51 any person who requests to be placed on the HCA's central registry will be provided the opportunity to indicate a choice between [~~ICF/MR~~] ICF/IID and home/community-based waiver services at the time of application to the central registry. The purpose of this information request is for system service planning to identify persons who may be potentially eligible for [~~ICF/MR~~] ICF/IID services.

**C.** All applicants to the central registry may choose to be placed on the central registry for both [~~ICF/MR~~] ICF/IID and home/community-based waiver services.

**D.** All persons referred for admission into an [~~ICF/MR~~] ICF/IID from the central registry may choose to remain on the central registry for home/community-based waiver services. All persons referred for admission into home/community-based waiver services may choose to remain on the central registry for [~~ICF/MR~~] ICF/IID services.

**E.** All persons applying to the central registry will be pre-screened by the HCA before placement on the central registry to determine each person's choice between [~~ICF/MR~~] ICF/IID and home/community-based waiver services, and whether the person has a developmental disability or related condition. Pre-screening does not include determination of financial eligibility and level of care, which are functions performed by the state medicaid agency.

**F.** The HCA will implement application procedures for the central registry that identifies applicant's freedom to choose between [~~ICF/MR~~] ICF/IID and home and community based services.

**G.** Upon notification from a [~~ICF/MR~~] ICF/IID to the HCA that a vacancy exist in their facility, the HCA will identify three persons from the central registry, in the order of date of application to the central registry, who have indicated a choice for [~~ICF/MR~~] ICF/IID services, and who:

**(1)** have never been admitted into an [~~ICF/MR~~] ICF/IID; or

**(2)** were discharged from an [~~ICF/MR~~] ICF/IID for at least 30 days; or

**(3)** did not qualify as a readmission;

**(4)** the group of three individuals will be classified as "new admission" for the purposes of these regulations.

**H.** The HCA will notify the three persons about the availability of a vacancy and request each person to reaffirm in writing their choice between [~~ICF/MR~~] ICF/IID, developmental disabilities home and community waiver services, or other services.

**I.** The HCA will furnish to an [~~ICF/MR~~] ICF/IID the names and contact information of any persons on the central registry who indicate a choice for [~~ICF/MR~~] ICF/IID services in the long term services division region in which the [~~ICF/MR~~] ICF/IID is located.

**J.** The [~~ICF/MR~~] ICF/IID will contact and review each person's request for admission in accordance with federal licensing and certification requirements.

**K.** The [~~ICF/MR~~] ICF/IID will refer any person referred by the central registry, and whom the [~~ICF/MR~~] ICF/IID determined appropriate for admission based on its admission decision, to the state medicaid agency for level of care and financial eligibility determination.

**L.** The [~~ICF/MR~~] ICF/IID will notify the HCA and the eligible central registry person of the results of its admission decision for all three persons referred by the HCA with an explanation for its decision on each person referred. The [~~ICF/MR~~] ICF/IID will notify any person not admitted of their right to a review of the admission decision.

**M.** The [~~ICF/MR~~] ICF/IID may admit any person who meets the definition of "readmission" without referral through the HCA's central registry. A readmission will not be subject to pre-screening by the HCA.

**N.** The health care authority central registry may refer an individual to an [~~ICF/MR~~] ICF/IID vacancy based on the HCA's determination that the referral is an emergency. The HCA may exempt an emergency referral from the central registry to be made based on the person's date of application to the central registry.

[8.371.9.8 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.9.9 TRANSFER:**

**A.** A person may be transferred to another [~~ICF/MR~~] ICF/IID operated by the same entity, or an [~~ICF/MR~~] ICF/IID that operates independent of the [~~ICF/MR~~] ICF/IID where the person currently resides without referral through the central registry, provided:

**(1)** the person's interdisciplinary team recommends the transfer;

**(2)** the person's transfer is based on the person's freedom of choice of providers; and

**(3)** the receiving [~~ICF/MR~~] ICF/IID has identified a vacancy.

**B.** An [~~ICF/MR~~] ICF/IID may transfer a person temporarily to a psychiatric acute care hospital, or temporarily to a nursing facility for care following a hospital stay. Persons returning to the [~~ICF/MR~~] ICF/IID under these conditions will be classified a "readmission" and will not be subject to pre-screening by the HCA.

**C.** Persons receiving services from an [~~ICF/MR~~] ICF/IID may be transferred to a home and community-based waiver program provided the person has been allocated to the program by the HCA in accordance with central registry policies and procedures.

**D.** The [~~ICF/MR~~] ICF/IID shall provide a complete copy of the person's medical and service records, including assessments required for individual program planning to the [~~ICF/MR~~] ICF/IID or community to which the person is transferred.

[8.371.9.9 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.9.10 DISCHARGE:**

**A.** A person may be discharged from an [~~ICF/MR~~] ICF/IID when the individual/guardian requests to be discharged; when the person's interdisciplinary team recommends the facility cannot meet the individual's needs; the individual no longer requires an active treatment program in an [~~ICF/MR~~] ICF/IID setting; the discharge would be more beneficial to the person; or for any other good cause. Any decision to discharge a person from an [~~ICF/MR~~] ICF/IID based on good cause must be adequately justified in writing by the [~~ICF/MR~~] ICF/IID and reviewed by the HCA prior to discharge.

**B.** The [~~ICF/MR~~] ICF/IID will ensure the person's family/guardian and the person's advocate is involved in the interdisciplinary team process, involving a discussion and proposed decision regarding discharge.

**C.** The [~~ICF/MR~~] ICF/IID will ensure a transition plan is developed 30 working days prior to discharge in accordance with HCA policies on discharge and transition of persons in services.

**D.** The [~~ICF/MR~~] ICF/IID will ensure the person and their guardian are fully informed of their right to a fair hearing in accordance with 42 CFR 431.200-431.250.

**E.** The [~~ICF/MR~~] ICF/IID will ensure any discharge decision is carried out in accordance with provisions of 42 CFR 456.380.

[8.371.9.10 NMAC - N, 7/1/2024; A, 9/1/2026]

**8.371.9.11 NOTIFICATION OF THE HCA:**

**A.** The [~~ICF/MR~~] ICF/IID will notify the HCA of any vacancy or anticipated vacancy in their facility.

**B.** The [~~ICF/MR~~] ICF/IID will notify the HCA of any person requesting [~~ICF/MR~~] ICF/IID services and for whom state funding may be necessary.

**C.** The HCA will notify an [~~ICF/MR~~] ICF/IID of any person on the central registry indicating a choice of [~~ICF/MR~~] ICF/IID services in the long term services division region in which the [~~ICF/MR~~] ICF/IID located.

**D.** Notice by either party shall be based on timelines adopted by the HCA.

[8.371.9.11 NMAC - N, 7/1/2024; A, 9/1/2026]

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## REGULATION AND LICENSING DIVISION
### CANNABIS CONTROL DIVISION

**This is an amendment to 16.8.1 NMAC, Section 7 and adding a new Section 11 and renumbering Section 12, effective 08/31/2026.**

**16.8.1.7 DEFINITIONS:** [~~Unless otherwise defined below, terms~~] Terms used in Title 16, Chapter 8, have the same meanings as set forth in the Cannabis Regulation Act and the Lynn and Erin Compassionate Use Act.

**A. Definitions beginning with "A":**

**(1) "Advisory committee"** means the cannabis regulatory advisory committee.

**(2) "Applicant"** means any person who is seeking to become licensed pursuant to the Cannabis Regulation Act, the Lynn and Erin Compassionate Use Act, or division rules.

**(3) "Audited Product"** means a cannabis product with an intended use of:

**(a)** metered dose nasal spray;

**(b)** vaginal administration;

**(c)** rectal administration.

**B. Definitions beginning with "B": "Batch"** means, with regard to cannabis, an identified quantity of cannabis no greater than 15 pounds that is of the same strain of cannabis, that is harvested during the same specified time period from the same specified cultivation area, and with respect to which the same agricultural practices were utilized, including the use of any pesticides; and with regard to concentrated and cannabis product, means an identified quantity that is uniform, that is intended to meet specifications for identity, strength, and composition, and that is manufactured, packaged, and labeled during a specified time period according to a single manufacturing, packaging, and labeling protocol.

**C. Definitions beginning with "C":**

**(1) "Cannabis Regulation Act"** means the Cannabis Regulation Act, as enacted in Chapter 4, Sections 1 through 42 of New Mexico Laws of 2021, and as may be amended thereafter.

**(2) "Cannabis Waste"** means all parts of the plant genus Cannabis which may or may not contain a delta-9-tetrahydrocannabinol concentration of more than three-tenths percent on a dry weight basis, whether growing or not; the seeds of the plant; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin; and the mature stalks of the plant; fiber produced from the stalks; oil or cake made from the seeds of the plant; any other compound, manufacture, salt, derivative, mixture or preparation of the mature stalks, fiber, oil or cake; or the sterilized seed of the plant that is incapable of germination which has been designated as no longer usable cannabis.

**(3) "Carbon dioxide solvent"** means carbon dioxide in a liquid or supercritical state.

**(4) "CBD"** means cannabidiol, a cannabinoid and a non-psychoactive ingredient found in cannabis.

**(5) "CBDA"** means cannabidiolic acid, a non-psychoactive ingredient found in cannabis and an acid precursor to CBD.

**(6) "Closed loop extraction system"** means a commercially manufactured extraction system that is sealed during operation and designed to recover all solvents used during the extraction process through a feedback loop.

**(7) "Concentrated cannabis product ("concentrate")"** means a cannabis product that is manufactured by a division approved mechanical or chemical process that separates any cannabinoid from the cannabis plant, and that contains or that is intended to contain at the time of sale or distribution, no less than thirty-percent THC by weight.

**D. Definitions beginning with "D":**

**(1) "Deli-style sales"** means the sale of finished cannabis flower, shake or trim at co-located licensed retail and manufacturing I premises where the product is not pre-packaged for consumer purchase but is instead portioned, packaged, or weighed at the time of sale in response to a consumer's request. Deli-style sales involve direct handling or measurement of cannabis by the licensee or their employees at the point of sale and must comply with all applicable manufacturing, packaging, labeling, and sanitation requirements.

**[~~(1)~~] (2) "Delivery agreement"** means a contract between a licensed cannabis establishment and a licensed cannabis courier to deliver cannabis or cannabis products from the cannabis establishment directly to consumers as permitted under the provisions of the Cannabis Regulation Act, the Lynn and Erin Compassionate Use Act, and division rule.

**[~~(2)~~] (3) "Division"** means the cannabis control division.

[~~(3)~~] **(4) "Diversion"** means the unlawful transfer of a cannabis plant, plant material, or cannabis product.

[~~(4)~~] **(5) "Dried cannabis"** means the dried leaves, flowers, and trim of the female cannabis plant, but does not include the seeds, stalks, or roots of the cannabis plant.

**E. Definitions beginning with "E": "Extraction area"** means the area of a licensed manufacturer's processing facility that is designed for solvent-based extraction, which the division has inspected and approved for the area's designated use.

**F. Definitions beginning with "F":**

**[~~[RESERVED]~~] "Flowering"** means the reproductive state of the cannabis plant in which there are physical signs of flower budding of the nodes of the stem.

**G. Definitions beginning with "G": [RESERVED]**

**H. Definitions beginning with "H":**

**(1) "Homogeneity"** means the reasonably equal dispersion of cannabinoids throughout a batch

of cannabis product and within the cannabis product as packaged or as intended for sale.

**(2) "Hydrocarbon solvent"** means N-butane, isobutene, propane, pentane, heptane, or any isomer or combination thereof.

**I. Definitions beginning with "I":**

**(1) "Independent professional engineer"** means an engineer licensed pursuant to the Engineering and Surveying Practice Act, Section 61-23-1 *et seq.,* NMSA 1978, that is not an employee, owner, officer, controlling person, board member, or manager of the cannabis establishment licensee.

**(2) "Inhaled product(s)"** means:

**(a)** flower, shake, or trim;

**(b)** pre-rolled cannabis and infused pre-rolled cannabis;

**(c)** solvent-based cannabis concentrate;

**(d)** physical separation-based cannabis concentrate;

**(e)** heat/pressure-based cannabis concentrate;

**(f)** vaporizer cannabis delivery device;

**(g)** pressurized metered dose cannabis inhaler.

**J. Definitions beginning with "J": [RESERVED]**

**K. Definitions beginning with "K": [RESERVED]**

**L. Definitions beginning with "L":**

**(1) "Licensee"** means any person who holds a license issued by the division pursuant to the Cannabis Regulation Act, the Lynn and Erin Compassionate Use Act, or division rules.

**(2) "Limited-access area"** means an indoor or outdoor area on the premises of a licensed cannabis establishment where cannabis or cannabis products are cultivated, stored or held, weighed, packaged, manufactured, disposed or wasted, all point-of-sale (POS) areas, and any room or area storing a digital video surveillance system storage device.

**(3) "Limit of detection"** means an estimate of the minimum amount of an analyte in a given matrix that an analytical process can reliably detect.

**(4) "Limit of quantitation"** means the minimum level, concentration, or quantity of a target analyte in a given matrix that an analytical process can reliably quantitate.

**(5) "Liquor Control Act"** mean the Liquor Control Act, Chapter 60, Articles 3A, 5A, 6A, 6B, 6C, 6E, 7A, 7B and 8A, NMSA 1978.

**(6) "Lot"** means an identified portion of a batch, that is uniform and that is intended to meet specifications for identity, strength, and composition; or, in the case of a cannabis product or concentrate, an identified quantity produced in a specified period of time in a manner that is uniform and that is intended to meet specifications for identity, strength, and composition.

**(7) "Lynn and Erin Compassionate Use Act"** means the Lynn and Erin Compassionate Use Act, Section 26-2B-1 *et seq.*, NMSA 1978.

**M. Definitions beginning with "M":**

**(1) "Minor"** means an individual who is less than 18 years of age.

**(2) "Mature plant"** means a flowering cannabis plant.

**N. Definitions beginning with "N": [RESERVED]**

**O. Definitions beginning with "O":**

**[~~[RESERVED]~~] "Oral consumption"** means a cannabis product that is:

**(1)** Food or drink infused with regulated cannabis;

**(2)** regulated cannabis concentrate intended to be consumed orally;

**(3)** pills and capsules;

**(4)** tinctures and sublingual products.

**P. Definitions beginning with "P":**

**(1) "Pesticide"** means a pesticide as defined by the New Mexico Pesticide Control Act, Section 76-4-1 *et seq.*, NMSA 1978.

**(2) "Plant"** means any cannabis plant, cutting, or clone that has roots or that is cultivated with the intention of growing roots.

**(3) "Plant material"** means leaves, stalks, stems, roots, and any other part of the cannabis plant.

**(4) "Pressure vessel"** means a component of a closed loop system containing cannabis plant material and solvents used during solvent-based extraction and designed to withstand pressure greater [~~that~~] than 15 psi.

**(5) "Policy"** means a written statement of principles that guides and determines present and future decisions and actions of the licensed person.

**(6) "POS"** means point of sale system.

**(7) "Person"** means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, or any other legal or commercial entity.

**(8) "Produce"** means to engage in any activity related to the planting or cultivation of cannabis.

**(9) "Proficiency testing"** means a standardized test administered by an ISO 17043 accredited laboratory to evaluate the ability of a laboratory to measure, within acceptable limits, the presence, quantity, or other factors pertaining to a given analyte.

**Q. Definitions beginning with "Q": [RESERVED]**

**R. Definitions beginning with "R":**

**(1) "Recall"** means to request the return of a product after the discovery of a safety issue or product defect.

**(2) "Representative sample"** means a sample of cannabis and cannabis product of the same size and composition that is required for cannabis product testing by a cannabis laboratory that represents a unique lot of cannabis product.

**[~~(2)~~] (3) "RLD"** means the regulation and licensing department.

**S. Definitions beginning with "S":**

**(1) "Safe moisture level"** means a level of moisture low enough to prevent the growth of undesirable microorganisms in the finished produce.

**(2) "Security alarm system"** means any device or series of devices capable of alerting law enforcement , including, but not limited to, a signal system interconnected with a radio frequency method such as cellular, private radio signals, or other mechanical or electronic device used to detect or report an emergency or unauthorized intrusion.

**(3) "Segregate"** means to separate and withhold from use or sale batches, lots, cannabis, usable cannabis, or cannabis products in order to first determine its suitability for use through testing by an approved laboratory.

**(4) "Skin and body products"** means:

**(a)** topical; or

**(b)** transdermal.

**[~~(4)~~] (5) "Solvent"** means a hydrocarbon solvent, carbon dioxide solvent, or organic solvent, which is used to dissolve or disperse chemical compounds from cannabis plant material in a closed loop system.

**[~~(5)~~] (6) "Solvent-based extraction"** means the process of dissolving or dispersing specific chemical compounds from the cannabis plant material using a solvent in a closed loop system.

**T. Definitions beginning with "T":**

**(1) "THC"** means tetrahydrocannabinol, a cannabinoid that is the primary psychoactive ingredient in cannabis.

**(2) "THCA"** means tetrahydrocannabinolic acid, a non-psychoactive ingredient in cannabis and an acid precursor to THC.

**(3) "Testing"** means testing of cannabis and cannabis products consistent with division rules.

**(4) "Track and trace system"** means the electronic system designated by the division to track and trace the production, transportation, sale, and wastage of cannabis and cannabis products.

**U. Definitions beginning with "U": [RESERVED]**

**V. Definitions beginning with "V":**

**(1) "Vault"** means a limited access storage room that is within a licensed cannabis establishment and is outfitted with adequate security features for the purposes of storing cannabis, cannabis products, or cash.

**(2) "Volatile solvent"** means a hydrocarbon solvent, alcohol, or acetone.

**W. Definitions beginning with "W":**

**(1) "Waste" or "wastage"** means the process of rendering cannabis or cannabis products unusable and unrecognizable, including the destruction of cannabis or cannabis products.

**(2) "Water activity"** means the measure of the free moisture in a manufactured cannabis product and is the quotient of the water vapor pressure of the substance divided by the vapor pressure of pure water at the same temperature.

**X. Definitions beginning with "X": [RESERVED]**

**Y. Definitions beginning with "Y": [RESERVED]**

**Z. Definitions beginning with "Z": [RESERVED]**

[16.8.1.7 NMAC - N, 08/24/2021; A, 12/28/2021; A, 01/11/2022; A, 08/31/2026]

**16.8.1.11 CANNABIS REGULATORY ADVISORY COMMITTEE MEETINGS:** Meetings of the cannabis regulatory advisory committee may be held remotely via a virtual platform at the discretion of the superintendent.

[16.8.1.11 NMAC – N, 08/31/2026]

**[~~16.8.1.11~~] 16.8.1.12 SEVERABILITY:** If any part or application of this rule is held to be invalid, the remainder or its application to other situations or persons shall not be affected. Any section of this rule legally severed shall not interfere with the remaining protections and duties provided by this rule.

[16.8.12.12 NMAC - N, 08/24/2021; Rn, 16.8.1.10, 07/12/2022; Rn, 16.8.1.11, 08/31/2026]

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## REGULATION AND LICENSING DIVISION

### CANNABIS CONTROL DIVISION

**This is an amendment to 16.8.7 NMAC, Section 15, effective 08/31/2026.**

**16.8.7.15 REQUIRED TESTING OF CANNABIS PRODUCTS:** A cannabis establishment shall segregate a batch of cannabis product and arrange for samples to be collected and tested by a cannabis testing laboratory if required by this section. The batch must pass all required tests prior to the sale or delivery to another licensee, a qualified patient, primary caregiver or consumer.

**A. Required testing for cannabis producers:** Unless an exception applies:

**(1)** A cannabis producer, cannabis producer microbusiness, vertically integrated cannabis establishment, or integrated cannabis microbusiness shall arrange for and pay for the testing specified in Table 1, *Required Testing of Cannabis Products*,

below, of any cannabis flower and trim that it harvests prior to:

**(a)** packaging for retail sale;

**(b)** transfer to another cannabis establishment for the purposes of retail sale;

**(c)** retail sale; or

**(d)** delivery to a patient or consumer.

**(2)** A cannabis manufacturer, vertically integrated cannabis establishment, or integrated cannabis microbusiness shall arrange for and pay for the testing specified in Table 1 of any cannabis product, including but not limited to a concentrate or extract, that it manufactures prior to:

**(a)** packaging for retail sale

**(b)** transfer to another cannabis establishment for the purposes or retail sale;

**(c)** retail sale; or

**(d)** delivery to a qualified patient, primary caregiver or consumer.

**(3)** A cannabis retailer, cannabis consumption lounge, vertically integrated cannabis establishment, or integrated cannabis microbusiness shall not sell or deliver to a patient or consumer any cannabis product unless the cannabis product has ~~[undergone all testing required by this section~~]:

**(a)** undergone all testing specified in Table 1, Required Testing of Cannabis and Cannabis Products below, and

**(b)** the licensee has confirmed that the cannabis or cannabis product has a certificate of analysis issued by a cannabis testing laboratory licensed by the division demonstrating that the product meets all applicable testing requirements.

**Table 1, Required Testing of Cannabis Products**

| Product category | Potency | ~~[Homogenity of Batch]~~ | Visual Inspection | Microbiological | Residual Pesticides | Residual Solvents |
|---|---|---|---|---|---|---|
| **Audited Product** | X | | X | X | X | X |
| **Concentrate (CO2)** | X | | X | X | X | |
| **Concentrate (non-volatile solvent) e.g. mechanical extraction** | X | | X | X | X | |
| **Concentrate (volatile solvent) e.g. Butane, Propane, Ethanol** | X | | X | X | X | X |
| **Flower** | X | | X | X | X | |
| **Infused Cannabis Materials (CO2)** | X | | X | X | X | |
| **Infused Cannabis Materials (non-volatile solvent)** | X | | X | X | X | |
| **Infused Cannabis Materials (volatile solvent)** | X | | X | X | X | X |
| **Infused-pre-roll (CO2)** | X | | X | X | X | |
| **Infused-pre-roll (non-volatile solvent)** | X | | X | X | X | |
| **Infused-pre-roll (volatile solvent)** | X | | X | X | X | X |
| **Oral Consumption e.g. strips, lozenges, edibles** | X | | X | X | X | X |
| **Other Inhalable (concentrate with added ingredients)** | X | | X | X | [*]X | X |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Pre-roll** | X | | X | X | X | |
| **Tincture (concentrate added to alcohol)** | X | | X | X | X | X |
| **Topical** | X | | X | X | X | X |
| **Trim** | X | | X | X | X | |
| **~~[Extract – alcohol]~~** | ~~X~~ | | | ~~X~~ | ~~X~~ | |
| **~~[Extract – other liquid]~~** | ~~[X]~~ | | | ~~[X]~~ | ~~[X]~~ | ~~[X]~~ |
| **~~[Kief]~~** | ~~[X]~~ | | ~~[X]~~ | ~~[X]~~ | ~~[X]~~ | ~~[X]~~ |
| **~~[Edible]~~** | ~~[X]~~ | | | ~~[X]~~ | ~~[*]~~ | |
| **~~[Other]~~** | ~~[X]~~ | | | ~~[X]~~ | ~~[*]~~ | ~~[X]~~ |

**~~[*Pesticide testing required unless exempted by Subsection E, below.]~~**

**B. Staggered implementation**:

**(1)** The division may within its discretion delay implementation of sample collection and testing requirements of this section, in whole or in part.

**(2)** In determining the start date of an individual testing requirement, the division shall consider whether a cannabis testing laboratory has validated a method for conducting the test.

**(3)** In determining the date on which a cannabis establishment must have its samples collected by an employee or contractor of a cannabis testing laboratory, the division shall consider the capacity of cannabis testing laboratories to collect and transport samples.

**(4)** The division may establish different implementation dates for sample collection requirements for:

**(a)** cannabis producer microbusinesses and integrated cannabis microbusinesses located up to 100 miles by automobile from the nearest licensed cannabis testing laboratory location;

**(b)** cannabis producers, cannabis manufacturers, and vertically integrated cannabis establishments located up to 200 miles by automobile from the nearest licensed cannabis testing laboratory location;

**(c)** cannabis producer microbusinesses and integrated cannabis microbusinesses located more than 100 miles by automobile from the nearest licensed cannabis testing laboratory location;

**(d)** cannabis producers, cannabis manufacturers, and vertically integrated cannabis establishments located more than 200 miles by automobile from the nearest licensed cannabis testing laboratory location; and

**(e)** cannabis establishments for which travel to a licensed cannabis testing laboratory location requires passing through a United States border patrol checkpoint.

**C. Collection and transportation of samples:** A cannabis testing laboratory is responsible for the collection of samples for the performance of any required test, re-test after a failing result, re-test after remediation, or test for the purposes of labeling.

**(1)** A cannabis testing laboratory may perform sample collection using:

**(a)** Laboratory employees with requisite training, as specified in 16.8.2.26 NMAC; or

**(b)** Contractors who have completed the sampling agent training offered by the U.S. department of agriculture's domestic hemp production program and sign an affidavit that they have no ownership interest in, and are not employed by, any cannabis establishment that produces or manufactures cannabis. The contractor shall obtain necessary training to comply with the cannabis testing laboratory's protocols, and the cannabis testing laboratory may reject any sample that it suspects was collected outside of its protocols.

**(2)** A cannabis testing laboratory may transport samples using:

**(a)** Laboratory employees with requisite training, as specified in 16.8.2.26 NMAC; or

**(b)** Contractors who sign an affidavit that they have no ownership interest in, and are not employed by, any cannabis establishment that produces or manufactures cannabis. Transporting cannabis for a cannabis establishment on a contractual basis does not preclude a person or entity from transporting samples in secure containers for cannabis testing laboratories.

**(3)** Nothing in these rules shall be interpreted to require a cannabis testing laboratory to collect samples from or transport samples on behalf of any cannabis establishment.

**(4)** If the division has delayed implementation of the requirement that the cannabis testing laboratory collect the sample from a cannabis establishment, based on its distance from the nearest cannabis testing laboratory or location beyond a U.S. border patrol

checkpoint, then any person collecting or transporting samples for required testing must receive training in sample collection and transportation protocols.

**(a)** Nothing in these rules shall be interpreted to require a cannabis testing laboratory to accept samples from a cannabis establishment.

**(b)** The cannabis testing laboratory may reject any sample that it suspects was collected outside of its protocols.

**(5)** A cannabis establishment may specify reasonable precautions prevent the contamination of batches of cannabis, except that the cannabis establishment must provide access to the entire batch of cannabis product. Precautions may include, but are not limited to:

**(a)** requiring the use of gloves and other personal protective equipment;

**(b)** inspecting tools and containers prior to their use;

**(c)** specifying the location within the cannabis establishment at which the samples will be collected;

**(d)** specifying locations within the cannabis establishment to which laboratory employees or contractors do not have access; and

**(e)** the right to refuse entry to any laboratory employee or contractor not in compliance with the precautions

**(6)** Nothing in these rules shall be interpreted to require routine testing of cannabis products before the cannabis establishment segregates cannabis products into batches and places the batches into containers for storage while awaiting test results.

**(7)** This Subsection C of 16.8.7.8 NMAC is effective March 1, 2023.

**D. Compliance with all rules and applicable laws required:** Passage of testing does not relieve an establishment of its obligation to comply with the Cannabis Regulation Act, the Lynn and Erin Compassionate Use Act, the Pesticide Control Act, division rules, or other local, state, and federal laws not in conflict with the Cannabis Regulation Act or the Lynn and Erin Compassionate Use Act.

**(1)** A cannabis establishment shall waste and dispose of any cannabis product to which a pesticide has been applied in violation of division rules or the Pesticide Control Act or any product manufactured using an unapproved solvent.

**(2)** Nothing in this rule shall be interpreted as precluding regulatory activities by other state agencies that do not conflict with the Cannabis Regulation Act or the Lynn and Erin Compassionate Use Act.

**E. Exceptions to required testing:**

**[~~(1) A cannabis establishment shall not be required to have tested for pesticide residue any cannabis product made from cannabis concentrate or cannabis extract with verified pesticide residue test results, so long as the establishment can demonstrate that the resulting product will not exceed action levels for that type of cannabis product.~~**

**~~(2)~~]** **(1)** A cannabis establishment shall not be required to have tested a cannabis product acquired from another cannabis establishment if the batch, in present form, was previously determined to have passed the testing requirements of this rule and is accompanied by a *Certificate of Analysis* issued by a licensed cannabis testing laboratory within the previous 90 days.

**[~~(3)~~]** **(2)** If additional testing requirements take effect after a cannabis testing laboratory obtains a sample of a cannabis product for required testing, the laboratory is required to perform only those tests required at the time the sample was obtained.

**F. Visual inspection:** A sample shall pass visual inspection if, under a minimum of 40X magnification, laboratory personnel detect in a one gram sample:

**(1)** no living or dead insects, hair, eggs, or feces; and

**(2)** no more than two percent sand, soil, mold, or rocks.

**G. Microbiological testing:** A sample shall pass microbiological testing if the sample contains concentrations of target microbes not exceeding the action levels set forth in Table 2, *Microbiological Testing Requirements*, below.

**(1)** The division may require required testing for additional microbes if quality control or inspection testing conducted by cannabis testing laboratories, NMDA, the department of health, or the division identifies their presence, in a quantity or amount that poses a threat to public health, in a cannabis product produced, manufactured, or sold by any cannabis establishment. The division shall provide written notice to licensees 30 days before requiring required testing for additional pesticide residues, except that such notice is not required when human illness is linked to contaminated cannabis products.

**(2)** The cannabis testing laboratory may report a collective total of the four Aspergillus strains listed without distinguishing individual totals.

**(3)** The test results shall be reported as "Present," "Absent," or in colony forming units (CFU) per one gram sample.

**(4)** Testing for shiga-toxin producing E. coli, Clostridium botulinum, and Pseudomonas aeruginosa is effective July 1, 2022.

**Continued Next Page**

| Table 2. Microbiological Testing Requirements | |
|---|---|
| **Target Microbe** | **Action Level** |
| *E. coli | 100 CFU/gram |
| Aspergillus flavus, Aspergillus fumigatus, Aspergillus niger, or Aspergillus terreus | Present in 1 gram |
| Salmonella spp. | Present in 1 gram |
| †Shiga-toxin producing E. coli | Present in 1 gram |
| †Clostridium botulinum | Present in 1 gram |
| †Pseudomonas aeruginosa | Present in 1 gram |
| *Cannabis product may be tested for shiga-toxin producing E. coli, rather than generic E. coli.<br>†Testing for shiga-toxin producing E. coli, Clostridium botulinum, and Pseudomonas aeruginosa is required only for edible cannabis products manufactured from fresh cannabis with a water activity of 0.65 or greater. | |

**H. Residual solvent testing:** A sample shall pass residual solvent testing if the sample contains concentrations of residual solvents lower than the action levels set forth in Table 3, *Residual Solvent Testing Requirements*, below. The test results shall be reported as described in the notes to Table 3.

| Table 3. Residual Solvent Testing Requirements | | | | |
|---|---|---|---|---|
| **Target Compounds** | **Common Chemical Name** | **IUPAC Name** | **CAS Number** | **Action Level*** |
| **Propane** | Propane | Propane | 74-98-6 | 5000 |
| **Butanes** | *n*-butane | Butane | 106-97-8 | 5000 |
| | Isobutane | 2-methylpropane | 75-28-5 | 5000 |
| **Pentane** | *n*-pentane | Pentane | 109-66-0 | 5000 |
| **Hexane** | *n*-hexane | Hexane | 110-54-3 | 290 |
| **Benzene** | Benzene | Benzene | 71-43-2 | 2.0 |
| **Toluene** | Toluene | Methylbenzene | 108-88-3 | 890 |
| **Heptane** | *n*-heptane | Heptane | 142-82-5 | 5000 |
| **Ethylbenzene and Xylenes** | Ethylbenzene | Ethylbenzene | 100-41-4 | 2170 Total |
| | *ortho*-xylene | 1,2-dimethylbenzene | 95-47-6 | |
| | *meta*-xylene | 1,3-dimethylbenzene | 108-38-3 | |
| | *para*-xylene | 1,4-dimethylbenzene | 106-42-3 | |
| **Ethanol†** | ethyl alcohol | Ethanol | 64-17-5 | 5000 |
| **Methanol** | methyl alcohol | Methanol | 67-56-1 | 3000 |
| **Isopropanol** | Isopropyl alcohol | 2-propanol | 67-63-0 | 5000 |
| **Acetone** | Acetone | 2-propanone | 67-64-1 | 5000 |

Use two significant digits when reporting residual solvent results.

Report levels less than the Limit of Quantitation for each solvent according to the following example:: "Benzene < 2.0 µg/g"

*Micrograms solvent per gram (µg/g) of sample/parts per million (ppm).

†Unless exempt from testing.

**I. Potency testing:** Potency testing requires determining the quantity of tetrahydrocannabinol (THC), tetrahydrocannabinolic acid (THCA), cannabidiol (CBD), cannabidiolic acid (CBDA) per gram of sample and the calculation of THC potency and CBD potency, according to Table 4, *Potency Testing Requirements*, below.

| **Table 4. Potency Testing Requirements** | | | |
|---|---|---|---|
| **Cannabinoid** | **Abbreviation** | **CAS Number** | **Reporting Units** |
| **Tetrahydrocannabinolic Acid** | THCA | 23978-85-0 | For solids: mg of analyte/ gram of sample and percentage by weight<br><br>For liquids: mg/ml |
| **Tetrahydrocannabinol** | THC | 1972-08-3 | |
| **Cannabidiolic Acid** | CBDA | 1244-58-2 | |
| **Cannabidiol** | CBD | 13956-29-1 | |
| **Total THC Potency (solids)** | THC Potency = (Percent THCA × 0.877) + Percent THC | | Percentage by weight |
| **Total CBD Potency (solids)** | CBD Potency = (Percent CBDA × 0.877) + Percent CBD | | |
| **Total THC Potency (liquids)** | THC Potency = (mg/ml THCA × 0.877) + mg/ml THC | | mg/ml |
| **Total CBD Potency (liquids)** | CBD Potency = (mg/ml CBDA × 0.877) + mg/ml CBD | | |

**J. Pesticide testing:** A sample shall pass pesticide testing if concentrations of residues of pesticides are lower than the action levels listed in Table 5, *Pesticide Testing Requirements*, below.

**(1)** The division may adopt required testing for additional pesticide residues if quality control or inspection testing conducted by cannabis testing laboratories, NMDA, the department of health, or the division identifies their presence in a cannabis product produced or manufactured by any cannabis establishment. The division shall provide written notice to licensees 30 days before implementing required testing for additional pesticide residues.

**(2)** Nothing in this section shall be interpreted to waive or diminish any requirement of the Pesticide Control Act, Sections 76-4-1 et seq. NMSA 1978. The division, alone or in conjunction with NMDA, may investigate any suspected use of a pesticide not registered with NMDA for use on cannabis.

**(3)** This Subsection J of 16.8.7.8 NMAC is effective July 1, 2022.

| **Table 5. Pesticide Testing Requirements** | | | |
|---|---|---|---|
| **Targeted Pesticide** | **CAS Number** | **Action Level: Inhalable*** | **Action Level: Non-Inhalable*** |
| **†Abamectin** | 71751-41-2 | 0.1 | 0.15 |
| **†Acequinocyl** | 57960-19-7 | 2.0 | 2.0 |
| **†Bifenazate** | 149877-41-8 | 0.2 | 0.2 |
| **†Bifenthrin** | 82657-04-3 | 0.1 | 0.1 |
| **†Etoxazole** | 153233-91-1 | 0.1 | 1.0 |
| **†Imazalil** | 35554-44-0 | 0.1 | 0.1 |
| **†Imidacloprid** | 138261-41-3 | 0.1 | 3.0 |
| **†Myclobutanil** | 88671-89-0 | 0.1 | 0.4 |
| **†Paclobutrazol** | 76738-62-0 | 0.04 | 0.04 |

| | | | |
|---|---|---|---|
| **Piperonyl butoxide** | 51-03-6 | 3.0 | 8.0 |
| **†Pyrethrins (cumulative total)** | 121-21-1<br>25402-06-6<br>4466-14-2 | 0.5 | 1.0 |
| **†Spinosyn A, D (cumulative total)** | 131929-60-7<br>131929-63-0 | 0.1 | 3.0 |
| **†Spiromesifen** | 283594-90-1 | 0.1 | 0.2 |
| **†Spirotetramat** | 203313-25-1 | 0.1 | 0.2 |
| **†Trifloxystrobin** | 141517-21-7 | 0.02 | 0.02 |
| **Other pesticide not registered with NMDA for use on cannabis** | Varies | 0.02 | 0.02 |
| *Micrograms of pesticide per gram (**µg/g**) of sample/parts per million (ppm).<br>Report levels less than the Limit of Quantitation for each pesticide residue according to the following example: "Paclobitrazol < 0.4 µg/g"<br>†Not registered with NMDA for use on cannabis. | | | |

**K. Release of batch after testing:** A cannabis establishment may release an entire batch of cannabis product for immediate manufacture, sale, or other use, provided that the sample taken from the batch passes the tests required in this section.

**L. Procedures for testing:** A cannabis establishment shall adhere to the following procedures:

**(1)** After collection of samples, a batch of cannabis product shall be segregated in a secure container and stored under controlled environmental conditions (temperature, humidity, light) designed to limit microbial growth or other spoilage until the cannabis establishment receives a certificate of analysis indicating the batch meets the testing requirements of this rule.

**(2)** The secured container shall be labeled with the identification number used in the track and trace system, the name of the cannabis testing laboratory, the date on which the samples were taken, and, in minimum 12-point font, all capital letters, “AWAITING TEST RESULTS. DO NOT TRANSFER.”

**(3)** The cannabis testing laboratory and the cannabis establishment submitting samples each shall appropriately document in the track and trace system the sampling and testing of cannabis product.

**(4)** A cannabis establishment shall maintain all results of laboratory tests conducted on cannabis products produced or manufactured by the cannabis establishment for a period of at least two years and shall make those results available to consumers or cannabis retailers upon request.

**M. Re-testing:** If a sample fails any test, the cannabis establishment may request re-testing by the same cannabis testing laboratory or another cannabis testing laboratory. If the repeated test is within acceptable limits, then the batch may be sold, transferred, or further manufactured.

**N. Remediation:** Within 120 days of a failed test, a cannabis establishment may remediate and retest the batch according to the procedures described in this subsection. A cannabis establishment shall adopt and maintain on the premises protocols regarding remediation consistent with this rule.

**(1)** A cannabis establishment may remediate dried cannabis or cannabis concentrates that fail microbiological testing by means of extraction using an approved volatile solvent. Other products that fail microbiological testing may not be remediated.

**(2)** A cannabis establishment may remediate any cannabis product that fails homogeneity testing through any approved manufacturing process, including extraction, chopping, melting, mixing, infusing, or otherwise combining the batch.

**(3)** A cannabis establishment may remediate any cannabis product that fails residual solvent testing by evaporating solvent using heat, vacuum pressure, or a combination of methods.

**(4)** A cannabis establishment may remediate cannabis that fails visual inspection for the presence of mold by means of extraction using an approved volatile solvent.

**(5)** A cannabis establishment may remediate cannabis that fails visual inspection for the presence of insects, hair, eggs, or feces by removing the contaminants, followed by extraction using an approved volatile solvent.

**(6)** A cannabis establishment may remediate cannabis that fails visual inspection for the presence of soil or rocks by removing the contaminants.

**(7)** Cannabis product that has been remediated must undergo any test that was previously failed.

**(8)** Cannabis product that has been remediated with the use of volatile solvents must additionally undergo residual solvent testing.

**O. Notice and destruction:** Any cannabis product that fails a test and cannot be remediated, including any remediated cannabis product that fails any test after remediation or any cannabis product that fails a test for pesticides pursuant to the New Mexico Pesticide Control Act, Section 76-4-1 *et seq.*, NMSA 1978, is subject to destruction in accordance with the wastage requirements of 16.8.2.15 NMAC. The cannabis establishment shall notify the division within 24 hours and shall confirm the wastage and disposal of the usable cannabis in accordance with this rule. The wasted product shall be removed from inventory, and the removal from inventory shall be noted in the track and trace system.

**P. Interpretation of differing results:** Results produced by a cannabis testing laboratory are valid only for the sample tested. A differing result produced by quality control or inspection testing of a different sample pursuant to 16.8.2.16 NMAC is not grounds for action against the cannabis testing laboratory that produced the original testing result.

[16.8.7.15 NMAC – N, 07/12/2022; A/E, 11/18/2022; A, 08/31/2026]

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## REGULATION AND LICENSING DIVISION
### PHARMACY, BOARD OF

**This is an amendment to 16.19.6 NMAC, Section 30 effective 08/25/2026**

**16.19.6.30 REPACKAGING AND DISTRIBUTION BY A PHARMACY**

**A.** Scope: This section applies only to repackaging by a pharmacy licensed by the board under the conditions specified in this section.

**B.** Definitions as used in this section:

**(1) "administer"** means the direct application of a drug to the body of a patient or research subject by injection, inhalation, ingestion or any other means as a result of an order of a licensed practitioner;

**(2) "board"** means the New Mexico Board of Pharmacy;

**(3) "distribute"** means the delivery of a drug or device other than by administering or dispensing;

**(4) "finished drug product"** of a prescription drug is defined as that form of the drug which is, or is intended, to be dispensed or administered to the patient and requires no further manufacturing or processing other than packaging and labeling;

**(5) "FD&C Act"** means the Federal Food Drug and Cosmetic Act;

**(6) "repackaging"** means the of taking a finished drug product from the container in which it was distributed by the original manufacturer and placing it into a different container without further manipulation of the drug, excluding:

**(a)** placing medication in a different container to dispense directly to the patient pursuant to a patient-specific prescription;

**(b)** removing a drug product from the original container at the point of care for immediate administration to a single patient after receipt of a valid patient-specific prescription or order for that patient.

**(7) "USP"** means United States Pharmacopoeia;

**(8) "USP standards"** means standards published in the current official United States pharmacopoeia-national formulary.

**C.** A pharmacy licensed by the board may repackage under the following conditions:

**(1)** The pharmacy must qualify for an exemption from registration and listing requirements under Section 510 of the FD&C Act. Specifically, under Section 510(g)(1), the registration and listing requirements of Section 510 do not apply to: pharmacies which maintain establishments in conformance with any applicable local laws regulating the practice of pharmacy and medicine and which are regularly engaged in dispensing prescription drugs or devices, upon prescriptions of practitioners licensed to administer such drugs or devices to patients under the care of such practitioners in the course of their professional practice, and which do not manufacture, prepare, propagate, compound, or process drugs or devices for sale other than in the regular course of their business of dispensing or selling drugs or devices at retail.

**(2)** The drug product is not sold or transferred by an entity other than the entity that repackaged such drug product. For purposes of this condition, a sale or transfer does not include administration of a repackaged drug product in a health care setting.

**(3)** The drug repackaged is a finished drug product of a prescription drug that is:

**(a)** a non-sterile solid or liquid oral dosage form;

**(b)** approved under Section 505 of the FD&C Act;

**(c)** repackaged by or under the direct supervision of a pharmacist, and undergoes a final check by a pharmacist;

**(d)** handled and repackaged in accordance with all applicable USP chapters numbered less than <1000>;

**(e)** assigned a beyond use date in accordance with USP standards;

**(f)** repackaged, stored, and shipped in a way that does not conflict with approved drug product labeling;

**(g)** not adulterated by preparing, packing, or holding the drug product under insanitary conditions; and

**(h)** repackaged into a sealed unit-dose container, unless distributed in an appropriately labeled and packaged form to a contracted correctional facility for distribution to an inmate upon release.

**(4)** The repackaged drug product is distributed under the following conditions:

**(a)** by a managing pharmacy for use in an automated drug distribution system to supply medications for patients of a health care facility licensed under 16.19.11 NMAC, or inpatient hospice facility licensed under 16.19.10.12 NMAC, in accordance with 16.19.6.27 NMAC, or emergency kit;

**(b)** to a correctional facility, licensed by the board under 16.19.10.11 NMAC, for administration to an inmate, or for distribution of a properly labeled take home supply to an inmate upon release to avoid interruption in prescribed treatment, pursuant to a patient-specific prescription or order;

**(c)** to a clinic licensed by the board under 16.19.10.11 NMAC, and under the same ownership as the repackaging pharmacy, for administration to a patient of the clinic pursuant to a patient-specific prescription or order.

**(d)** by a contracted pharmacy to a custodial care facility authorized to provide dangerous drugs for medically monitored withdrawal management or directly related supportive care pursuant to 16.19.11.9 NMAC, for administration to a patient of the facility, consistent with state and federal law.

**(5)** All units of repackaged medication must be labeled with the following information:

**(a)** name, address, and telephone number of repackaging pharmacy, unless the repackaged drug is used in an automated drug distribution system in accordance with 16.19.6.27 NMAC;

**(b)** name, strength, and quantity of the drug;

**(c)** lot number or control number;

**(d)** name of manufacturer;

**(e)** beyond use date;

**(f)** date drug was repackaged;

**(g)** name or initials of repackager; and

**(h)** federal caution label, if applicable.

**(6)** A record of drugs repackaged must be maintained, and include the following:

**(a)** date of repackaging;

**(b)** name and strength of drug;

**(c)** manufacturer assigned drug lot number, and expiration date;

**(d)** name of drug manufacturer;

**(e)** assigned beyond-use date and lot number or control number;

**(f)** total number of dosage units (tabs, caps) repackaged;

**(g)** quantity per each repackaged unit container;

**(h)** number of dosage units wasted; and

**(i)** initials of repackager, and of pharmacist performing final check.

**(7)** Records as required by the Pharmacy Act including the Drug, Device, and Cosmetic Act; the Controlled Substance Act; and board regulations shall be maintained.

[16.19.6.30 NMAC - N, 11/28/2017; A, 5/07/2024; A, 08/25/2026]

## End of Adopted Rules

## Other Material Related to Administrative Law

## ENVIRONMENT DEPARTMENT

### NOTICE OF RADIOACTIVE MATERIALS LICENSE TERMINATIONS

The New Mexico Environment Department (Department) is hereby providing notice pursuant to Subsection E of 20.3.4.426 NMAC that the following licensees have submitted applications for the termination of their radioactive materials licenses:

HDR Construction Control Corporation Subsidiary of Engineering Inc, 2155 Louisiana Blvd, NE Suite 3000 Albuquerque, NM 87110
Pro Inspection Inc, 3762 Kermit Highway Odessa Texas, 79764
Marco Inspection Services Inc, PO Box 1941 Kilgore Texas, 75663
Constructors Inc, 812 George Shoup Relief Route Carlsbad, NM 88220
City of Deming, P.O. Box 706 Deming, NM 88031

During the evaluation period, the Department reviews and comments upon the application. The Department may, at its discretion, retain consultants to assist it in its evaluation of the application. Upon receipt of a license termination plan or decommissioning plan from the licensee, or a proposal by the licensee for release of the site pursuant to Subsections C or D of 20.3.4.426 NMAC, the Department will notify and solicit comments from local governments in the vicinity of the site of the licensed activity and any Indian nation or other indigenous people that have treaty or statutory rights that could be affected by the decommissioning of the site of the licensed activity. In the case where the licensee proposes to release a site pursuant to Subsection D of 20.3.4.426 NMAC, the Department will notify and solicit comments from the United States Environmental Protection Agency. Relevant comments and questions received by the Department from various agencies and interested parties will be forwarded to the applicant for response. Correspondence associated with the application will be on file with the Radiation Control Bureau and will be available for inspection by the applicant and any other interested party.

The Department requires an applicant to provide a license termination plan or decommissioning plan, and other materials addressing, among other things, the public health, safety and environmental aspects for the termination of the license.

The Department will analyze the license termination application carefully. During this analysis, the application will be reviewed to ensure that there are no deficiencies, that the application meets all applicable requirements and that there is no reason to believe that the termination of the license will result in the violation of any laws or regulations. If the Department is so satisfied, it will grant the application for the termination of the license.

The application is available for review at the following location:

New Mexico Environment Department
Radiation Control Bureau
525 Camino de los Marquez, Suite 1B
Santa Fe, NM 87502

It is anticipated that the review period will require about one month. Written comments and requests for public hearing will be accepted for 30 days after publication of this notice. Written comments regarding this license application should be directed to: New Mexico Environment Department, Radiation Control Bureau, P.O. Box 5469, Santa Fe, New Mexico 87502-5469.

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## ENVIRONMENT DEPARTMENT

### NOTIFICACIÓN DE TERMINACIONES DE LICENCIAS DE MATERIAL RADIACTIVO

El Departamento de Medio Ambiente de Nuevo México (Departamento) por el presente aviso notifica, de conformidad con la Subsección E de 20.3.4.426 NMAC, que los siguientes licenciatarios han presentado solicitudes para la terminación de sus licencias de materiales radiactivos:

HDR Construction Control Corporation Subsidiary of Engineering Inc, 2155 Louisiana Blvd, NE Suite 3000 Albuquerque, NM 87110
Pro Inspection Inc, 3762 Kermit Highway Odessa Texas, 79764
Marco Inspection Services Inc, PO Box 1941 Kilgore Texas, 75663
Constructors Inc, 812 George Shoup Relief Route Carlsbad, NM 88220
City of Deming, P.O. Box 706 Deming, NM 88031

Durante el período de evaluación, el Departamento revisa y hace comentarios sobre la solicitud. El Departamento puede, a su discreción, contratar consultores para que lo asistan en la evaluación de la solicitud. Tras recibir un plan de terminación de la licencia o un plan de desmantelamiento del licenciatario, o una propuesta por el licenciatario para la liberación del sitio de conformidad con las Subsecciones C o D de 20.3.4.426 NMAC, el Departamento notificará y solicitará comentarios a los gobiernos locales en las inmediaciones del sitio de la actividad autorizada, así como a cualquier nación indígena u otro pueblo indígena que tenga derechos legales por tratados o estatuarios que pudieran verse afectados por el desmantelamiento del sitio de la actividad autorizada. En caso de que el licenciatario proponga

liberar un sitio de conformidad con la Subsección D de 20.3.4.426 NMAC, el Departamento notificará a la Agencia de Protección Ambiental de los Estados Unidos (EPA, por sus siglas en inglés) y solicitará sus comentarios. Los comentarios y preguntas pertinentes que reciba el Departamento de diversas agencias y partes interesadas se remitirán al solicitante para su respuesta. La correspondencia relacionada con la solicitud se archivará en la Oficina de Control de la Radiación y estará disponible para su revisión por parte del solicitante y cualquier otra parte interesada.

El Departamento exige al solicitante que presente un plan de terminación de la licencia o un plan de desmantelamiento, así como otros documentos que aborden, entre otras cosas, los aspectos de salud pública, seguridad y medio ambiente para la terminación de la licencia.

El Departamento analizará cuidadosamente la solicitud de terminación de la licencia. Durante este análisis, se revisará la solicitud para garantizar que no presente deficiencias, que cumpla con todos los requisitos aplicables y que no exista razón para creer que la terminación de la licencia resultará en la violación de alguna ley o regulación. Si el Departamento considera que esto es así, aprobará la solicitud de terminación de la licencia.

La solicitud está disponible para revisión en la siguiente dirección:

Departamento de Medio Ambiente de Nuevo México
Oficina de Control de la Radiación
525 Camino de los Marquez, Suite 1B
Santa Fe, NM 87502

Se prevé que el período de revisión dure aproximadamente un mes. Se aceptarán comentarios por escrito y solicitudes de audiencia pública durante los 30 días posteriores a la publicación de este aviso. Los comentarios por escrito sobre esta solicitud de licencia deben dirigirse a: Departamento de Medio Ambiente de Nuevo México, Oficina de Control de la Radiación, P.O. Box 5469, Santa Fe, Nuevo México 87502-5469.

## End of Other Material Related to Administrative Law

# 2026 New Mexico Register

## Submittal Deadlines and Publication Dates

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| Issue 1 | January 2 | January 13 |
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