INDEX

8.305.1 GENERAL PROVISIONS

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TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 1 GENERAL PROVISIONS

8.305.1.1 ISSUING AGENCY: Human Services Department
[8.305.1.1 NMAC - Rp 8.305.1.1 NMAC, 7-1-04]

8.305.1.2 SCOPE: This rule applies to the general public.
[8.305.1.2 NMAC - Rp 8.305.1.2 NMAC, 7-1-04]

8.305.1.3 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 human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.305.1.3 NMAC - Rp 8.305.1.3 NMAC, 7-1-04]

8.305.1.4 DURATION: Permanent
[8.305.1.4 NMAC - Rp 8.305.1.4 NMAC, 7-1-04]

8.305.1.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.305.1.5 NMAC - Rp 8.305.1.5 NMAC, 7-1-04]

8.305.1.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.1.6 NMAC - Rp 8.305.1.6 NMAC, 7-1-04]

8.305.1.7 DEFINITIONS: The state of New Mexico is committed to improving the health status of New Mexico residents whose health care services are funded by the Title XIX (medicaid) program. As a means of improving health status, a capitated managed care plan has been implemented. This section contains the glossary for the New Mexico medicaid managed care policy. The following definitions apply to terms used in this chapter.

A. Definitions beginning with letter "A":

(1) **Abuse:** Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to medicaid in reimbursement for services that are not medically necessary, or in services that fail to meet professionally recognized standards for health care. Abuse also includes client or member practices that result in unnecessary costs to medicaid.

(2) **Action:** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

(3) **Appeal, member:** A request from a member or provider, on the member's behalf with the member's written permission, for review by the managed care organization (MCO) or the single statewide entity (SE) for behavioral health of an MCO or SE action as defined above in Paragraph (2) of Subsection A of 8.305.1.7 NMAC.

(4) **Appeal, provider:** A request by a provider for a review by the MCO or SE of an MCO or SE action related to the denial of payment or an administrative denial.

(5) **Approvals:** Approvals are either initial or concurrent review decisions, which yield utilization management authorizations based on the client meeting the clinical criteria for the requested medicaid service(s) or level of care.

(6) **Assignment algorithm:** Predetermined method for assigning mandatory enrollees who do not select an MCO.

B. Definitions beginning with letter "B":

(1) **Behavioral health:** Refers to mental health and substance abuse.

(2) **Behavioral health planning council (BHPC):** Refers to the council created by HB 271 to meet federal advisory council requirements and to provide consistent, coordinated input to behavioral health service delivery in New Mexico. The SE will be expected to interact with the BHPC as an advisory council.

(3) **Behavioral health purchasing collaborative:** Refers to the interagency behavioral health purchasing collaborative pursuant to the passage of HB 271, effective May 19, 2004. The collaborative is made up of 17 publicly funded statutory member agencies, including eight agencies that provide and fund direct services, including the human services department.

(4) **Benefit package:** Medicaid covered services that must be furnished by the MCO/SE and for which payment is included in the capitation rate.

C. Definitions beginning with letter "C":

(1) **Capitation:** A per-member, monthly payment to an MCO/SE that covers contracted services and is paid in advance of service delivery. A set amount of money received or paid out, based on membership rather than on services delivered. It is usually expressed as "per member per month" (PM/PM).

(2) **Care coordination for behavioral health:** An office-based administrative function to assist members with multiple, complex and special cognitive, behavioral or physical health care needs on an as needed basis. It is member-centered and consumer-directed, family-focused when appropriate, culturally competent and strengths-based. Care coordination ensures that medical and behavioral health needs are identified and services are provided and coordinated with the member and family, if appropriate. Care coordination operates independently within the SE and has separately defined functions with a dedicated care coordination staff, but is structurally linked to other SE systems, such as quality assurance, member services and grievances. Clinical decisions shall be based on the medically necessary covered services and not fiscal or administrative considerations. The care coordinator coordinates services within the behavioral health delivery system, as well as with other service providing systems. The care coordinator may interface and collaborate with the consumer's case manager, if applicable, for those who receive case management services. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute.

(3) **Care coordination for physical health:** An office-based administrative function to assist members with multiple, complex and special cognitive, behavioral or physical health care needs on an as needed basis. It is member-centered and consumer-directed, family-focused when appropriate, culturally competent and strengths-based. Care coordination ensures that medical and behavioral health needs are identified and services are provided and coordinated with the member and family if appropriate. Care coordination operates independently within the MCO and has separately defined functions with a dedicated care coordination staff, but is structurally linked to other MCO systems, such as quality assurance, member services and grievances. Clinical decisions shall be based on the medically necessary covered services and not fiscal or administrative considerations. The care coordinator coordinates services within the physical health delivery system, as well as with other service providing systems. The care coordinator may interface and collaborate with the member's case manager, if applicable, for those who receive case management services. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute.

(4) **Care coordination plan/individual plan of care (SE only):** The care coordination plan is based on a comprehensive assessment of the goals, capacities and the behavioral health service needs of the member and with consideration of the needs and goals of the family, if appropriate.

(5) **Case:** A household that medicaid treats as a unit for purposes of eligibility determination; for example, a parent and child; a legal guardian and child; or a set of siblings.

(6) **Case management for physical health:** The targeted case management programs, that are part of the medicaid benefit package. The targeted case management programs will continue to be important service components. In these programs, case managers typically function independently and assess a member's/family's needs and strengths; develop a service/treatment plan, coordinate, advocate for and link members to all needed services related to the targeted case management program.

(7) **Children with special health care needs (CSHCN):** Individuals under 21 years of age, who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally.

(8) **Clean claim:** A manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside the health plan's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A clean claim is not materially deficient or improper, such as lacking substantiating documentation currently required by the health plan, or has no particular or unusual circumstances requiring special treatment that prevents payment from being made by the health plan within 30 days of the date of receipt if submitted electronically or 45 days if submitted manually.

(9) **Client:** An individual who has applied for and been determined eligible for Title XIX (medicaid). A "client" may also be referred to as a "member", "customer", or "consumer".

(10) **CMS:** Centers for medicare and medicaid services.

(11) **Community-based care:** A system of care, which seeks to provide services to the greatest extent possible, in or near the member's home community.

(12) **Comprehensive community support services:** These services are goal-directed mental health rehabilitation services and supports for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. These services assist in the development and coordination of a member's service plan and include therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community.

(13) **Continuous quality improvement (CQI):** CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer-oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modification of improvements, as indicated.

(14) **Coordination of long-term services (CoLTS):** A coordinated program of physical health and community-based supports and services implemented under the authority of concurrent section 1915(b) and section 1915(c) home and community-based waivers. The CoLTS program includes individuals eligible for both medicare and medicaid, and persons eligible for medicaid long-term care services based on assessed need for nursing facility level of care. The CoLTS program does not include individuals who meet eligibility criteria set forth in New Mexico's developmental disabilities, AIDS and medically fragile waiver programs.

(15) **Cultural competence:** A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

(1) **Delegation:** A formal process by which an MCO/SE gives another entity the authority to perform certain functions on its behalf. The MCO/SE retains full accountability for the delegated functions.

(2) **Denial-administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by medicaid, not being on the MCO/SE formulary or due to provider noncompliance with administrative policies and procedures established by either the MCO/SE or the medical assistance division.

(3) **Denial-clinical:** A non-authorization decision at the time of an initial request for a medicaid service or a formulary exception request based on the member not meeting medical necessity for the requested service. The utilization management (UM) staff may recommend an alternative service, based on the client's need for a lower level of service. If the requesting provider accepts this alternative service, it is considered a new request for the alternative service and a clinical denial of the original service request.

(4) **Disease management plan:** A comprehensive plan following nationally recognized components for chronic disease interventions including population identification/stratification process, collaborative practice models, patient self-management education process, evidence-based practice guidelines, process and outcomes measurements, and internal quality improvement processes.

(5) **Disenrollment, MCO initiated:** When requested by an MCO for substantial reason, removal of a medicaid member from membership in the requesting MCO, as determined by HSD, on a case-by-case basis.

(6) **Disenrollment, member initiated (switch):** When requested by a member for substantial reason, transfer of a medicaid member as determined by HSD on a case-by-case basis, from one MCO to a different MCO during a member lock-in period.

(7) **Durable medical equipment (DME):** Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is not useful to individuals in the absence of an illness or injury and is appropriate for use at home.

E. Definitions beginning with letter "E":

(1) **Emergency:** An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (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.

(2) **Encounter:** The record of a physical or behavioral health service rendered by a provider to an MCO/SE member, client, customer, or consumer.

(3) **Enrollee:** A medicaid recipient who is currently enrolled in a managed care organization in a given managed care program.

(4) **Enrollee rights**: Rights which each managed care enrollee is guaranteed.

(5) **Enrollment:** The process of enrolling eligible clients in an MCO/SE for purposes of management and coordination of health care delivery.

(6) **EPSDT:** Early and periodic screening, diagnostic and treatment.

(7) **Exempt:** The enrollment status of a client who is not mandated to enroll in managed care.

(8) **Exemption:** Removal of a medicaid member from mandatory enrollment in managed care and placement in the medicaid fee-for-service program. Such action is only for substantial reason, as determined by HSD on a case-by-case basis.

(9) **Expedited appeal:** A federally mandated provision for an expedited resolution within three working days of the requested appeal, which includes an expedited review by the MCO/SE of an MCO/SE action.

(10) **External quality review organization (EQRO):** An independent organization with clinical and health services expertise capable of reviewing the evidence of compliance of health care delivery and internal quality assurance/improvement requirements.

F. Definitions beginning with letter "F":

(1) **Family-centered care:** When a child is the patient, the system of care reflects the importance of the family or legal guardian in the way services are planned and delivered. Family-centered care facilitates collaboration between family members and medical professionals, builds on individual and family strengths and respects diversity of families.

(2) **Family planning services:** Services provided to members of childbearing age to temporarily or permanently prevent or delay pregnancy (see MAD-762, *Reproductive Health Services*).

(3) **Fee-for-service (FFS):** The traditional medicaid payment method whereby payment is made by HSD to a provider after services are rendered and billed.

(4) **Fraud:** An intentional deception or misrepresentation made by an entity or person, including but not limited to, an MCO/SE, subcontractor, provider or client with the knowledge that the deception could result in some unauthorized benefit to himself or to some other previously described entity or person. It includes any act that constitutes fraud under applicable federal or state law.

(5) **Full risk contracts:** Contracts that place the MCO/SE at risk for furnishing or arranging for comprehensive services.

G. Definitions beginning with letter "G":

(1) **Gag order:** Subcontract provisions or MCO/SE practices, either written, oral or implied, that effectively prevent a provider from furnishing accurate or complete information to members about options for diagnosis or treatment of physical, mental or behavioral illness, injury, or condition; or prevent a provider from talking to the member or HSD about the MCO/SE or its business practices.

(2) **Grievance (member):** Oral or written statement by a member expressing dissatisfaction with any aspect of the MCO/SE or its operations that is not an MCO/SE action.

(3) **Grievance (provider):** Oral or written statement by a provider to the MCO/SE expressing dissatisfaction with any aspect of the MCO/SE or its operations that is not an MCO/SE action.

H. Definitions beginning with letter "H":

(1) **HCFA:** Health care financing administration. Effective 2001, the name was changed to centers for medicare and medicaid services (CMS).

(2) **Health plan:** A health maintenance organization (HMO), managed care organization (MCO), prepaid inpatient health plan (PIHP), or third party payer or their agents.

(3) **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

(4) **Hospitalist:** A physician employed by a hospital to manage the care of a member admitted to the hospital for inpatient care.

(5) **Human services department (HSD):** The sole executive department in New Mexico responsible for the administration of Title XIX (medicaid). "HSD" may also indicate the department's designee, as applicable.

I. Definitions beginning with letter "I":

(1) **IBNR (claims incurred but not reported):** Claims for services authorized or rendered for which the MCO/SE has incurred financial liability, but the claim has not been received by the MCO/SE. This estimating

method relies on data from prior authorization and referral systems, other data analysis systems and accepted accounting practices.

(2) **Individuals with special health care needs (ISHCN):** Individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or have low to severe functional limitation and who also require health and related services of a type or amount beyond that required by individuals generally.

J - L: [RESERVED]

M. Definitions beginning with letter "M":

(1) **Managed care organization (MCO):** An organization licensed to manage, coordinate and assume financial risk on a capitated basis for the delivery of specified services to enrolled members from a certain geographic area. Also referred to as a managed care plan and managed care program.

(2) **Marketing:** The act or process of promoting a business or commodity. Marketing includes brochures, leaflets, internet, newspaper, magazine, radio, television, billboard materials, MCO/SE yellow page advertisements, and any other presentation materials used by an MCO/SE, MCO/SE representative, or MCO/SE subcontractor to attract or retain medicaid enrollment.

(3) **MCO/SE:** The use of MCO/SE in these medicaid managed care regulations indicates the following regulation applies to both the MCO and the SE who must each comply with the regulation independent of each other.

(4) **MCO/SE mandatory enrollee:** A client whose enrollment into an MCO/SE is mandated.

(5) **Medicaid:** The medical assistance program authorized under Title XIX of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.

(6) **Medical/clinical home:** A conceptual model that facilitates the provision of quality care that is accessible, family-centered, continuous, coordinated, compassionate and culturally competent.

(7) **Medically necessary services:**

(a) Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(i) are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;

(ii) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;

(iii) are provided within professionally accepted standards of practice and national guidelines; and

(iv) are required to meet the physical and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.

(b) Application of the definition:

(i) a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit;

(ii) the MCO/SE making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the medicaid benefit package applicable to an eligible individual shall do so by: 1) evaluating individual physical and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate; 2) considering the views and choices of the individual or the individual's legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views; and 3) considering the services being provided concurrently by other service delivery systems;

(iii) physical and behavioral health services shall not be denied solely because the individual has a poor prognosis; required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness or condition; and

(iv) decisions regarding benefit coverage for children shall be governed by the EPSDT coverage rules.

(8) **Member:** A client enrolled in an MCO/SE.

(9) **Member month:** A calendar month during which a member is enrolled in an MCO/SE.

(10) **Mi via home and community-based waiver:** The New Mexico self-directed medicaid waiver program that supports New Mexicans with disabilities and the elderly by allowing recipients to be active participants in choosing where and how they live and what services and supports they purchase.

N. Definitions beginning with letter "N":

(1) **National committee for quality assurance (NCQA):** A private national organization that develops quality standards for managed health care.

(2) **Network provider:** An individual provider, clinic, group, association or facility employed by or contracted with an MCO/SE to furnish medical or behavioral health services to the MCO's/SE's members under the provisions of the medicaid managed care contract.

O. [RESERVED]

P. Definitions beginning with letter "P":

(1) **Pend decision:** A prior authorization decision is considered pended when the decision is delayed due to lack of documentation, inability to contact parties involved or other reason which delays finalizing an approval. A decision by an MCO/SE to pend approval does not extend or modify required utilization management decision timelines.

(2) **Performance improvement project (PIP):** An MCO/SE QM program activity must include projects that are designed to achieve significant improvement in clinical or non-clinical care areas. PIPs must involve measurements using objective quality indicators, system intervention to achieve improvement, evaluation of the effectiveness of interventions and activities for increasing or sustaining improvement. Outcomes must be measurable over a period of time.

(3) **Performance measurement (PM):** Data specified by the state that enables the MCO/SE's performance to be determined.

(4) **Plan of care:** A written document including all medically necessary services to be provided by the MCO/SE for a specific member.

(5) **Policy:** The statement or description of requirements.

(6) **Potential enrollee:** A medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO/SE.

(7) **Pregnancy-related services:** Medically necessary medical or surgical services related to pregnancy, including procedures to terminate pregnancy.

(8) **Primary care:** All health services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician assistant or certified nurse practitioner.

(9) **Preventive health services:** Services that follow current national standards for prevention including both physical and behavioral health.

(10) **Primary care case management (PCCM):** A medical care model in which clients are assigned to a primary care provider who is responsible for managing the quality, appropriateness, and efficiency of the care they receive. The primary care provider is responsible for furnishing case management services to medicaid eligible recipients that include the location, coordination, and monitoring of primary health care services and the appropriate referral to specialty care services.

(11) **Primary care case manager :** A physician, a physician group practice, an entity that medicaid-eligible recipients employ or arrange with physicians to furnish primary care case management services or, at state option, any of the following:

(a) a physician assistant;

(b) a nurse practitioner; or

(c) a certified nurse midwife.

(12) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to members in the managed care program.

(13) **Procedure:** Process required to implement a policy.

(14) **Protected behavioral health information:** All of the information from the individual receiving behavioral health services, obtained in conversation or in writing, held in memory or written down, learned by behavioral health professionals in the course of assessment or treatment for mental or emotional problems, substance abuse issues or problems with living and includes the thoughts, opinions, diagnoses and assessments that the behavioral health professional develops based on the information the individual has given.

Q. [RESERVED]

R. Definitions beginning with letter "R":

(1) **Rate cell:** A combination of category of eligibility and demographics used to isolate utilization patterns for the determination of capitation.

(2) **Received but unpaid claims (RBUC):** Claims received by the MCO/SE but not paid affecting appropriate expense and aging accounting categories. Such claims are counted as of the date of receipt by the MCO/SE.

(3) **Reduction of care:** A utilization management staff authorization of the type of service requested by the provider but in lesser amounts or units of service than were originally requested. The authorization is based on the client's physical health (medical needs) or behavioral health (clinical needs).

(4) **Referral:** Any specialty, inpatient, outpatient, or diagnostic services that a physician or physician group orders or arranges, but does not provide directly.

(5) **Reinsurance:** Reinsurance is a proactive financial tool that may be used by an MCO/SE to minimize exposure to losses incurred when members utilize health care services beyond anticipated levels or overall member utilization is greater than expected.

(6) **Risk:** The possibility that revenues of the MCO/SE will not be sufficient to cover expenditures incurred in the delivery of contractual services.

(7) **Routine care:** All care, which is not emergent or urgent.

S. Definitions beginning with letter "S":

(1) **Salud!:** The New Mexico managed care program implemented in 1997, covering children, pregnant women and disabled New Mexicans. Parents of medicaid-eligible children are also covered by medicaid if they meet eligibility requirements.

(2) **Single statewide entity (SE):** The entity selected by the state of New Mexico through the behavioral health collaborative to perform all contract functions defined in the behavioral health request for proposal (RFP). The SE is a single contractor selected to provide all defined service responsibilities statewide, including medicaid behavioral health benefits. The SE will administer both the medicaid managed care and medicaid fee-for-service (FFS) programs for all medicaid behavioral health services. The SE shall be responsible for contracting with providers, paying provider claims, assuring care coordination, conducting utilization review and utilization management activities, assuring quality review and service delivery improvement, credentialing practitioners and provider agencies, privileging practitioners to deliver critical services or service approaches, evaluating and monitoring of service delivery and conducting any other administrative functions necessary to achieve the goals of the collaborative. The SE is the agent of the collaborative and shall "coordinate", "braid" or "blend" the funding, human resources and service capacity available from the various state agencies so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for New Mexico.

(3) **Subcontract:** A written agreement between the MCO/SE and a third party, or between a subcontractor and another subcontractor, to provide services.

(4) **Subcontractor:** A third party who contracts with the MCO/SE or an MCO/SE subcontractor for the provision of services.

T. Definitions beginning with letter "T":

(1) **Targeted case management:** Services that are aimed specifically at special groups of members like adults with developmental disabilities.

(2) **Terminations of care:** The utilization management review decision made during a concurrent review, which yields a denial, based on the current service being no longer medically necessary.

(3) **Third party:** An individual entity or program, which is or may be, liable to pay all or part of the expenditures for medicaid members for services furnished under a state plan.

(4) **Transition of care:** The process when a member is assisted with access to necessary care when the member moves from one health care practitioner or setting to another as their condition and care needs change.

U. Definitions beginning with letter "U": **Urgent condition:** Acute signs and symptoms, which, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.

V. Definitions beginning with letter "V": **Value added service:** Any service offered to members by the MCO/SE that is not included in the managed care medicaid benefit package and is not a medicaid funded service, benefit or entitlement under the NM Public Assistance Act.

[8.305.1.7 NMAC - Rp 8.305.1.7 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.1.8 MISSION STATEMENT: The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New

Mexico equal participation in the life of their communities.
[8.305.1.8 NMAC - Rp 8.305.1.8 NMAC, 7-1-04; A, 7-1-09]

HISTORY OF 8.305.1 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
8 NMAC 4.MAD.606.1.1, Managed Care Policies, Definitions, 6-19-97.

History of Repealed Material:
8 NMAC 4.MAD.606.1.1, Managed Care Policies, Definitions - Repealed, 7-1-01.
8.305.1 NMAC, General Provisions - Repealed 7-1-04.