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TITLE 8 SOCIAL SERVICES
CHAPTER 291 MEDICAID ELIGIBILITY - AFFORDABLE CARE
PART 400 ELIGIBILITY REQUIREMENTS

8.291.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.291.400.1 NMAC - Rp, 8.291.400.1 NMAC, 10/1/2017]

8.291.400.2 SCOPE: The rule applies to the general public.
[8.291.400.2 NMAC - Rp, 8.291.400.2 NMAC, 10/1/2017]

8.291.400.3 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 or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.291.400.3 NMAC - Rp, 8.291.400.3 NMAC, 10/1/2017]

8.291.400.4 DURATION: Permanent.
[8.291.400.4 NMAC - Rp, 8.291.400.4 NMAC, 10/1/2017]

8.291.400.5 EFFECTIVE DATE: October 1, 2017, unless a later date is cited at the end of a section.
[8.291.400.5 NMAC - Rp, 8.291.400.5 NMAC, 10/1/2017]

8.291.400.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.291.400.6 NMAC - Rp, 8.291.400.6 NMAC, 10/1/2017]

8.291.400.7 DEFINITIONS:

A. Action: an approval, termination, suspension, or reduction of medicaid eligibility or a reduction in the level of benefits and services, including a determination of income for the purposes of imposing any premiums, enrollment fees, or cost-sharing. It also means determinations made by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determination made by a state with regard to the preadmission screening and resident review requirements.

B. Advance payments of the premium tax credit (APTC): payment of the tax credits specified in Section 36B of the Internal Revenue Code which are provided on an advance basis to an eligible individual enrolled in a qualified health plan through an exchange.

C. Affordable Care Act (ACA): the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and the Three Percent Withholding Repeal and Job Creation Act (Public Law 112-56).

D. Affordable insurance exchanges (exchanges): a governmental agency or non-profit entity that meets the applicable requirements and makes qualified health plans available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to state exchanges, regional exchanges, subsidiary exchanges, and a federally-facilitated exchange.

E. Agency: the single state agency designated or established by a state to administer or supervise the administration of the medicaid state plan. This designation includes a certification by the state attorney general, citing the legal authority for the single state agency to make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

F. Appeal record: the appeal decision, all papers and requests filed in the proceeding, and if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing, and any exhibits introduced at the hearing.

G. Appeal request: a clear expression, either verbally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have any eligibility determination or redetermination contained in a notice issued reviewed by an appeals entity.

H. Appeals entity: a body designated to hear appeals of eligibility determinations or redeterminations contained in notices, or notices issued in accordance with future guidance on exemptions.

I. Appeals decision: a decision made by a hearing officer adjudicating a fair hearing, including by a

hearing officer employed by an exchange appeals entity to which the agency has delegated authority to conduct such hearings.

J. Applicable modified adjusted gross income (MAGI) standard: the income standard for each category of ACA eligibility.

K. Application: the single streamlined application required by ACA and other medicaid applications used by the agency.

L. Authorized representative: the agency must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency.

(1) Such a designation must be in writing including the applicant's signature, and must be permitted at the time of application and at other times. Legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the applicant or beneficiary.

(2) Representatives may be authorized to:

(a) sign an application on the applicant's behalf;

(b) complete and submit a renewal form;

(c) receive copies of the applicant or beneficiary's notices and other communications from the agency; and

(d) act on behalf of the applicant or beneficiary in all other matters with the agency.

(3) The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on their behalf, or the authorized representative informs the agency that they are no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and should include the applicant or authorized representative's signature as appropriate.

(4) The authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual they represent, and must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

(5) As a condition of serving as an authorized representative, a provider, staff member or volunteer of an organization must sign an agreement that they will adhere to the regulations relating to confidentiality (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

M. Beneficiary: an individual who has been determined eligible and is currently receiving medicaid.

N. Citizenship: a national of the United States means a citizen of the United States or a person who, though not a citizen of the United States, owes permanent allegiance to the United States.

O. Code: the internal revenue code.

P. Coordinated content: information included in an eligibility notice regarding the transfer of the individual's or households electronic account to another insurance affordability program for a determination of eligibility.

Q. Current beneficiaries: individuals who have been determined financially eligible for medicaid using MAGI-based methods.

R. Dependent child: an un-emancipated child who is under the age of 19.

S. Documentary evidence: a photocopy facsimile, scanned or other copy of a document must be accepted to the same extent as an original document.

T. Electronic account: an electronic file that includes all information collected and generated by the state regarding each individual's medicaid eligibility and enrollment, including all documentation required to support the agency's decision on the case.

U. Expedited appeals: the agency must establish and maintain an expedited review process for hearings when an individual requests or a provider requests, or supports the individual's request, that the time otherwise permitted for a hearing could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function. If the agency denies a request for an expedited appeal, it must use the standard appeal timeframe.

V. Family size: the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant individual, the pregnant individual is counted as themselves plus the number of children they are expected to deliver. In the case of determining the family size of other individuals who

have a pregnant individual in their household, the pregnant individual is counted as themselves plus the number of children they are expected to deliver.

W. Insurance affordability program: a state medicaid program under Title XIX of the act, state children's health insurance program (CHIP) under Title XXI of the act, a state basic health program established under ACA and coverage in a qualified health plan through the exchange with cost-sharing reductions established under Section 1402 of ACA.

X. MAGI-based income: For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine a modified adjusted gross income as defined in Section 36B(d)(2) (B) of the Internal Revenue Code, with the certain exceptions.

Y. Managed care organization (MCO): an organization licensed or authorized through an agreement among state entities to manage, coordinate and receive payment for the delivery of specified services to medicaid eligible members.

Z. Modified adjusted gross income (MAGI): has the meaning of 26 CFR 1.36B-1 Section (2).

AA. Non-applicant: an individual who is not seeking an eligibility determination for themselves and is included in an applicant's or beneficiary's household to determine eligibility for such applicant or beneficiary.

BB. Non-citizen: an individual who is not a citizen or national of the United States (8 USC 1101(a)(22).

CC. Parent caretaker: a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes) and who is one of the following:

(1) the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;

(2) the spouse of such parent or relative, even after the marriage is terminated by death or divorce; or

(3) other relatives within the fifth degree of relationship (42 CFR 435.4).

DD. Patient Protection and Affordable Care Act (PPACA): also known as the Affordable Care Act (ACA) and is the health reform legislation passed by the 111th congress and signed into law in March of 2010.

EE. Tax dependent: has the same meaning as the term "dependent" under Section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under Section 151 of the Internal Revenue Code for a taxable year.

[8.291.400.7 NMAC - Rp, 8.291.400.7 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.8 MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.291.400.8 NMAC - Rp, 8.291.400.8 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.9 LEGAL BASIS: HSD is the single state agency designated to administer the New Mexico Title XIX medicaid program in accordance with 42 CFR 431.10, single state agency. State authority is provided by Section 27-2-12 NMSA 1978 (Repl. 1984). Title XIX of the Social Security Act and United States department of health and human services rules establish the requirements for state plans for medical assistance.

[8.291.400.9 NMAC - Rp, 8.291.400.9 NMAC, 10/1/2017]

8.291.400.10 BASIS FOR DEFINING GROUP: Medicaid is a federally matched program that makes certain essential health care services available to eligible New Mexico residents who otherwise would not have the financial resources to obtain them. With certain exceptions, medicaid benefits are provided through the department's medicaid managed care program.

A. Requirements outlined in 8.291.400 through 8.298.600 NMAC provides eligibility requirements for the ACA related categories listed below.

B. ACA related categories include the following:

(1) other adult;

(2) parent caretaker;

(3) pregnant women;

(4) pregnancy-related services;

(5) children under 19 years of age;

(6) adult caretaker recipients who are in transition to self-support due to the amount of

spousal support; and

(7) adult caretaker recipients who are in transition to self-support due to the amount of earned income.

[8.291.400.10 NMAC - Rp, 8.291.400.10 NMAC, 10/1/2017]

8.291.400.11 CONTINUOUS ELIGIBILITY FOR CHILDREN(42 CFR 435.926):

A. HSD provides continuous eligibility for the period specified in Subsection B of 8.291.400.11 NMAC for an individual who is:

(1) under age 19; and

(2) eligible and enrolled for mandatory or optional coverage under the state plan.

B. The continuous eligibility period is 12 months. The continuous eligibility period begins on the effective date of the individual's eligibility or most recent redetermination or renewal of eligibility.

C. A child's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) the child attains the maximum age of 19;

(2) the child or child's representative requests a voluntary termination of eligibility;

(3) the child ceases to be a resident of New Mexico;

(4) the agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or

(5) The child dies.

[8.291.400.11 NMAC - Rp, 8.291.400.11 NMAC, 10/1/2017]

8.291.400.12 REPORTING REQUIREMENTS: A medicaid eligible recipient is required to report certain changes which might affect their eligibility to ISD within 10 calendar days from the date the change occurred. A timely change that is reported within 10 calendar days that may result in a more beneficial medicaid eligibility category shall be evaluated in the month the change occurred. An untimely change that is reported after 10 calendar days that may result in a more beneficial medicaid eligibility category shall be evaluated in the month the change was reported. A reported change that does not result in the same or a more beneficial medicaid category is considered an adverse action and is applied prospectively in accordance with 8.100.180.10 NMAC. See 8.100.110.9 NMAC for the various ways applicants and recipients can submit changes to the HSD. The following changes must be reported to ISD:

A. living arrangements or change of address: any change in where an individual lives or receives mail must be reported;

B. household size: any change in the household size must be reported, this includes the death of an individual included in the assistance unit or budget group;

C. enumeration: any new social security number must be reported; or

D. income: any increase or decrease in the amount of income or change in the source of income must be reported.

[8.291.400.12 NMAC - Rp, 8.291.400.12 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.13 PRESUMPTIVE ELIGIBILITY: Presumptive eligibility (PE) provides medicaid benefits under one of the eligible groups outlined in Subsection B of 8.291.400.10 NMAC, starting with the date of the PE determination and ending with the last day of the following month or, if an ongoing application is submitted at the time the PE is granted or at any time during the approved PE period, the PE will remain open until the ongoing application is approved or denied.

A. Only one PE approval is allowed per pregnancy or per 12-month period for other ACA related categories.

B. Determinations can only be made by individuals employed by eligible entities and certified as presumptive eligibility determiners (PEDs) by the medical assistance division (MAD).

(1) Processing PE information: PEDs must notify MAD within 24 hours of the determination of presumptive eligibility.

(2) PE: The PED must process the presumptive eligibility and encourage clients to submit an ongoing application for medicaid eligibility. If the client elects to do so, the PED must assist the client with the submission of an application for medical assistance.

(3) Provider eligibility: Entities who may participate in the PE program must be:

(a) a qualified hospital that participates as a provider under the medicaid state plan or a medicaid 1115 demonstration who notifies the medicaid agency of its election to make presumptive eligibility determinations and agrees to make PE determinations consistent with state policies and procedures; or

(b) an entity or provider that has not been disqualified by the medicaid agency for failure to make PE determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the medicaid agency; or

(c) a federally qualified health center (FQHC), an Indian health service (IHS) facility, a state of New Mexico agency, a school, or a head start agency or a primary care provider who is contracted with at least one HSD contracted MCO; or

(d) other entities HSD has determined as an eligible presumptive participant.

C. PE approval limitations:

(1) all MAD authorized PE determiners can approve PE for children and pregnant women ACA categories;

(2) hospitals opting to participate in the PE program and correctional facilities (state prisons and county jails), health facilities operated by the Indian health service, a tribe, or tribal organization or an urban Indian organization can approve PE for all ACA related categories.

D. If, at the time of a PE approval, the client agrees to submit an application for ongoing coverage, the PED must submit the application within ten days of the PE approval.

E. A pregnant individual who has been approved for PE can receive ambulatory prenatal care during the PE approval period as defined in 8.291.400.13 NMAC.

(1) For PE, an approved PED must accept self-attestation of pregnancy.

(2) The needs and income of the unborn child(ren) are considered when determining the woman's countable family size.

[8.291.400.13 NMAC - Rp, 8.291.400.13 NMAC, 10/1/2017; A, 4/5/2022]

8.291.400.14 PREGNANT INDIVIDUALS ELIGIBLE FOR EXTENDED OR CONTINUOUS ELIGIBILITY (42 CFR 435.170):

A. Extended eligibility for pregnant individuals: For a pregnant individual who was eligible and enrolled for mandatory or optional coverage under the state plan on the date their pregnancy ends (regardless of the reason the pregnancy ends), HSD provides full medicaid coverage through the last day of the month in which the 12-month postpartum period ends.

B. Continuous eligibility for pregnant individuals: For a pregnant individual who was eligible and enrolled for mandatory or optional coverage under the state plan and who, because of a change in circumstance (e.g., income, household, composition, aging out etc.), will not otherwise remain eligible, HSD provides full medicaid coverage through the last day of the month in which the 12-month postpartum period ends.

(1) The following populations are provided continuous eligibility effective April 1, 2022:

(a) Current medicaid recipients who are pregnant as of April 1, 2022 or who enroll based on pregnancy or become pregnant after April 1, 2022.

(b) Current medicaid recipients who are receiving medicaid while pregnant and who are no longer pregnant as of April 1, 2022, but who are still within a 12-month postpartum period; and

(c) Individuals who apply for medicaid after their pregnancy ends, who received medicaid-covered services while pregnant on or after April 1, 2022 if such services were received during an approved period of retroactive eligibility.

(**2**) The following applies to certain categories or individuals:

(a) An individual approved on the other adult category who becomes pregnant may remain on the adult category and receive services under the alternative benefit plan (ABP). The ABP is considered full benefits for the purpose of the 12-month extended postpartum period. An individual on the other adult category who becomes pregnant may also transition to another full coverage medicaid category such as pregnant women or parent/caretaker and will remain eligible until their 12-month postpartum period expires.

(b) Children turning age 19 aging out of a children's medicaid category will remain on a children's medicaid category until their 12-month postpartum period expires.

(c) An individual covered on the parent/caretaker category during a 12-month postpartum period and who has increased earnings or spousal support above the parent/caretaker category limit will remain on the parent/caretaker category until their 12-month postpartum period expires and then can transition to a four or 12-month transitional medical assistance period.

(d) An individual who becomes pregnant during the 12-month postpartum period is

entitled to 12-months continuous coverage through the end of the second pregnancy and the 12-month postpartum period following.

(e) The extended 12-month postpartum period applies to individuals receiving medicaid who are lawfully residing children under age 21 and pregnant individuals referred to as "CHIPRA 214".

C. Renewals: Medicaid renewals are conducted at the end of the individual's 12-month postpartum period. Individuals remain enrolled in the eligibility group in which the individual was enrolled during pregnancy through the end of the 12-month postpartum period as described in subparagraph (b) of 8.291.400.14 NMAC.

D. There is not extended or continuous medicaid eligibility for a pregnant individual covered during a presumptive eligibility period under section 1920 of the ACT.

E. An individual's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) the individual or their representative requests a voluntary termination of eligibility;

(2) the individual ceases to be a resident of New Mexico;

(3) eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of HSD error or fraud, abuse, or perjury attributed to the individual; or

(4) the individual dies.

[8.291.400.14 NMAC - N, 4/5/2022]

HISTORY OF 8.291.400 NMAC:

History of Repealed Material:
8.291.400 NMAC, Eligibility Requirements, filed 9/17/2013 - Duration expired 12/31/2013.
8.291.400 NMAC, Eligibility Requirements, filed 12/2/2013 - Repealed effective 10/1/2017.

NMAC History:
8.291.400 NMAC, Eligibility Requirements, filed 9/17/2013 was replaced by 8.291.400 NMAC, Eligibility Requirements effective 10/1/2017.