State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
MEDICARE SAVINGS PROGRAMS

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY
The Human Services Department (HSD) is proposing to update the Special Low-Income Medicare Beneficiary (SLIMB) and the Qualified Individual (QI-1) Medicare Savings Programs, Category of Eligibility 045. Changes include: the removal of parental support as a condition of eligibility because it does not apply to Medicaid programs; citizenship and identity requirements; correction of citations and grammatical errors; and the removal of outdated material.

VI. REGULATIONS
These proposed regulations will be contained in SMB-400 (8.245.400 NMAC), SMB-500 (8.245.500 NMAC), SMB-600 (8.245.600 NMAC), QIS-400 (8.250.400 NMAC), QIS-500 (8.250.500 NMAC), and QIS-600 (8.250.600 NMAC) of the Medical Assistance Program Manual. All manual sections are available on the Medical Assistance Division web site at www.state.nm.us/hsd/mad/progmanindex.htm. If you do not have Internet access, a copy of the regulations may be requested by contacting the Medical Assistance Division at 827-3156.

VII. EFFECTIVE DATE
The Department proposes to implement these regulations effective December 1, 2009.

VIII. PUBLIC HEARING
A public hearing to receive testimony on these proposed regulations will be held at 9:00 a.m. on Thursday, October 15, 2009 in the HSD Law Library in Pollon Plaza. 2009 S. Pacheco St., Santa Fe, New Mexico.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division

toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Pamela S. Hyde, J.D., Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 PM on October 15, 2009. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons my also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these regulations approved on

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PAMELA S. HYDE, J.D, SECRETARY
HUMAN SERVICES DEPARTMENT

400 SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) - CATEGORY 045

To be eligible for Category 045, an applicant/recipient must be covered by Medicare Part A. The Part A insurance is a free entitlement to Social Security beneficiaries who are [~~sixty-five (65)~~] 65 years of age or older or who have received Social Security disability payments for [~~twenty-four (24)~~] 24 months. Fully or currently insured workers, or their dependents, with end-stage renal disease are also covered under Medicare. [2-1-95]

412 CITIZENSHIP AND IDENTITY

[~~Refer to Medical Assistance Program Manual Section MAD 412, 412.1, and 412.2.~~] Individuals entitled to or receiving medicare already meet citizenship and identity requirements. [2-1-95, 4-30-98]

[~~**412.1 Verification of Citizenship**~~

~~Citizenship determinations rendered by the Social Security Administration (SSA) for SSI are final.~~

~~412.11 Documentation of Citizenship~~ ~~Primary documentation of citizenship is a birth certificate. Secondary documentation includes:.~~

~~Certificate of naturalization;~~

~~2. Citizenship certificate;~~

~~3. Other resident identification documents issued by the U.S. Immigration and Naturalization Service, such as:~~

~~A. U.S. passport issued by the U.S. State Department;~~

~~B. Consular report of birth;~~

~~C. Certification of birth issued by the United States State Department, proof of marriage to a U.S. citizen before September 2, 1922, and a card of identity and registration of a U.S. citizen; or~~

~~D. Official communication from an American Foreign~~

~~Service Post indicating that the applicant/recipient is registered as a United States citizen.~~

~~**412.12 Declaration of Citizenship, Nationality or Immigration Status**~~
~~As a condition of eligibility, the Human Services Department (HSD) requires a declaration by the applicant/recipient, another person on behalf of a child or an applicant/recipient who is mentally incapacitated, which specifies whether the applicant/recipient is a citizen or national of the United States. If not, the declaration must also state that the applicant/recipient is in satisfactory immigration status.~~

~~Eligibility is not denied solely because an applicant/recipient cannot legally sign the declaration and the individual who is legally able to do so refuses to sign on behalf of the applicant/recipient or to cooperate, as required.~~]

[2-1-95]

434 ASSIGNMENT OF SUPPORT [2-1-95]

434.2 [~~Assignment of Parental Support~~

~~Assignment of parental support rights is required for all minor Medicaid recipients with absent or deceased parents. By signing applications and receiving Medicaid benefits, applicants/recipients have assigned support rights and indicated agreement to cooperate with parental support requirements. See Section MAD-425, ELIGIBILITY ASSIGNMENT AND COOPERATION REQUIREMENTS.~~

~~Medicaid benefits are not denied to otherwise eligible recipients solely because they cannot legally assign their own support rights when the individual who is legally able to assign their rights refuses to assign or cooperate, as required by law.~~]

[2-1-95]

510 RESOURCE STANDARDS

The value of an applicant/recipient's countable resources must not exceed $4,000.

The resource limit for an applicant couple is $6,000. An applicant/recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed $6,000, when resources are deemed.

A resource determination is always made as of the first moment of the first day of the month. An applicant/recipient is ineligible for any month in which the countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the amount of resources during a month do not affect eligibility for that month. [~~See Section SSI-510, SUPPLEMENTAL SECURITY INCOME METHODOLOGY~~] See 8.215.500.11 NMAC, *Resource Standards*, for information on exclusions, disregards, and countable resources.

515 RESOURCE TRANSFERS

The Social Security Administration excluded transfer of resources as a factor of eligiblity for non-institutionalized SSI recipients. Transfer of resources is not a factor for consideration in [~~categories that use SSI methodology in the eligibility determination.~~] the medicare savings programs.

520 INCOME STANDARDS

Income standards for this category are at least 100% but no more than [~~110%~~] 120% of the federal income poverty guidelines. The federal income poverty guidelines are adjusted annually, effective April 1. [~~See Section MAD-520, INCOME STANDARDS and Section SSI-521, SUPPLEMENTAL SECURITY INCOME METHODOLOGY~~] See 8.200.520 NMAC, *Income Standards*, and 8.215.500.19 NMAC, *Income Standards*, for information on exclusions, disregards, and countable income.

[~~Effective January 1, 1995 the upper SLIMB income limit will be 120% of the current federal poverty income level.~~]

Verification of income must be documented in the case file.

523 DEEMED INCOME

If an applicant/recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered.

If an applicant/recipient is married and lives with a spouse, deemed income from the spouse must be considered. [~~See Section SSI-523, SUPPLEMENTAL SECURITY INCOME METHODOLOGY~~] See 8.215.500.12 NMAC, *Deemed Income*, for information on deemed incomes.

600 BENEFIT DESCRIPTION

Most individuals [~~sixty-five (65)~~] 65 or older receive free Medicare Part A. Those who do not receive free part A can voluntarily enroll for hospital insurance coverage and pay the monthly premium. medicaid does not pay the medicare part A monthly premium for this category of recipients. Voluntary enrollees for premium/conditional medicare part A must enroll for supplementary medical insurance, medicare part B, and pay that premium also. After an application for SLIMB benefits is approved, medicaid begins to pay the medicare part B premium.

Applicants/recipients eligible for medicaid coverage under another medicaid category may also be eligible for SLIMB. SLIMB eligibility allows the state to receive federal matching funding for the purchase of medicare part B.

Since payment of the medicare part B premium is the only benefit, no medicaid card is issued and there is no interaction with the medicaid claims processing contractor.

620 BENEFIT DETERMINATION

Application for SLIMB is made on the assistance application form. Applications are acted on and notice of action taken is sent to the applicant within [~~forty-five (45)~~] 45 days of the application.

Determination of SLIMB eligibility for current recipients of medicaid is made without a separate application. Recipients of supplemental security income (SSI) [~~and/or~~] or qualified medicare beneficiaries are not eligible for SLIMB.

624 ONGOING BENEFITS

A redetermination of eligibility is made every [~~twelve (12)~~] 12 months.

625 RETROACTIVE BENEFIT COVERAGE

Up to three [~~(3)~~] months of retroactive medicaid coverage can be furnished to applicants who have received medicaid-covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three [~~(3)~~] months prior to the month of application [42 CFR Section 435.914].

~~**[625.1 Application for Retroactive Benefit Coverage**~~

~~Application for retroactive Medicaid can be made by checking "yes" in the "Application for Retroactive Medicaid Payments" box on the Application/Redetermination of Eligibility for Medical Assistance [(MAD 381) form or by checking "yes" to the question "Does anyone in your household have unpaid medical expenses in the last three (3) months?" on the Application for Assistance (ISD 100 S) form.~~

~~Applications for retroactive SSI Medicaid benefits for recipients of Supplemental Security Income (SSI) must be made by 180 days from the date of approval for SSI. Medicaid-covered services which were furnished more than two (2) years prior to approval are not covered.~~

~~625.2 Approval Requirements~~

~~To establish retroactive eligibility, the ISS must verify that all conditions of eligibility were met for each of the three (3) retroactive months and that the applicant received Medicaid-covered services. Eligibility for each month is approved or denied on its own merits.~~

~~625.21 Applicable Benefit Rate~~ ~~The Federal Benefit Rate (FBR) in effect during the retroactive months based on the applicant's living arrangements is applicable for retroactive Medicaid eligibility determinations. See [MAD-520] INCOME STANDARDS. If the applicant's countable income in a given month exceed the applicable FBR, the applicant is not eligible for retroactive Medicaid for that month. If the countable income is less that the FBR, the applicant is eligible on the factor of income for that month.~~

~~A separate determination must be made for each of the three (3) months in the retroactive period.~~]

A. Application for retroactive benefit coverage: Application for retroactive medicaid is made by checking "yes" to the question on the application form about having unpaid medical bills in the three months prior to application for assistance. Applications for retroactive medicaid benefits must be made no later than 180 days from the date of application for assistance.

B. Approval requirements: To establish retroactive eligibility, the ISD worker must verify that all conditions of eligibility were met for each of the three retroactive months. Each month must be approved or denied on its own merits. In certain cases this may involve using the federal benefit rate (FBR) in effect during the retroactive months based on the applicant's living arrangement. See 8.200.520 NMAC, Income Standards.

C. Benefit coverage: Retroactive benefits in this category of eligibility are limited to the payment of the medicare part B premium only.

625.22 Disability Determination Required If a determination is needed as of the date of onset of blindness or disability, the [~~ISS~~] ISD caseworker must send a referral to [~~Disability Determination Services (ISD 305) to~~] the disability determination unit. Medical records for the requested months of determination must accompany the referral.

625.3 Notice

625.31 Notice to Applicant The applicant must be informed if any of the

retroactive months are denied.

625.32 Recipient Responsibility to Notify Provider After the retroactive eligibility has been established, the [~~ISS~~] ISD worker must notify the recipient that he/she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient does not inform all providers and furnish verification of eligibility which can be used for billing and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the recipient is responsible for payment of the bill.

400 QUALIFIED INDIVIDUALS 1 (QI1s) - CATEGORY 045

To be eligible for the qualified individual 1 program (category 045), an applicant/recipient must be covered by medicare part A. The part A insurance is a free entitlement to social security beneficiaries who are [~~sixty-five (65)~~] 65 years of age or older or who have received social security disability payments for [~~twenty-four (24)~~] 24 months. Fully or currently insured workers, or their dependents, with end-stage renal disease are also covered under medicare. [4-30-98]

412 CITIZENSHIP

Undocumented aliens cannot purchase Medicare coverage and, therefore, are not eligible for QI1 benefits. To be eligible for QI1 an applicant/recipient must be one of the following:

1. A citizen of the United States; or

2. An alien who entered the United States prior to August 22, 1996, as one of the classes of aliens described in [~~Section MAD 412.1~~] Subsection A of 8.200.410 NMAC. Citizenship, or an alien who entered the United States as a qualified alien on or after August 22, 1996, and who has met the five year bar listed in [~~section MAD 412.2~~] Subsection B of 8.200.410.11 NMAC.

[4-30-98]

412.1 Verification of Citizenship

[~~Citizenship determinations rendered by the Social Security Administration (SSA) for SSI are final.~~

~~412.11 Documentation of Citizenship~~ ~~Primary documentation of citizenship is a birth certificate. Secondary documentation includes:~~

~~1. Certificate of naturalization;~~

~~2. Citizenship certificate;~~

~~3. Other resident identification documents issued by the U.S. Immigration and Naturalization Service, such as:~~

~~A. U.S. passport issued by the U.S. State~~

~~Department;~~

~~B. Consular report of birth;~~

~~C. Certification of birth issued by the United States State Department, proof of marriage to a U.S. citizen before September 2, 1922, and a card of identity and registration of a U.S. citizen; or~~

~~D. Official communication from an American Foreign Service Post indicating that the applicant/recipient is registered as a United States citizen.~~

~~**412.12 Declaration of Citizenship, Nationality or Immigration Status** As a condition of eligibility, the Human Services Department (HSD) requires a declaration by the applicant/recipient, another person on behalf of a child or an applicant/recipient who is mentally incapacitated, which specifies whether the applicant/recipient is a citizen or national of the United States. If not, the declaration must also state that the applicant/recipient is in satisfactory immigration status.~~

~~Eligibility is not denied solely because an applicant/recipient cannot legally sign the declaration and the individual who is legally able to do so refuses to sign on behalf of the applicant/recipient or to cooperate, as required.~~]

Individuals entitled to or receiving medicare already meet citizenship and identity requirements.

[4-30-98]

414 NONCONCURRENT RECEIPT OF ASSISTANCE

QI1s cannot be otherwise eligible for medical assistance under [~~the~~] any of the other categories of NM medicaid eligibility. [4-30-98]

~~**[434 ASSIGNMENT OF SUPPORT**~~

~~**434.1 Assignment of Medical Support**~~

~~As a condition of eligibility, applicants for or recipients of benefits must do the following, [42 CFR § 433.146; NMSA 1978 § 27-2-28 (G)(Repl. Pamp. 1991)]:~~

1. ~~Assign individual rights to medical support and payments to Human Services Department (HSD). The assignment authorizes HSD to pursue and make recoveries from liable third parties on behalf of a recipient;~~
2. ~~Assign the rights to medical support and payments of other individuals eligible for Medicaid, for whom they can legally make an assignment; and~~

3. ~~Assign their individual rights to any medical care support available under an order of a court or an administrative agency.~~

~~[4-30-98]~~

~~434.2 Assignment of Parental Support~~

~~Assignment of parental support rights is required for all minor Medicaid recipients with absent or deceased parents. By signing applications and receiving Medicaid benefits, applicants/recipients have assigned support rights and indicated agreement to cooperate with parental support requirements. See Section MAD 425, ELIGIBILITY ASSIGNMENT AND COOPERATION REQUIREMENTS.~~

~~Medicaid benefits are not denied to otherwise eligible recipients solely because they cannot legally assign their own support rights when the individual who is legally able to assign their rights refuses to assign or cooperate, as required by law.~~]

[4-30-98]

451 REPORTING REQUIREMENTS

Medicaid recipients must report any change in their circumstances which may affect eligibility within [~~ten (10)~~] 10 days after the change to the local income support division ISD) office. [4-30-98]

510 RESOURCE STANDARDS

The value of an applicant/recipient's countable resources must not exceed $4,000.

The resource limit for an applicant couple is $6,000. An applicant/recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed $6,000, when resources are deemed.

A resource determination is always made as of the first moment of the first day of the month. An applicant/recipient is ineligible for any month in which the countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the amount of resources during a month do not affect eligibility for that month. [~~See Section SSI 510, SUPPLEMENTAL SECURITY INCOME METHODOLOGY~~] See 8.215.500.11 NMAC, Resource Standards, for information on exclusions, disregards, and countable resources.
[4-30-98]

520 INCOME STANDARDS

Income standards for this category are at least 120% but [~~no more~~] less than 135% of the federal income poverty guidelines. The federal income poverty guidelines are adjusted annually, effective April 1. [~~See Section MAD 520, INCOME STANDARDS and Section SSI 521, SUPPLEMENTAL SECURITY INCOME METHODOLOGY~~] See 8.200.520 NMAC, Income Standards, and 8.215.500.19 NMAC, Income Standards, for information on exclusions, disregards, and countable income. Verification of income must be documented in the case file.
[4-30-98]

523 DEEMED INCOME

If an applicant/recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered.

If an applicant/recipient is married and lives with a spouse, deemed income from the spouse must be considered. [~~See Section SSI 523, SUPPLEMENTAL SECURITY INCOME METHODOLOGY~~] See 8.215.500.21 NMAC, Deemed Income, for information on deemed income.

[4-30-98]

600 BENEFIT DESCRIPTION

Most individuals [~~sixty-five (65)~~] 65 or older receive free medicare part A. Those who do not receive free part A can voluntarily enroll for hospital insurance coverage and pay the monthly premium. Medicaid does not pay the medicare part A monthly premium for this category of recipients. Voluntary enrollees for premium/conditional medicare part A must enroll for supplementary medical insurance, medicare part B, and pay that premium also. After an application for QI benefits is approved, medicaid begins to pay the medicare part B premium.

Applicants/recipients eligible for QI1 coverage under another medicaid category may not be eligible for QI1. QI1 eligibility is funded by limited block grant funding beginning in 1998 and ending [~~after the year 2002~~] when the congressional extension period expires.

Since payment of the medicare part B premium is the only benefit, no medicaid card is issued [~~and there is no interaction with the Medicaid claims processing contractor~~].

[4-30-98]

620 BENEFIT DETERMINATION

Application for QI1 is made on the assistance application form. Applications are acted on and notice of action taken is sent to the applicant within [~~forty-five (45)~~] 45 days of the application. [4-30-98]

624 ONGOING BENEFITS

A redetermination of eligibility is made every [~~twelve (12)~~] 12 months. [4-30-98]

625 RETROACTIVE BENEFIT COVERAGE

Up to three [~~(3)~~] months of retroactive coverage can be furnished to applicants who have been on medicare during the retroactive period and would have met applicable eligibility criteria had they applied during the three [~~(3)~~] months prior to the month of application. [4-30-98]

[~~625.1 Application for Retroactive Benefit Coverage~~

~~Application for retroactive Medicaid can be made by checking "yes" in the "Application for Retroactive Medicaid Payments" box on the Application/Redetermination of Eligibility for Medical Assistance [(MAD 381) form] or by checking "yes" to the question on "Does anyone in your household have unpaid medical expenses in the last three (3) months?" on the Application for Assistance [(ISD 100 S) form.~~

~~Prior to January 1, 1998, no retroactive Medicaid coverage is available for applicants/recipients.~~

~~[4-30-98]~~

~~**625.2 Approval Requirements**~~

~~To establish retroactive eligibility, the ISS must verify that all conditions of eligibility were met for each of the three (3) retroactive months. Eligibility for each month is approved or denied on its own merits.~~

~~**625.21 Applicable Benefit Rate** The Federal Benefit Rate (FBR) in effect during the retroactive months based on the applicant's living arrangements is applicable for retroactive Medicaid eligibility determinations. See [MAD-520], INCOME STANDARDS. If the applicant's countable income in a given month exceeds the applicable FBR, the applicant is not eligible for retroactive Medicaid for that month. If the countable income is less than the FBR, the applicant is eligible on the factor of income for that month.~~

~~A separate determination must be made for each of the three (3) months in the retroactive period.~~]

[4-30-98]

A. **Application for retroactive benefit coverage:** Application for retroactive medicaid is made by checking "yes" to the question on the application form about having unpaid medical bills in the three months prior to application for assistance. Applications for retroactive medicaid benefits must be made no later than 180 days from the date of application for assistance.

B. Approval requirements: To establish retroactive eligibility, the ISD worker must verify that all conditions of eligibility were met for each of the three retroactive months. Each month must be approved or denied on its own merit. In certain cases this may involve

using the federal benefit rate (FBR) in effect during the retroactive months based on the applicant's living arrangement. See 8.200.520 NMAC, *Income Standards*.

C. Benefit coverage: Retroactive benefits in this category of eligibility are limited to the payment of the medicare part B premium only.

625.3 Notice

625.31 Notice to Applicant The applicant must be informed of which months are approved or denied.

[4-30-98]