State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT

NEW MEXICO HUMAN SERVICES DEPARTMENT (HSD)

II. SUBJECT

MEDICAID ELIGIBILITY

8.200.400 NMAC, 8.200.410 NMAC, 8.200.420 NMAC, 8.200.430 NMAC, 8.200.520 NMAC, 8.202.400 NMAC, 8. 202.500 NMAC, 8.202.600 NMAC, 8.206.400 NMAC, 8.227.400 NMAC, 8.227.500 NMAC,8.227.600 NMAC, 8.228.400 NMAC, 8.228.500 NMAC,8.228.600 NMAC, 8.230.400 NMAC, 8.230.500 NMAC, 8.230.600 NMAC, 8.231.600 NMAC, 8.232.400 NMAC, 8.232.500 NMAC, 8.232.600 NMAC, 8.234.400 NMAC, 8.234.500 NMAC, 8.234.600 NMAC, 8.235.400 NMAC, 8.235.500 NMAC, 8.235.600 NMAC, 8.242.400 NMAC, 8.242.500 NMAC, 8.242.600 NMAC, 8.249.400, NMAC 8.249.500 NMAC, 8.249.600 NMAC, 8.250.400 NMAC, 8.250.500 NMAC, 8.252.500 NMAC, 8.252.600 NMAC, 8.259.400 NMAC, 8.259.500 NMAC, 8.259.600 NMAC, AND 8.285.400 NMAC.

III. PROGRAM AFFECTED

(TITLE XIX) MEDICAID

IV. ACTION

PROPOSED RULES AND REPEAL OF EXISTING RULES

V. BACKGROUND SUMMARY

The Human Services Department (the Department) is proposing changes to general recipient rules and eligibility categories for the medical assistance program administered by the Medical Assistance Division. These changes are necessary to comply with the Affordable Care Act (ACA). In addition to ACA changes, several rules are updated for clarity and consistency as identified in the attached rule grid.

VI. RULES

These proposed rules will be contained in 8.200.400 NMAC, 8.200.410 NMAC, 8.200.420 NMAC, 8.200.430 NMAC, 8.200.520 NMAC, 8.202.400 NMAC, 8. 202.500 NMAC, 8.202.600 NMAC, 8.206.400 NMAC, 8.227.400 NMAC, 8.227.500 NMAC,8.227.600 NMAC, 8.228.400

NMAC, 8.228.500 NMAC,8.228.600 NMAC, 8.230.400 NMAC, 8.230.500 NMAC, 8.230.600 NMAC, 8.231.600 NMAC, 8.232.400 NMAC, 8.232.500 NMAC, 8.232.600 NMAC, 8.234.400 NMAC, 8.234.500 NMAC, 8.234.600 NMAC, 8.235.400 NMAC, 8.235.500 NMAC, 8.235.600 NMAC, 8.242.400 NMAC, 8.242.500 NMAC, 8.242.600 NMAC, 8.249.400, NMAC 8.249.500 NMAC, 8.249.600 NMAC, 8.250.400 NMAC, 8.250.500 NMAC, 8.252.500 NMAC, 8.252.600 NMAC, 8.259.400 NMAC, 8.259.500 NMAC, 8.259.600 NMAC, AND 8.285.400 NMAC. This register and the proposed changes including a summary chart are available on the Medicaid Assistance Division web site at http://www.hsd.state.nm.us/mad/registers/2013. If you do not have internet access, a copy of the proposed rules may be requested by contacting the Medicaid Assistance Division at 827-3152.

VII. EFFECTIVE DATE

The Department proposes to implement these rules effective January 1, 2014.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held at 10:00 a.m. on Monday, November 18, 2013 in the Rio Grande Room of the Toney Anaya Building, 2055 Cerrillos Road, Santa Fe.

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 7-3152. In Santa Fe, call 827-3152. 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 10 days advance notice to provide requested alternative formats and special accommodations.

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.

IX. ADDRESS

Interested persons may address written or recorded testimony to:

Sidonie Squier, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5 p.m. on Monday, November 18, 2013. Written and recorded comments will be given the same consideration as oral testimony made at the

public hearing. Interested persons may address comments via telephone to 505-827-3152 or via electronic mail to: Emily.Floyd@state.nm.us.

X. PUBLICATION

Publication of these rules approved by:

Kenessa Saavedra for

SIDONIE SQUIER, SECRETARY
HUMAN SERVICES DEPARTMENT

NMAC citation and chapter name	Description of change(s)
8.200.400 Medicaid Eligibility - General Recipient Policies General Medicaid Eligibility	• Statutory authority section has been clarified to describe the effects of PRWORA. • The objective and mission have been slightly revised. • Medicaid categories, Refugee Medical Assistance, presumptive eligibility and continuous eligibility sections are revised for more consistent language and better flow of information. • All eligibility group descriptions have been updated for clarity. • Presumptive eligibility (PE) has been revised to reflect that there will be no new PE approvals beginning January 01, 2014 for children's and pregnancy-related Medicaid, under category of eligibility (COE) 032 and 035, respectively. PE for children and pregnant women will be approved under new Affordable Care Act categories as described in 8.291.400 NMAC. • Continuous eligibility information for children and pregnant women has been added.
8.200.410 Medicaid Eligibility - General Recipient Policies General Recipient Requirements	• Defines "lawfully residing" for pregnant women and children exempt from the five year bar. • Non-concurrent receipt of assistance is clarified. • Additional language updates were made to enumeration, residence, non-concurrent receipt of assistance, and application for other benefits sections for more consistent language and better flow of information.
8.200.420 Medicaid Eligibility - General Recipient Policies Special Recipient Requirements	• Updates to the language in the disability section. • Assignment of medical support rights (third party liability) and Medicaid estate recovery regulations have been deleted from this section and moved to 8.200.430.
8.200.430 Medicaid Eligibility - General Recipient Policies Recipient Rights and Responsibilities	• Revisions in this part clarify language in all sections. • Assignment of medical support rights (third party liability) and MAD Estate Recovery sections have been moved to this rule from 8.200.420 NMAC. • This rule introduces new co-payments for some Medicaid recipients. There is a $3.00 co-payment for brand drugs when a generic is available. There are new co-payments for non-emergency use of the emergency room. • References to State Coverage Insurance (SCI) co-payments have been removed since SCI ends January 1, 2014. • Requirements for reporting changes that could affect eligibility has been added.
8.200.520 Medicaid Eligibility - General Recipient Policies Income Standards	• The gross and net income standards have been added for JUL, Refugee medical assistance, and category 30 pregnant women. These standards are added for clarity and have not been changed. • The COLA increase/disregard table has been corrected and reformatted.
8.202.400 Medicaid Eligibility - JUL Medicaid Recipient Requirements	• This part has been revised to specify cash assistance (TANF) regulations that do not apply to JUL Medicaid. • "Budget group" and "assistance unit" have been described in greater detail. • Living arrangements and relationships sections have been revised for greater clarity, with no changes to policy.
8.202.500 Medicaid Eligibility - JUL Medicaid Income and Resource Standards	• The establishing need section of this rule was expanded to clarify the income tests. • Additional revisions were made to reflect that income will be rounded down prior to application of income conversion to a monthly amount. • New sections were added to identify available/unavailable income and earned/unearned income types that were not previously listed. • The exempt unearned income section has been updated to comport with current federal law.
8.202.600 Medicaid Eligibility - JUL Medicaid Benefit Description	• This rule is being revised to reflect that there will be no new approvals beginning January 01, 2014 for JUL Medicaid COE 072. JUL Medicaid is being replaced by an Affordable Care Act (ACA) category as described in the new proposed ACA rules.

NMAC citation and chapter name	Description of change(s)
	• For current recipients redeterminations will continue through March 31, 2014. Beginning April 01, 2014 recipients of JUL Medicaid will be evaluated for transition to the new ACA categories at redetermination.
8.206.400 Medicaid Eligibility - Children for whom CYFD has full or partial responsibility Recipient Requirements	• This rule is being amended to add language that Medicaid provides extended coverage to former foster care recipients up to age 26 years of age as required by ACA. • Categories of eligibility have been updated to more current mandates.
8.227.400 Medicaid Eligibility – Loss of AFDC cases closed due to child support Recipient Policies	• Changed AFDC to JUL throughout rule. • Language revisions throughout rule for more consistent language and better flow of information.
8.227.500 Medicaid Eligibility – Loss of AFDC cases closed due to child support Income and Resource Standards	• Changed AFDC to JUL throughout rule. • Minor language revisions to improve the flow of information.
8.227.600 Medicaid Eligibility – Loss of AFDC cases closed due to child support Benefit Description	• Changed AFDC to JUL throughout rule. • Minor rewording changes were made for clarity. • Information added about no new approvals for transitional Medicaid (COE 027 and 028) due to the loss of JUL Medicaid. Category 027 and 028 will still exist, but will be due to the loss of the parent/caretaker category as described in the proposed Affordable Care Act rules (located in 8.297.400, 8.297.500 and 8.297.600) rather than due to the loss of JUL Medicaid.
8.228.400 Medicaid Eligibility – Loss of AFDC – Transitional Medicaid Recipient Requirements	• Clarified conditions of eligibility. • Other minor language revisions for increased clarity.
8.228.500 Medicaid Eligibility – Loss of AFDC – Transitional Medicaid Income and Resource Standards	• Minor language revisions for increased clarity.
8.228.600 Medicaid Eligibility – Loss of AFDC – Transitional Medicaid Benefit Description	• Minor language revisions for increased clarity. • Also, there will be no new approvals for transitional Medicaid (COE 027 and 028) due to the loss of JUL Medicaid. Category 027 and 028 will still exist, but will be due to the loss of the parent/caretaker category as described in the proposed Affordable Care Act rules (located in 8.297.400, 8.297.500 and 8.297.600) rather than due to the loss of JUL Medicaid.
8.230.400 Medicaid Eligibility – Full Coverage for Pregnant Women Recipient Requirements	• Language has been added to specify that a pregnant woman with no other children can be eligible for this category. (If she has other children, she'll be eligible for JUL Medicaid.) • Information has also been added regarding the legal presumption that a child born to a married woman is the child of the husband. • More information has been added to explain the construction of the budget group, and the deeming rules. This represents a more thorough explanation, not a change in policy. • Information on living in the home has been added.
8.230.500 Medicaid Eligibility – Full Coverage for Pregnant Women Income and Resource Standards	• The income section has been expanded to incorporate the July 16, 1996 AFDC Medicaid methodology. This does not represent a policy change, merely a clarification of existing policy. • New sections were added to identify available/unavailable income and earned/unearned income types that were not previously listed. • The exempt unearned income section has been updated to comport with current federal law. • Income will be rounded down prior to application of income conversion to a monthly amount.

NMAC citation and chapter name	Description of change(s)
8.230.600 Medicaid Eligibility – Full Coverage for Pregnant Women Benefit Description	• The benefit description includes information on the 2-month post-partum period followed by 12 months of family planning, without a new application or eligibility determination. • The rule also explains presumptive and retroactive eligibility as they apply to category 30. This does not represent a change in policy, but explains it in more detail. • The rule is being revised to reflect that there will be no new approvals beginning January 01, 2014 for full Medicaid for pregnant women (COE 030). This category of Medicaid is being replaced by Affordable Care Act (ACA) categories as described in the new proposed ACA sections. Additional language changes were made to this rule for clarity.
8.231.600 Medicaid Eligibility – Infants of Mothers who are Medicaid Eligible Benefit Description	• Clarification of change in eligibility qualifications.
8.232.400 Medicaid Eligibility – Children Under 19 – under 235 Federal Poverty Level Recipient Requirements	• CHIP eligibility criteria have been clarified. • More information has been added to explain the construction of the budget group, and the deeming rules. This represents a more thorough explanation, not a change in policy. • Information on living in the home has been added. • Other minor language revisions have been made to improve the flow of information.
8.232.500 Medicaid Eligibility – Children Under 19 – under 235 Federal Poverty Level Income and Resource Standards	• Need determination and income standards sections have been clarified. • New sections were added to identify available/unavailable income and earned/unearned income types that were not previously listed. • The exempt unearned income section has been updated to comport with current federal law. • The income methodology language has been fully developed.
8.232.600 Medicaid Eligibility – Children Under 19 – under 235 Federal Poverty Level Benefit Description	• Additional language changes were made to this rule for clarity. • CHIP criteria and copayment information has been reworded for increased clarity. • The rule is being revised to reflect that there will be no new approvals beginning January 01, 2014 for children's Medicaid COE 032. This category of Medicaid is being replaced by Affordable Care Act (ACA) categories as described in the new proposed ACA sections. For current recipients redeterminations will continue through March 31, 2014. Beginning April 01, 2014 recipients on children's Medicaid will be evaluated for transition to the new ACA categories at redetermination.
8.234.400 Medicaid Eligibility – Loss of SSI – Income or Resources Available from an Alien Sponsor Recipient Requirements	• This chapter describes the population eligible for Medicaid due to ineligibility for SSI due to income or resources deemed from an alien sponsor. • These rules are revised to better clarify language and for information flow. • Living in the home has been revised to comport with policy in other sections.
8.234.500 Medicaid Eligibility – Loss of SSI – Income or Resources Available from an Alien Sponsor Income and Resource Standards	• This section was revised for increased clarity. No policy changes. • These rules are revised to better clarify language and for information flow. • Living in the home section has been revised to similar language in other rule changes. • Some sections have been removed and are referenced to general provisions sections.
8.234.600 Medicaid Eligibility – Loss of SSI – Income or Resources Available from an Alien Sponsor Benefit Description	• No policy changes- just revisions for better clarity and information flow.

NMAC citation and chapter name	Description of change(s)
8.235.400 Medical Assistance Program Eligibility – Pregnancy and Family Planning Services Recipient Requirements	• Definition of eligible recipient has been clarified. • Language has been clarified throughout the rule.
8.235.500 Medical Assistance Program Eligibility – Pregnancy and Family Planning Services Income and Resource Standards	• New sections were added to identify available/unavailable income and earned/unearned income types that were not previously listed. • The exempt unearned income section has been updated to comport with current federal law. • Income will be rounded down prior to application of income conversion to a monthly amount.
8.235.600 Medical Assistance Program Eligibility – Pregnancy and Family Planning Services Benefit Description	• The rule is being revised to reflect that there will be no new approvals beginning January 01, 2014 for pregnancy related Medicaid (COE 035) or family planning (COE 035F). • Family planning for current recipients will end January 31, 2014. • Pregnancy related Medicaid is being replaced by Affordable Care Act (ACA) categories as described in the new proposed ACA sections. • Additional language changes were made to this rule for clarity.
8.242.400 Recipient Requirements	• These rules are being amended to reflect a change in category number from 042 to 050
8.242.500 Income and Resource Standards	• These rules are being amended to reflect a change in category number from 042 to 050
8.242.600 Benefit Description	• These rules are being amended to reflect a change in category number from 042 to 050
8.249.400 Recipient Requirements	• New sections were added to identify available/unavailable income and earned/unearned income types that were not previously listed.
8.249.500 Income and Resource Standards	• New sections were added to identify available/unavailable income and earned/unearned income types that were not previously listed.
8.249.600 Benefit Description	• New sections were added to identify available/unavailable income and earned/unearned income types that were not previously listed.
8.250.400 Recipient Requirements	• These rules are being amended to reflect a change in category number from 045 to 042.
8.250.500 Income and Resource Standards	• These rules are being amended to reflect a change in category number from 045 to 042.
8.252.500 Income and Resource Standards	• These rules are being amended to update the statutory authority, objectives, mission statement, and to make minor language changes.
8.252.600 Benefit Description	• These rules are being amended to update the statutory authority, objectives, mission statement, and to make minor language changes.
8.259.400 Recipient Requirements	• These rules are being amended to update the statutory authority, objectives, mission statement, and to make minor language changes.
8.259.500 Income and Resource Standards	• These rules are being amended to update the statutory authority, objectives, mission statement, and to make minor language changes.
8.259.600 Benefit Description	• These rules are being amended to update the statutory authority, objectives, mission statement, and to make minor language changes.
8.285.400 Medical Assistance Program Eligibility – Emergency Medical Services for Aliens Recipient Requirements	• The new Affordable Care Act eligibility categories (outlined in chapters 291-298) have been added to the applicable list of Medicaid categories for Emergency Medical Services for Aliens.

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT POLICIES
PART 400 GENERAL MEDICAID ELIGIBILITY

8.200.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.200.400.1 NMAC - Rp, 8.200.400.1 NMAC, 1-1-14]

8.200.400.2 SCOPE: The rule applies to the general public.
[8.200.400.2 NMAC - Rp, 8.200.400.2 NMAC, 1-1-14]

8.200.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.200.400.3 NMAC - Rp, 8.200.400.3 NMAC, 1-1-14]

8.200.400.4 DURATION: Permanent.
[8.200.400.4 NMAC - Rp, 8.200.400.4 NMAC, 1-1-14]

8.200.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.200.400.5 NMAC - Rp, 8.200.400.5 NMAC, 1-1-14]

8.200.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.200.400.6 NMAC - Rp, 8.200.400.6 NMAC, 1-1-14]

8.200.400.7 DEFINITIONS [RESERVED]

8.200.400.8 MISSION: 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.
[8.200.400.8 NMAC - Rp, 8.200.400.8 NMAC, 1-1-14]

8.200.400.9 GENERAL MEDICAID ELIGIBILITY: Medicaid services are jointly financed by the federal government and the state of New Mexico and are administered by MAD.

A. Within broad federal regulations, New Mexico determines categories of eligible recipients, eligibility requirements, types and range of services, levels of provider reimbursement and managed care capitation, and administrative and operating procedures.

B. New Mexico administers medical assistance programs using waivers of the Social Security Act for comparability of services, rules for income and resources and freedom of choice of provider.

C. Payments for medical and behavioral health services, durable equipment and supplies are made directly to service providers, not to the medicaid eligible recipient.

D. This chapter describes the New Mexico categories of medicaid and medical assistance programs eligibility. Each medicaid and medical assistance program includes detailed eligibility requirements which are organized into the following three chapter types:

(1) recipient requirements (.400);
(2) income and resources standards (.500); and
(3) benefit description (.600).

[8.200.400.9 NMAC - Rp, 8.200.400.9 NMAC, 1-1-14]

8.200.400.10 BASIS FOR DEFINING GROUP - MEDICAID CATEGORIES

A. **Medical assistance for women, children (MAWC) and families:** Section 1931 of the Social Security Act provides statutory authority for states to use less restrictive methodologies than the aid to families with

dependent children (AFDC) IV-A program in place as of July 16, 1996. This less restrictive methodology is applicable to medicaid programs for families, women and children. Except where noted, the HSD income support division (ISD) determines eligibility in the categories listed below.

(1) **JUL - Category 072:** provides medicaid for eligible families with a dependent child. Refer to 8.202 NMAC.

(2) **Loss of JUL due to child or spousal support - Category 027:** provides four months of extended medicaid for eligible families.

(3) **Loss of JUL due to increased earned income - Category 28:** provides 12 months of extended medicaid benefits for eligible families.

(4) **Pregnant women - Category 030:** provides full medicaid coverage for a pregnant woman. Refer to 8.230 NMAC for more information.

(5) **Pregnancy related and family planning - Category 035:** provides medicaid coverage for pregnancy-related services for an eligible pregnant woman and family planning and related services for an eligible man or woman.

(6) **Newborn - Category 031:** provides medicaid coverage for a newborn who is less than 12 months of age, born to a mother who, at the time of the birth, was either eligible for or receiving New Mexico medicaid.

(7) **Children's medicaid and children's health insurance program (CHIP) - Category 032:**

(a) **children's medicaid:** provides medicaid coverage to an eligible recipient who is under 19 years of age in families with incomes up to 185 percent of the federal poverty limit (FPL);

(b) **CHIP:** provides coverage to an uninsured eligible recipient who is under 19 years of age and in a family with income from185 up to 235 percent FPL. Co-payments apply to CHIP; native American children are exempt from co-payments.

(8) **Children, youth, and families department (CYFD) medicaid - Categories 017, 037, 046, 047, 066, and 086:** CYFD medicaid covers certain eligible recipients who are court ordered into full or partial responsibility of CYFD. The eligibility determination for these categories is made by CYFD.

(a) **Medicaid for a Title IV-E eligible recipient:** Individuals who receive a Title IV-E adoption, foster care or kinship guardianship assistance payment are deemed categorically eligible for medicaid.

(i) **Category 037:** adoption payments made by New Mexico for an eligible recipient placed in New Mexico.

(ii) **Category 047:** adoption payments made by New Mexico for an eligible recipient placed in a new state of residence.

(iii) **Category 017:** adoption payments made by another state for an eligible recipient placed in New Mexico.

(iv) **Category 066:** foster care payments made by New Mexico for an eligible recipient placed in New Mexico.

(v) **Category 046:** foster care payments made by New Mexico for an eligible recipient placed in a new state of residence.

(vi) **Category 086:** foster care payments made by another state for an eligible recipient placed in New Mexico.

(b) **Medicaid for the Chafee foster care independence program:** An eligible recipient who leaves foster care because they reach the age of 18 is eligible for extended medicaid coverage when they are between 18 and 21 years of age.

B. **Medicare savings program (MSP):** MSP assists an eligible recipient with the cost of medicare.

(1) Medicare is the federal government program that provides health care coverage for individuals 65 or older; or under 65 who have a disability. Individuals under 65 who have a disability are subject to a waiting period of 24 months from the approval date of social security disability insurance (SSDI) benefits before they receive medicare coverage. Coverage under medicare is provided in four parts.

(a) Part A hospital coverage is usually free to beneficiaries when medicare taxes are paid while working.

(b) Part B medical coverage requires monthly premiums, co-insurance and deductibles to be paid by the beneficiary.

(c) Part C advantage plan allows a beneficiary to choose to receive all medicare health care services through a managed care organization.

(d) Part D provides prescription drug coverage.

(2) The following MSP programs can assist an eligible recipient with the cost of medicare.

(a) **Qualified medicare beneficiaries (QMB) - Category 040:** QMB covers low income medicare beneficiaries who have or are conditionally eligible for medicare Part A. QMB benefits are limited to the following:

(i) cost for the monthly medicare Part B premium;

(ii) cost of medicare deductibles and coinsurance; and

(iii) cost for the monthly medicare Part A premium (for those enrolling conditionally).

(b) **Specified low-income medicare beneficiaries (SLIMB) - Category 045:** SLIMB medicaid covers low-income medicare beneficiaries who have medicare Part A. SLIMB is limited to the payment of the medicare Part B premium.

(c) **Qualified individuals 1 (QI1s) – Category 042:** QI1 medicaid covers low-income medicare beneficiaries who have medicare Part A. QI1 is limited to the payment of the medicare part B premium.

(d) **Qualified disabled working individuals (QDI) - Category 050:** QDI medicaid covers low income individuals who lose entitlement to free medicare Part A hospital coverage due to gainful employment. QDI is limited to the payment of the monthly Part A hospital premium.

(e) **Medicare Part D prescription drug coverage - low income subsidy (LIS) - Category 048:** LIS provides individuals enrolled in medicare Part D with a subsidy that helps pay for the cost of Part D prescription premiums, deductibles and co-payments. An eligible recipient receiving medicaid through QMB, SLMB or QI1 is automatically deemed eligible for LIS and need not apply. Other low-income medicare beneficiaries must meet an income and resource test and submit an application to determine if they qualify for LIS.

C. **Supplemental security income (SSI) related medicaid:**

(1) **SSI - Categories 001, 003 and 004:** Medicaid for individuals who are eligible for SSI. Eligibility for SSI is determined by the social security administration (SSA). This program provides cash assistance and medicaid for an eligible recipient who is:

(a) aged (Category 001);

(b) blind (Category 003); or

(c) disabled (Category 004).

(2) **SSI medicaid extension - Categories 001, 003 and 004:** MAD provides coverage for certain groups of applicants or eligible recipients who have received supplemental security income (SSI) benefits and who have lost the SSI benefits for specified reasons listed below and pursuant to 8.201.400 NMAC:

(a) the Pickle Amendment and 503 lead;

(b) early widow(er);

(c) disabled widow(er) and a disabled surviving divorced spouse;

(d) child insurance benefits, including disabled adult children (DAC);

(e) nonpayment SSI status (E01);

(f) revolving SSI payment status "ping-pongs"; and

(g) certain individuals who become ineligible for SSI cash benefits and, therefore, may receive up to two months of extended medicaid benefits while they apply for another MAD category of eligibility.

(3) **Working disabled individuals (WDI) and medicare wait period - Category 043:** There are two eligibility types:

(a) a disabled individual who is employed; or

(b) a disabled individual who has lost SSI medicaid due to receipt of SSDI and the individual does not yet qualify for medicare.

D. **Long term care medicaid:**

(1) medicaid for individuals who meet a nursing facility (NF) level of care (LOC), intermediate care facilities for the intellectually disabled (ICF-ID) LOC, or acute care in a hospital. SSI income methodology is used to determine eligibility. An eligible recipient must meet the SSA definition of aged (Category 081); blind (Category 083); or disabled (Category 084).

(2) **Institutional care (IC) medicaid - Categories 081, 083 and 084:** IC covers certain inpatient, comprehensive and institutional and nursing facility benefits.

(3) **Program of all-inclusive care for the elderly (PACE) - Categories 081, 083 and 084:** PACE uses an interdisciplinary team of health professionals to provide dual medicaid/medicare enrollees with coordinated care in a community setting. The PACE program is a unique three-way partnership between the federal

government, the state, and the PACE organization. The PACE program is limited to specific geographic service area(s). Eligibility may be subject to a wait list for the following:

(a) the aged (Category 081);
(b) the blind (Category 083); or
(c) the disabled (Category 084).

(4) **Home and community-based 1915 (c) waiver services (HCBS) – Categories 090, 091, 092, 093, 094, 095 and 096:** A 1915(c) waiver allows for the provision of long term care services in home and community based settings. These programs serve a variety of targeted populations, such as people with mental illnesses, intellectual disabilities, or physical disabilities. Eligibility may be subject to a wait list.

(a) **There are two HCBS delivery models:**

(i) traditional agency delivery where HCBS are delivered and managed by a MAD enrolled agency; or

(ii) mi via self-directed where an eligible recipient, or his or her representative, has decision-making authority over certain services and takes direct responsibility to manage the eligible mi via recipient's services with the assistance of a system of available supports; self-direction of services allows an eligible mi via recipient to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

(b) **HCBS waiver programs include:**

(i) acquired immunodeficiency syndrome (AIDS) and AIDS-related condition (ARC) (Category 090);

(ii) disabled and elderly aged (Category 091), blind (Category 093), disabled (Category 094);

(iii) medically fragile (Category 095);
(iv) developmental disabilities (Category 096);
(v) brain injury (Category 092); and
(vi) mi via (self directed model for Categories 090, 091, 093, 094, 095, 096 and 092).

E. **Emergency medical services for aliens (EMSA):** EMSA medicaid covers certain noncitizens who either are undocumented or who do not meet the qualifying alien criteria specified in 8.200.410 NMAC. Non-citizens must meet all eligibility criteria for one of the medicaid categories noted in 8.285.400 NMAC, except for citizenship or qualified alien status. An eligible EMSA recipient does not receive the full medicaid benefit package. Medicaid eligibility for and coverage of services under EMSA are limited to the payment of emergency services from a medicaid provider.

F. **Refugee medical assistance (RMA) - Categories 049 and 059:** RMA offers health coverage to certain low income refugees during the first eight months from their date of entry to the United States (U.S.) when they do not qualify for other medicaid categories of eligibility. A RMA eligible refugee recipient has access to a benefit package that parallels the full coverage medicaid benefit package. RMA is funded through a grant under Title IV of the Immigration and Nationality Act (INA). A RMA applicant who exceeds the RMA income standards may "spend-down" below the RMA income standards for Category 059 by subtracting incurred medical expenses after arrival into the U.S.

G. **Breast and cervical cancer (BCC) - Category 052:** BCC medicaid provides coverage to an eligible uninsured woman, under the age of 65 who has been screened and diagnosed by the department of health (DOH) as having breast or cervical cancer to include pre-cancerous conditions. The screening criteria are set forth in the centers for disease control and prevention's national breast and cervical cancer early detection program (NBCCEDP). Eligibility is determined using DOH notification and without a separate medicaid application or determination of eligibility.

[8.200.400.10 NMAC - Rp, 8.200.400.10 NMAC, 1-1-14]

8.200.400.11 PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN: PE provides immediate access to health services when an individual appears to be eligible for Category 035. Effective January 1, 2014, MAD will end new PE application approvals for Category 035. Refer to 8.291.400 NMAC for the new Affordable Care Act presumptive eligibility for pregnant women categories.

A. **Pregnancy related medicaid (Category 035):** PE provides a pregnant woman with temporary medicaid coverage for ambulatory prenatal care during a limited PE period. Only one PE period is allowed per pregnancy.

B. PE is determined by a qualified entity certified by HSD. Qualified entities may include community

and rural health centers, hospitals, physician offices, local health departments, family planning agencies and schools.

C. The PE period begins on the date the provider determines presumptive eligibility and terminates at the end of the following month.

D. During the PE period, medicaid services will be provided on a fee-for-service basis. Providers shall notify the MAD claims processing contractor of the determination within 24-hours of the PE determination.

E. For continued medicaid eligibility beyond the PE period, a completed and signed application for medicaid must be submitted to HSD/ISD. An eligible PE provider must submit the application to ISD within 10 calendar days from the receipt of the application.

[8.200.400.11 NMAC - Rp, 8.200.400.11 NMAC, 1-1-14]

8.200.400.12 PRESUMPTIVE ELIGIBILITY FOR CHILDREN: PE provides immediate access to health services when an individual appears to be eligible for Category 032. Effective January 1, 2014, MAD will end new PE application approvals for Category 032. Refer to 8.291.400 NMAC for the new Affordable Care Act presumptive eligibility for children categories.

A. **Medicaid and children's health insurance program (CHIP) (Category 032):** PE for a child provides temporary full coverage medicaid benefits during the limited PE period.

B. PE is determined by a qualified entity certified by HSD. Qualified entities may include community and rural health centers, hospitals, physician offices, local health departments, family planning agencies and schools.

C. The PE period begins on the date the provider determines presumptive eligibility and terminates at the end of the following month.

D. During the PE period, medicaid services will be provided on a fee-for-service basis. Providers shall notify the MAD claims processing contractor of the determination within 24-hours of the PE determination.

E. For continued medicaid eligibility beyond the PE period, a completed and signed application for medicaid must be submitted to HSD/ISD. An eligible PE provider must submit the application to ISD within 10 calendar days from the receipt of the application.

[8.200.400.12 NMAC - Rp, 8.200.400.12 NMAC, 1-1-14]

8.200.400.13 PRESUMPTIVE ELIGIBILITY FOR BREAST AND CERVICAL CANCER: PE provides immediate access to health services when an individual appears to be eligible for Category 052.

A. **Breast and cervical cancer (BCC) (Category 052):** PE provides temporary medicaid coverage for an uninsured woman, under the age of 65 who has been screened and diagnosed by the DOH as having breast or cervical cancer to include pre-cancerous conditions. Only one PE period is allowed per calendar year.

B. PE is determined by a qualified entity certified by HSD. Qualified entities may include community and rural health centers, hospitals, physician offices, local health departments, family planning agencies and schools.

C. The PE period begins on the date the provider determines presumptive eligibility and terminates at the end of the following month.

D. During the PE period, medicaid services will be provided on a fee-for-service basis. Providers shall notify the MAD claims processing contractor of the determination within 24-hours of the PE determination.

E. For continued medicaid eligibility beyond the PE period, a completed and signed application for medicaid must be submitted to HSD/ISD. An eligible PE provider must submit the application to ISD within 10 calendar days from the receipt of the application.

[8.200.400.13 NMAC - Rp, 8.200.400.13 NMAC, 1-1-14]

8.200.400.14 12 MONTHS CONTINUOUS ELIGIBILITY FOR CHILDREN: Children eligible for medicaid under category of eligibility: 032, 072, HCBS waivers, IV-E, and SSI-004, and 003 will remain eligible for a period of 12 months, regardless of changes in income. This provision applies even if it is reported that the family income exceeds the applicable federal income poverty guidelines. The 12 months of continuous medicaid starts with the month of approval or redetermination and is separate from any months of presumptive or retroactive eligibility. This provision does not apply when there is a death of a household member, the member or the family moves out of state, or the child turns 19 years of age.

[8.200.400.14 NMAC - Rp, 8.200.400.14 NMAC, 1-1-14]

8.200.400.15 CONTINUOUS ELIGIBILITY:

A. Continuous medicaid eligibility is provided to the following eligible medicaid recipients regardless of changes in income.

(1) A child under the age of 19 remains medicaid eligibility for a period of 12-months. A 12-month period of continuous eligibility starts with the month of approval or redetermination. Presumptive and retroactive eligibility are not counted in the 12 month continuous period.

(2) A pregnant woman's medicaid eligibility is continuous for the:

(a) duration of the pregnancy; and

(b) two-month post-partum period; and

(c) 12-month family-planning coverage.

B. The provision of continuous eligibility does not apply when the medicaid eligible recipient moves out of state or is deceased.

[8.200.400.12 NMAC - N, 8-15-13]

HISTORY OF 8.200.400 NMAC: The material in this part was derived from that previously filed with the State Records Center:

8 NMAC 4.MAD.400, Recipient Policies, Recipient Rights and Responsibilities, filed 12-30-94.

History of Repealed Material:

8.200.400 NMAC, General Medicaid Eligibility, filed 6-15-01 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT POLICIES
PART 410 GENERAL RECIPIENT REQUIREMENTS

8.200.410.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.200.410.1 NMAC - Rp, 8.200.410.1 NMAC, 1-1-14]

8.200.410.2 SCOPE: The rule applies to the general public.
[8.200.410.2 NMAC - Rp, 8.200.410.2 NMAC, 1-1-14]

8.200.410.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.200.410.3 NMAC - Rp, 8.200.410.3 NMAC, 1-1-14]

8.200.410.4 DURATION: Permanent.
[8.200.410.4 NMAC - Rp, 8.200.410.4 NMAC, 1-1-14]

8.200.410.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.200.410.5 NMAC - Rp, 8.200.410.5 NMAC, 1-1-14]

8.200.410.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.200.410.6 NMAC - Rp, 8.200.410.6 NMAC, 1-1-14]

8.200.410.7 DEFINITIONS: [RESERVED]

8.200.410.8 MISSION: 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.
[8.200.410.8 NMAC - Rp, 8.200.410.8 NMAC, 1-1-14]

8.200.410.9 GENERAL RECIPIENT REQUIREMENTS: To be eligible or continue eligibility for medicaid or other medical assistance programs, an applicant or eligible recipient must meet specific non-financial requirements. In addition to the rules in this chapter, refer to 8.100.130 NMAC regarding the following requirements:

A. citizenship or alien status;
B. enumeration;
C. residence;
D. non-concurrent receipt of assistance;
E. applications for other benefits; and
F. assignment of medical support rights.

[8.200.410.9 NMAC - Rp, 8.200.410.9 NMAC, 1-1-14]

8.200.410.10 ENUMERATION: The social security administration (SSA) is responsible for the assigning of social security numbers (SSN), a process called enumeration. HSD uses the SSN as a unique identifier to the individual and eligible recipient and to verify income and resources where applicable.

A. **Applicant and an eligible recipient**: Except as noted in Subsection B of this section, it is mandatory for a medicaid applicant and an eligible recipient to report his or her SSN. If an applicant or an eligible recipient does not have a valid SSN, he or she must apply for one. Applications for an SSN are available at any SSA or HSD ISD office. An application for an SSN can be made by completing and submitting an SSN application form. Proof of the SSN application must be provided to ISD.

B. **Applicant and eligible recipient exception:** The following applicants or eligible recipients in the following categories are not required to report an SSN. Reporting an SSN is voluntary for:

(1) emergency medical services for aliens (EMSA); and

(2) refugee medical assistance (RMA).

C. **Non-applicants and non-eligible recipients**: Reporting an SSN is voluntary for individuals who are not seeking medicaid services for themselves.

[8.200.410.10 NMAC - Rp, 8.200.410.10 NMAC, 1-1-14]

8.200.410.11 CITIZENSHIP: To be eligible for medicaid, an individual must be a citizen of the United States; or an alien who meets the requirements set forth in either Subsection A or B of this section.

A. **Aliens who entered the United States prior to August 22, 1996:** Aliens who entered the United States prior to August 22, 1996, will not be subject to the five-year bar on eligibility for purposes of medicaid eligibility, and will continue to be eligible for medicaid on the basis of alien regulations in effect prior to August 22, 1996. These classes of aliens are as follows.

(1) Aliens who entered the United States prior to August 22, 1996, and remained continuously present in the United States until the date they obtained qualified alien status on or after August 22, 1996; any single absence from the United States of more than 30 days, or a total aggregate of absences of more than 90 days, is considered to interrupt "continuous presence".

(2) Aliens lawfully admitted for permanent residence or permanently residing in the United States under color of law as follows.

(a) The individual may be eligible for medicaid if the individual is an alien residing in the United States with the knowledge and permission of the United States immigration and customs enforcement (ICE) and ICE does not contemplate enforcing the alien's departure. ICE does not contemplate enforcing an alien's departure if it is the policy or practice of ICE not to enforce the departure of aliens in the same category, or if from all the facts and circumstances in a particular case it appears that ICE is otherwise permitting the alien to reside in the United States indefinitely, as determined by verifying the aliens status with ICE;

(b) Aliens who are permanently residing in the United States under color of law are listed below. None of the categories include applicants for an alien status other than those applicants listed in item (vi) or (xvi) of this Subparagraph. None of the categories allow medicaid eligibility for non-immigrants; for example, students or visitors. Also listed are the most commonly used documents that ICE provides to aliens in these categories.

(i) Aliens admitted to the United States pursuant to 8 U.S.C. 1153(a)(7)(Section 203(a)(7) of the Immigration and Nationality Act); ask for a copy of ICE Form I-94 endorsed "refugee-conditional entry".

(ii) Aliens, including Cuban/Haitian entrants, paroled in the United States pursuant to 8 U.S.C. 1182(d)(5)(Section 212(d)(5) of the Immigration and Nationality Act; for Cuban/Haitian entrant (Status Pending) reviewable January 15, 1981; (although the forms bear this notation, Cuban/Haitian entrants are admitted under section 212(d)(5) of the Immigration and Nationality Act).

(iii) Aliens residing in the United States pursuant to an indefinite stay of deportation; ask for an immigration and naturalization services letter with this information or ICE Form I-94 clearly stated that voluntary departure has been granted for an indefinite period of time.

(iv) Aliens residing in the United States pursuant to an indefinite voluntary departure; ask for an immigration and naturalization services letter or ICE Form I-94 showing that voluntary departure has been granted for an indefinite time period.

(v) Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure (under 8 CFR 242.5(a)(2)(vi)) and whose departure ICE does not contemplate enforcing; ask for a copy of ICE Form I-94 or Form I-210 or a letter clearly stating that status;

(vi) Aliens who have filed applications for adjustment of status pursuant to Section 245 of the Immigration and Nationality Act (8 U.S.C. 1255) that ICE has accepted as properly filed (within the meaning of 8 CFR 245.2(a)(1) or (2) and whose departure ICE does not contemplate enforcing; ask for a copy of ICE Form I-94 or I-181 or a passport appropriately stamped.

(vii) Aliens granted stays of deportation by court order, statute, or regulation, or by individual determination of ICE pursuant to Section 106 of the Immigration and Nationality Act (8 U.S.C. 1105 a) or relevant ICE instructions, whose departure that agency does not contemplate enforcing; ask for a copy of ICE Form I-94 or a letter from ICE, or a copy of a court order establishing the alien's status.

(viii) Aliens granted asylum pursuant to Section 208 of the Immigration and Nationality Act (8 U.S.C. 1158); ask for a copy of ICE Form I-94 and a letter establishing this status.

(ix) Aliens admitted as refugees pursuant to Section 207 of the Immigration and Nationality Act (8 U.S.C. 1157) or Section 203(a)(7) of the Immigration and Nationality Act (8 U.S.C. 1153(a)(7)); ask for a copy of ICE Form I-94 properly endorsed.

(x) Aliens granted voluntary departure pursuant to Section 242(b) of the Immigration and Nationality Act (8 U.S.C. 1252(b)) or 8 CFR 242.5 whose departure ICE does not contemplate enforcing; ask for a Form I-94 or Form I-210 bearing a departure date.

(xi) Aliens granted deferred action status pursuant to Immigration and Naturalization Service Operations Instruction 103.1(a)(ii) prior to June 15, 1984 or 242.1(a)(22) issued June 15, 1984 and later; ask for a copy for ICE Form I-210 or a letter showing that departure has been deferred.

(xii) Aliens residing in the United States under orders of supervision pursuant to Section 242 of the Immigration and Nationality Act (8 U.S.C. 1252(d)); ask for a copy of Form I-220 B.

(xiii) Aliens who have entered and continuously resided in the United States since before January 1, 1972, (or any date established by Section 249 of the Immigration and Nationality Act, 8 U.S.C. 1259); ask for any proof establishing this entry and continuous residence.

(xiv) Aliens granted suspension for deportation pursuant to Section 244 of the Immigration and Naturalization Act (8 U.S.C. 1254) and whose departure ICE does not contemplate enforcing; ask for an order from an immigration judge showing that deportation has been withheld.

(xv) Aliens whose deportation has been withheld pursuant to Section 243(h) of the Immigration and Nationality Act (8 U.S.C. 1253(h)); ask for an order from an immigration judge showing that deportation has been withheld.

(xvi) Any other aliens living in the United States with the knowledge and permission of the immigration and naturalization service and whose departure the agency does not contemplate enforcing (including permanent non-immigrants as established by Public Law 99-239, and persons granted extended voluntary departure due to conditions in the alien's home country based on a determination by the secretary of state).

(3) Aliens granted lawful temporary resident status under Section 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind or disabled as defined in Section 1614(a)(1) of the act, under 18 years of age, or a Cuban/Haitian entrant as defined in Section 510(e)(1) and (2)(A) of the Public Law 96-422.

(4) Aliens granted lawful temporary resident status under Section 210 of the Immigration and Nationality Act unless the alien would, but for the 5-year bar to receipt of AFDC contained in such section, be eligible for AFDC.

B. **Aliens who entered the United States on or after August 22, 1996:**

(1) Aliens who entered the United States on or after August 22, 1996, are barred from medicaid eligibility for a period of five years, other than emergency services (under Category 085). The five-year bar begins on the date of the alien's entry into the United States with a status of qualified alien. The following classes of qualified aliens are exempt from the five-year bar:

(a) an alien admitted to the United States as a refugee under Section 207 of the Immigration and Nationality Act;

(b) an alien granted asylum under Section 208 of the Immigration and Nationality Act;

(c) an alien whose deportation is withheld under Section 243(h) of the Immigration and Nationality Act;

(d) an alien who is lawfully residing in the state and who: is a veteran with an honorable discharge not on account of alien status; is on active duty other than on active duty for training, in the armed forces of the United States; or the spouse or unmarried dependent child under the age of 18 of such veteran or active duty alien;

(e) an alien who was granted status as a Cuban and Haitian entrant, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980;

(f) an alien granted Amerasian immigrant status as defined under Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act, 1988;

(g) victims of a severe form of trafficking, in accordance with Section 107(b)(1) of the Trafficking Victims Protection Act of 2000, P.L. 106-386;

(h) battered aliens who meet the conditions set forth in Section 431(c) of PRWORA, as added by Section 501 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, P.L. 104-208 (IIRIRA), and amended by Section 5571 of the Balanced Budget Act of 1997, P.L. 105-33 (BBA), and Section 1508

of the Violence Against Women Act of 2000, P.L. 106-386. Section 431(c) of PRWORA, as amended, is codified at 8 USC 1641(c);

(i) members of a federally recognized Indian tribe, as defined in 25 U.S.C. 450b(e);

(j) American Indians born in Canada to whom Section 289 of the Immigration and Nationality Act applies; and

(k) Afghan and Iraqi special immigrants under section 8120 of Pub. L. 111-118 of the Department of Defense Appropriations Act, 2010.

(2) Qualified alien: A "qualified alien", for purposes of this regulation, is an alien, who at the time the alien applies for, receives, or attempts to receive a federal public benefit, is:

(a) an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act; or

(b) an alien who is granted asylum under Section 208 of such act; or

(c) a refugee who is admitted to the United States under Section 207 of the act (including certain Amerasian immigrants as refugees); or

(d) an alien who is paroled into the United States under Section 212(d)(5) of such act for a period of at least one year; or

(e) an alien whose deportation is being withheld under Section 243(h) of such act; or

(f) an alien who is granted conditional entry pursuant to 203(a)(7) or such act as in effect prior to April 1, 1980; or

(g) an alien who is a Cuban or Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980); or

(h) certain battered women and alien children of battered parents (only those who have begun the process of becoming a lawful permanent resident under the Violence Against Women Act); or

(i) victims of a severe form of trafficking; or

(j) members of a federally recognized Indian tribe, as defined in 25 U.S.C. 450b(e); or

(k) American Indians born in Canada to whom Section 289 of the Immigration and Nationality Act applies; or

(l) Afghan and Iraqi special immigrants under section 8120 of Pub. L. 111-118 of the Department of Defense Appropriations Act, 2010.

(3) **Children and pregnant women exempt from the five year bar:** As authorized by CHIPRA 2009 legislation, New Mexico medicaid allows a lawfully residing child and pregnant woman, if otherwise eligible, to obtain medicaid coverage. A lawfully residing child and pregnant woman must meet the residency requirement as set forth in 8.200.410.12 NMAC. A child or pregnant woman is considered lawfully present if he or she is:

(a) a qualified alien as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. Section1641);

(b) an alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission (e.g. nonimmigrant visa holders, citizens of Micronesia, the Marshall Islands, and Palau, a lawful temporary resident and applicant for legalization under IRCA, legalization under the LIFE Act, family unity, an applicant for cancellation of removal or suspension of deportation, order of supervision, and registry applicant;

(c) an alien who has been paroled into the U.S. pursuant to Section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. Section 1182(d)(5)) for less than one year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(d) an alien who belongs to one of the following classes:

(i) aliens currently in temporary resident status pursuant to Section 210 or 245A of the INA (8 U.S.C. Section1160 or 1255a, respectively);

(ii) aliens currently under temporary protected status (TPS) pursuant to Section 244 of the INA (8 U.S.C. Section 1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) family unity beneficiaries pursuant to Section 301 of Pub. L. 101-649, as amended;

(v) aliens currently under deferred enforced departure (DED) pursuant to a decision made by the president;

(vi) aliens currently in deferred action status; or

(vii) aliens whose visa petitions have been approved and who have a pending application for adjustment of status;

(e) pending applicants for asylum under section 208(a) of the INA (8 U.S.C. Section 1158) or for withholding of removal under Section 241(b)(3) of the INA (8 U.S.C. Section 1231) or under the convention against torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(f) aliens whose applications for withholding of removal under the convention against torture have been granted;

(g) children who have pending applications for special immigrant juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. section1101(a)(27)(J));

(h) aliens who are lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. Section 1806(e); or

(i) aliens who are lawfully present in American Samoa under the immigration laws of American Samoa.

(4) **Alien sponsors (where an affidavit of sponsorship was executed pursuant to Section 213 of the Immigration and Nationality Act subsequent to August 22, 1996):** The income and resources of an alien sponsor, and the spouse of the sponsor, of any individual applying for medicaid, are deemed available to the applicant, when an affidavit of support is executed pursuant to Section 213 of the Immigration and Nationality Act, on or after August 22, 1996. This counting of alien sponsor income and resources is effective until the sponsored alien achieves citizenship, or can be credited with 40 qualifying quarters.

(5) **Quarters of coverage:** For purposes of determining the number of quarters of coverage under Title II of the Social Security Act, an alien will be credited with all of the quarters that were worked by him or her, as well as all of the qualifying quarters of coverage worked by a parent of such alien, while the alien was under 18; and all of the quarters credited to a spouse, if the alien remains married to the spouse or such spouse is deceased. Beginning January 1, 1997, any quarter in which the alien received a means-tested federal benefit is not counted as a qualifying quarter.

(6) **Federal means-tested benefit:** For purposes of determining whether an alien has or has not received any federal means-tested benefits during a quarter, starting with January 1, 1997, the definition of federal means-tested benefits will not include:

(a) medical assistance under Title XIX of the Social Security Act (medicaid) for emergency treatment of an alien, not related to an organ transplant procedure, if the alien otherwise meets eligibility for medical assistance under the state plan;

(b) short-term, noncash, in-kind emergency disaster relief;

(c) assistance or benefits under the National School Lunch Act;

(d) assistance or benefits under the Child Nutrition Act of 1966;

(e) public health assistance (not including any assistance under Title XIX medicaid) for immunizations, and testing or treatment of symptoms of communicable diseases, whether or not such symptoms are caused by communicable diseases;

(f) payments for foster care and adoption assistance under Part B and E of Title IV of the Social Security Act for a parent or child who would, in the absence of the restriction of eligibility for aliens contained in PRWORA of 1996, be eligible for such payments made on the child's behalf, but only if the foster or adoptive parent (or parents) of such child, is a qualified alien;

(g) programs, services, or assistance, delivering in-kind services at the community level and necessary for the provision of life or safety; that do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided, on the individual recipient's income or resources;

(h) programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act;

(i) means-tested programs under the Elementary and Secondary Education Act of 1965;

(j) benefits under the Head Start Act; or

(k) benefits under the Job Training Partnership Act.

[8.200.410.11 NMAC - Rp, 8.200.410.11 NMAC, 1-1-14]

8.200.410.12 RESIDENCE: To be eligible for medicaid, an applicant or eligible recipient must be living in New Mexico on the date of application and final determination of eligibility and have demonstrated an intention to remain in the state.

A. **Establishing residence:** Residence is established by living in the state and carrying out the types of activities associated with day-to-day living, such as occupying a home, enrolling a child in school or getting a state driver's license. An applicant or recipient who is homeless is considered to have met the residence requirements if he or she intends to remain in the state.

B. **Recipients receiving benefits out-of-state:** An applicant or an eligible recipient who receives financial or medical assistance in another state which makes residence in that state a condition of eligibility are considered residents of that state until the ISD office receives verification from the other state agency indicating that it has been notified by an applicant or eligible recipient of the abandonment of residence in that state.

C. **Individuals court ordered into full or partial responsibility of the state children youth and families department (CYFD):** When CYFD places a child in a new state of residence, the new state of residence is responsible for the provision of medicaid; however, the state must provide limited medicaid coverage for medicaid services that are part of the state medicaid benefit package and not available in the new state of residence.

D. **Abandonment:** Residence is not abandoned by temporary absences. Temporary absences occur when an eligible recipient leaves the state for specific purposes with time-limited goals. Residence is considered abandoned when the applicant or the eligible recipient leaves the state for any of the following reasons:

(1) intends to establish residence in another state;

(2) for no specific purpose with no clear intention of returning;

(3) applies for financial, food or medical assistance in another state which makes residence in that state a condition of eligibility; or

(4) for more than 30 consecutive calendar days, without notifying HSD of his or her departure or intention of returning.

[8.200.410.12 NMAC - Rp, 8.200.410.12 NMAC, 1-1-14]

8.200.410.13 NON-CONCURRENT RECEIPT OF ASSISTANCE:

A. **An applicant or an eligible recipient receiving medicaid in another state is not medical assistance program eligible in New Mexico except when:**

(1) institutional care medicaid begins on a specific date within the month rather than automatically reverting to the first day of the month, if an applicant for institutional care medicaid (Category 081, 083 or 084) moves to New Mexico from another state and it can be verified that the other state will terminate the individual's medicaid eligibility under that state program prior to the initial eligibility date in New Mexico, the application may be approved even though the individual receives medicaid from the other state for part of the month; coverage in New Mexico begins after the end date of services from the other state;

(2) individuals court ordered into full or partial responsibility CYFD: when CYFD places a child in a new state of residence, the new state of residence is responsible for the provision of medicaid; however, New Mexico must provide limited medicaid coverage for medicaid services that are part of New Mexico's medicaid benefit package and not available in the new state of residence.

B. An individual who is eligible for a full-coverage medicaid program may also be eligible for one of the medicare cost sharing medical assistance program categories. See 8.200.400 NMAC.

C. When a supplemental security income (SSI) recipient enters into a nursing home or hospital (institutionalized), SSA will re-evaluate SSI and related medicaid eligibility.

(1) When SSA determines that the individual remains eligible for SSI while institutionalized, the SSI benefit is adjusted as follows:

(a) if institutionalized for more than 90 calendar days – the SSI benefit is limited to $30 a month; or

(b) if institutionalized for 90 calendar days or less – the SSI benefit continues at the regular amount.

(2) When SSA determines that the individual is not eligible for SSI, the individual or his or her authorized representative should file an application at HSD for institutional care medicaid. If the individual meets all factors of eligibility, approval of the institutional care medicaid application should be coordinated with the SSI closure date. If eligible, there will not be a break in eligibility and the individual shall not receive both SSI and institutional care medicaid in the same month pursuant to 8.281.400.10 NMAC.

[8.200.410.13 NMAC - Rp, 8.200.410.13 NMAC, 1-1-14]

8.200.410.14 APPLICATIONS FOR OTHER BENEFITS: As a condition of eligibility, a medicaid applicant or an eligible recipient must take all necessary steps to obtain any annuities, pensions, retirement, and

disability benefits to which they are entitled, within 30 calendar days from the date HSD furnishes notice of the potential benefit, unless they can show good cause for not doing so.

A. **Benefit types:** Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, old age survivors and disability insurance (OASDI) benefits, railroad retirement benefits, and unemployment compensation.

B. **Exceptions to general requirement/good cause:** An individual may request a good cause waiver to this requirement by presenting ISD with corroborating evidence that:

(1) applying for other benefits is against the best interest of the individual, child or others, including physical or emotional harm to a child, parent or caregiver relative, adoption proceedings, and potential for emotional impairment; or

(2) exceptions applicable to institutional care medicaid, the SSI-related categories and the home and community based waivers are pursuant to Subsection B of 8.281.500.9 NMAC, Subsection B of 8.215.500.9 NMAC and Subsection B of 8.290.500.9 NMAC.

C. **Failure to apply for and take steps to determine eligibility for other benefits:** When the parent(s) or where applicable the specified relative fails or refuses to apply for and take steps to determine eligibility within 30 calendar days from the date HSD furnishes notice of the potential benefit, the parent(s) or specified relative is not eligible for medicaid. An eligible recipient under the age of 18 years shall not lose his or her medicaid eligibility under this provision.

[8.200.410.14 NMAC - Rp, 8.200.410.14 NMAC, 1-1-14]

8.200.410.15 INMATE IN A PUBLIC INSTITUTION:

A. An applicant or a recipient who is an inmate of a public institution is not medicaid or medical assistance program eligible. A public institution is an institution which is the responsibility of a governmental unit of which a governmental unit exercises administrative control.

B. Public institutions include jails, prisons, detention centers, diagnostic holding centers, the New Mexico boys and girls schools, "wilderness camps", or halfway houses and reintegration centers which are not certified to furnish medical care.

C. An individual is not considered to be an inmate of an institution if he or she is placed in a detention center for a temporary period pending other arrangements appropriate to his or her needs. For purposes of medicaid eligibility, an individual who is placed in a detention center is considered temporarily absent from the home, up to the 60th day or once adjudicated, whichever first occurs.

[8.200.410.15 NMAC - Rp, 8.200.410.15 NMAC, 1-1-14]

HISTORY OF 8.200.410 NMAC:

History of Repealed Material:

8.200.410 NMAC, General Recipient Requirements, filed 6-11-03 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT POLICIES
PART 420 SPECIAL RECIPIENT REQUIREMENTS

8.200.420.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.200.420.1 NMAC - Rp, 8.200.420.1 NMAC, 1-1-14]

8.200.420.2 SCOPE: The rule applies to the general public.
[8.200.420.2 NMAC - Rp, 8.200.420.2 NMAC, 1-1-14]

8.200.420.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.200.420.3 NMAC - Rp, 8.200.420.3 NMAC, 1-1-14]

8.200.420.4 DURATION: Permanent.
[8.200.420.4 NMAC - Rp, 8.200.420.4 NMAC, 1-1-14]

8.200.420.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.200.420.5 NMAC - Rp, 8.200.420.5 NMAC, 1-1-14]

8.200.420.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.200.420.6 NMAC - Rp, 8.200.420.6 NMAC, 1-1-14]

8.200.420.7 DEFINITIONS: [RESERVED]

8.200.420.8 MISSION: 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.
[8.200.420.8 NMAC - Rp, 8.200.420.8 NMAC, 1-1-14]

8.200.420.9 AGE: For certain medicaid categories, an individual must meet specified age requirements. See specific NMAC eligibility chapters for each medicaid category for age requirements.
[8.200.420.9 NMAC - Rp, 8.200.420.9 NMAC, 1-1-14]

8.200.420.10 SCHOOL ATTENDANCE: School attendance is a factor in determining JUL medicaid eligibility for 18 year-old applicants or re-determining recipients. School attendance is not a factor in determining JUL medicaid for children under the age of 18 years.
[8.200.420.10 NMAC - Rp, 8.200.420.10 NMAC, 1-1-14]

8.200.420.11 DISABILITY: For an individual applying for a specific MAD category of eligibility, disability is a condition of eligibility. The determination of disability is made by the disability determination services unit. The social security administration's (SSA) definition of disability is used for that determination.
[8.200.420.11 NMAC - Rp, 8.200.420.11 NMAC 1-1-14]

8.200.420.12 THIRD PARTY LIABILITY: Refer to 8.200.430.13 NMAC.
[8.200.420.12 NMAC - Rp, 8.200.420.12 NMAC, 1-1-14]

8.200.420.13 MEDICAID ESTATE RECOVERY: Refer to 8.200.430.20 NMAC.
[8.200.420.13 NMAC - Rp, 8.200.420.13 NMAC, 1-1-14]

HISTORY 8.200.420 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 304.1000, Provider Reimbursement Responsibility, filed 1-7-80.
ISD 304.1000, Provider Reimbursement Responsibility, filed 9-9-81.
ISD 304.2000, Recipient Reimbursement Responsibility, filed 1-9-80.
ISD 304.3000, Reimbursement Limitations, filed 1-7-80.
ISD 304.3000, Reimbursement Limitations, filed 9-9-81.
ISD Rule 304.3000, Reimbursement Limitations, filed 12-17-85.
ISD 304.4000, Billing Limitations, filed 1-7-80.
ISD 304.4000, Billing Limitations, filed 9-9-81.
ISD 304.7000, Reimbursement To Out-Of-State Providers, filed 1-7-80.
ISD 304.7000, Reimbursement To Out-Of-State Providers, filed 9-9-81.
ISD 304.8000, Third Party Liability, filed 1-7-80.
ISD 304.8000, Third Party Liability, filed 9-9-81.
ISD 304.9000, Usual And Customary, filed 1-7-80.
ISD 304.9000, Reasonable Charge Pricing, filed 9-9-81.
ISD Rule 304.9000, Reasonable Charge Pricing, filed 2-17-84.
ISD Rule 304.9000, Reasonable Charge Pricing, filed 3-30-84.
MAD Rule 304.9, Reimbursement, filed 12-15-87.
MAD Rule 304.9, Reimbursement, filed 8-11-88.
MAD Rule 304, Billing And Reimbursement, filed 11-8-89.
MAD Rule 304, Billing And Reimbursement, filed 4-21-92.

History of Repealed Material:
8.200.420 NMAC, Special Recipient Requirements, filed 6-13-01 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT POLICIES
PART 430 RECIPIENT RIGHTS AND RESPONSIBILITIES

8.200.430.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.200.430.1 NMAC - Rp, 8.200.430.1 NMAC, 1-1-14]

8.200.430.2 SCOPE: The rule applies to the general public.
[8.200.430.2 NMAC - Rp, 8.200.430.2 NMAC, 1-1-14]

8.200.430.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.200.430.3 NMAC - Rp, 8.200.430.3 NMAC, 1-1-14]

8.200.430.4 DURATION: Permanent.
[8.200.430.4 NMAC - Rp, 8.200.430.4 NMAC, 1-1-14]

8.200.430.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.200.430.5 NMAC - Rp, 8.200.430.5 NMAC, 1-1-14]

8.200.430.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.200.430.6 NMAC - Rp, 8.200.430.6 NMAC, 1-1-14]

8.200.430.7 DEFINITIONS: [RESERVED]

8.200.430.8 MISSION: 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.
[8.200.430.8 NMAC - N, 1-1-14]

8.200.430.9 RECIPIENT RIGHTS AND RESPONSIBILITIES:

A. An individual has the right to apply for medicaid and other health care programs HSD administers regardless of whether it appears he or she may be eligible.

(1) ISD determines eligibility for medicaid health care programs, unless otherwise determined by another entity as stated in 8.200.400 NMAC. A decision shall be made promptly on applications in accordance with the timeliness standards set forth in 8.100.130.11 NMAC.

(2) Individuals who might be eligible for supplemental security income (SSI) are referred to the social security administration (SSA) office to apply.

B. **Application:** A paper or electronic application is required from the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant may complete a joint medicaid, cash assistance, supplemental nutrition assistance program (SNAP) and low income home energy assistance (LIHEAP) application or a medicaid-only application.

(1) The following do not require an application unless a re-determination is due in that month or the following month, as applicable:

(a) switching from one of the medical assistance for women, children (MAWC) and families MAD categories to another;

(b) switching between medicaid and refugee medical assistance; and

(c) switching to or from one of the long term care medicaid categories.

(2) Medicare savings programs (MSP):

(a) A medicaid eligible recipient receiving full benefits is automatically deemed eligible for

MSP when she or he receives free medicare Part-A hospital insurance; the eligible recipient does not have to apply for medicare MSP;

(b) When an individual is not eligible for free medicare Part A hospital insurance, a separate application for the qualified medicare beneficiary (QMB) eligibility category 040 is required. Individuals must apply for medicare Part A with the SSA. This is called, "conditional Part A" because they will receive medicare part A on the condition that QMB category of eligibility is approved. When QMB is approved, the cost of the premium for Part A will be covered by medicaid.

C. **Responsibility in the application or recertification process:** The applicant or the re-determining eligible recipient is responsible for providing verification of eligibility. Refer to 8.100.130 NMAC.

(1) An applicant or an eligible recipient's failure to provide necessary verification results in medicaid ineligibility.

(2) An applicant or a re-determining eligible recipient must give HSD permission to contact other individuals, agencies, or sources of information which are necessary to establish eligibility.

[8.200.430.9 NMAC - Rp, 8.200.430.9 NMAC, 1-1-14]

8.200.430.10 FREEDOM OF CHOICE: Except when specifically waived from MAD, an eligible recipient has the freedom to obtain medical and behavioral health services from a MAD provider of his or her choice.

[8.200.430.10 NMAC - Rp, 8.200.430.10 NMAC, 1-1-14]

8.200.430.11 RELEASE OF INFORMATION: By signing the medicaid application, an applicant or a re-determining eligible recipient gives HSD explicit consent to release information to applicable state or federal agencies, medical or behavioral health providers, or an HSD designee when the information is needed to provide, monitor, or approve medicaid services. Medical and behavioral health information is confidential and is subject to the standards for confidentiality per 8.300.11 NMAC.

[8.200.430.11 NMAC - Rp, 8.200.430.11 NMAC, 1-1-14]

8.200.430.12 RIGHT TO HEARING: An applicant or an eligible recipient is entitled to adequate notice of state agency actions and for an opportunity to have an impartial review of those decisions at an administrative hearing. This includes any action to deny or terminate medicaid or another health care program's eligibility or deny, terminate, suspend or reduce a medicaid covered service [42 CFR Section 431.220(a)(1)(2)].

A. Adequate notice rules regarding medicaid eligibility are detailed at 8.100.180 NMAC. Fair hearing rules regarding medicaid eligibility are detailed at 8.100.970 NMAC.

B. Adequate notice and recipient hearing rules regarding MAD covered services are detailed in 8.352.2 NMAC.

[8.200.430.12 NMAC - Rp, 8.200.430.12 NMAC, 1-1-14]

8.200.430.13 ASSIGNMENT OF SUPPORT: As a condition of MAD eligibility, HSD requires an applicant or a re-determining eligible recipient to assign his or her medical care support rights to HSD for medical support and any third party payments. The assignment authorizes HSD to pursue and make recoveries from liable third parties [42 CFR 433.146; NMSA 1978 27-2-28 (G)].

A. **Assigning medical support rights**: The assignment to HSD of an eligible recipient's rights to medical support and payments occurs automatically under New Mexico law when the applicant or the re-determining eligible recipient signs the application.

B. **Third party liability (TPL):** This section describes HSD responsibility to identify and collect from primarily responsible third parties and recipient responsibility to cooperate with HSD to uncover such payments. Medicaid is the payer of last resort. If other third party resources are available, these health care resources must be used before medicaid. As a condition of medicaid eligibility, an applicant assigns his or her rights to medical and behavioral health support and payments to HSD and promises to cooperate in identifying, pursuing, and collecting payments from these resources. Third party resources include the gross recovery by a recipient, including personal injury protection benefits, before any reduction in attorney's fees or costs, obtained through settlement or verdict, for personal injury negligence or intentional tort claims or actions, up to the full amount of medicaid payments for treatment of injuries causally related to the occurrence that is the subject of the claim or action.

(1) **Required TPL information:** During the initial determination or re-determininination of eligibility for medicaid services, ISD must obtain information about TPL from either the applicant or the re-determining

eligible recipient.

(a) HSD is required to take all reasonable measures to determine the legal liability of third parties, including health insurers in paying for the medical and behavioral health services furnished to an eligible recipient [42 CFR 433.138(a)].

(b) HSD uses the information collected at the time of determination in order for medicaid to pursue claims against third parties.

(2) **Availability of health insurance:** If an applicant or an eligible recipient has health insurance, the applicant or the eligible recipient shall notify ISD. ISD must collect all relevant information, including name and address of the insurance company; individuals covered by the policy, effective dates, covered services, and appropriate policy numbers.

(a) An applicant or an eligible recipient with health insurance coverage or coverage by a health maintenance organization (HMO) or other managed care plan (plan) must be given a copy of the TPL recipient information letter.

(b) If there is an absent parent, ISD may request the absent parent's name and social security number (SSN).

(c) ISD must determine if an absent parent, relative, applicant or any member of the household is employed and has health insurance coverage.

(3) **Eligible recipients with health insurance coverage:** An applicant or an eligible recipient must inform medicaid providers of his or her TPL. An applicant or an eligible recipient must report changes to or terminations of insurance coverage to ISD. If an applicant or an eligible recipient has health coverage through an HMO or plan, payment from medicaid is limited to applicable copayments required under the HMO or plan and to medicaid covered services documented in writing as exclusions by the HMO or plan.

(a) If the HMO or plan uses a drug formulary, the medical director of the HMO or plan must sign and attach a written certification for each drug claim to document that a pharmaceutical product is not covered by the HMO or plan. The signature is a certification that the HMO or plan drug formulary does not contain a therapeutic equivalent that adequately treats the medical or behavioral health condition of the HMO or plan subscriber.

(b) Medical and behavioral health services not included in the HMO or plan are covered by MAD only after review of the documentation and on approval by MAD.

(c) An applicant or an eligible recipient covered by an HMO or plan is responsible for payment of medical services obtained outside the HMO or plan and for medical services obtained without complying with the rules or policies of the HMO or plan.

(d) An applicant or an eligible recipient living outside an HMO or plan coverage area may request a waiver of the requirement to use HMO or plan providers and services. The applicant or the eligible recipient for whom a coverage waiver is approved by MAD may receive reimbursement for expenses which allow him or her to travel to an HMO or plan participating provider, even when the provider is not located near the applicant or the eligible recipient's residence.

(4) **Potential health care resources:** ISD must evaluate the presence of a TPL source if certain factors are identified during the medicaid eligibility interview.

(a) When the age of the applicant or the eligible recipient is over 65 years old medicare must be explored. A student, especially a college student, may have health or accident insurance through his or her school.

(b) An application on behalf of deceased individual must be examined for "last illness" coverage through a life insurance policy.

(c) Certain specific income sources are indicators of possible TPL which include:

(i) railroad retirement benefits and social security retirement or disability benefits indicating eligibility for Title XVIII (medicare) benefits;

(ii) workers' compensation (WC) benefits paid to employees who suffer an injury or accident caused by conditions arising from employment; these benefits may compensate employees for medical and behavioral health expenses and lost income; payments for medical and behavioral health expenses may be made as medical and behavioral health bills are incurred or as a lump sum award;

(iii) black lung benefits payable under the coal mine workers' compensation program, administered by the federal department of labor (DOL), can produce benefits similar to railroad retirement benefits if the treatment for illness is related to the diagnosis of pneumoconiosis; beneficiaries are reimbursed only if services are rendered by specific providers, authorized by the DOL; black lung payments are made monthly and medical and behavioral health expenses are paid as they are incurred; and

(iv) Title IV-D support payments or financial support payments from an absent parent may indicate the potential for medical and behavioral health support; if a custodial party does not have health insurance that meets a minimum standard, the court in a divorce, separation or custody and support proceeding may order the parent(s) with the obligation of support to purchase insurance for the eligible recipient child [45 CFR 303.31(b)(1); NMSA 1978, Section 40-4C-4(A)(1)]; insurance can be obtained through the parent's employer or union [NMSA 1978, Section 40-4C-4(A)(2)]; parents may be ordered to pay all or a portion of the medical, behavioral health or dental expenses; for purposes of medical and behavioral health support, the minimum standards of acceptable coverage, deductibles, coinsurance, lifetime benefits, out-of-pocket expenses, co-payments, and plan requirements are the minimum standards of health insurance policies and managed care plans established for small businesses in New Mexico; see New Mexico insurance code.

(d) An applicant or an eligible recipient has earned income: Earned income may indicate that medical, behavioral health and health insurance made available by an employer.

(e) Work history or military services: Work history may indicate eligibility for other cash and medical and behavioral benefits. Previous military service suggests the potential for veterans administration (VA) or department of defense (DOD) health care, including the civilian health and the medical program of the United States (CHAMPUS) who reside within a 40-mile radius of a military health care facility. An applicant or an eligible recipient who is eligible for DOD health care must obtain certification of non-availability of medical services from the base health benefits advisor in order to be eligible for CHAMPUS.

(f) An applicant or an eligible recipient's expenses show insurance premium payments: Monthly expense information may show that the applicant or the eligible recipient pay private insurance premiums or are enrolled in an HMO or plan.

(g) The applicant or the eligible recipient has a disability: Disability information contained in applications or brought up during interviews may indicate casualties or accidents involving legally responsible third parties.

(h) The applicant or the eligible recipient has a chronic disease: Individuals with chronic renal disease are probably entitled to medicare. Applications for social security disability may be indicative of medicare coverage.

(5) Communicating TPL information: Information concerning health insurance or health plans is collected and transmitted to MAD by ISD, child support enforcement division (CSED), SSA, and the children, youth and families department (CYFD).

[8.200.430.13 NMAC - Rp, 8.200.430.13 NMAC, 1-1-14]

8.200.430.14 ELIGIBLE RECIPIENT RESPONSIBILITY TO COOPERATE WITH ASSIGNMENT OF SUPPORT RIGHTS:

A. **Cooperation:** As a condition of medicaid eligibility, an applicant or an eligible recipient must cooperate with HSD to:

(1) obtain medical and behavioral health support and payments for his or herself and other individuals for whom he or she can legally assign rights;

(2) pursue liable third parties by identifying individuals and providing information to HSD;

(3) cooperate with CSED to establish paternity and medical support as appropriate, see 8.50.105.12 NMAC;

(4) appear at a state or local office designated by HSD to give information or evidence relevant to the case, appear as a witness at a court or other proceeding or give information or attest to lack of information, under penalty of perjury;

(5) refund HSD any money received for medical or behavioral health care that has already been paid; this includes payments received from insurance companies, personal injury settlements, and any other liable third party; and

(6) respond to the trauma inquiry letter that is mailed to an eligible recipient [42 CFR 433.138(4)]; the letter asks an eligible recipient to provide more information about possible accidents, causes of accidents, and whether legal counsel has been obtained [42 CFR 433.147; 45 CFR 232.42, 232.43; NMSA 1978 27-2-28(G)(3)].

B. **Good cause waiver of cooperation:** The requirements for cooperation may be waived by HSD if it decides that the applicant or the eligible recipient has good cause for refusing to cooperate. Waivers can be obtained for cooperating with CSED. The applicant or the eligible recipient should request a good cause waiver from CSED per 8.50.105.14 NMAC.

C. **Penalties for failure to cooperate:**

(1) When the parent, the specified relative or legal guardian fails or refuses to cooperate, the parent or specified relative will not be eligible for medicaid services. The eligible recipient child maintains medicaid eligibility provided all other eligibility criteria are met.

(2) When the parent or the specified relative fails or refuses to refund payments received from insurance or other settlement sources, such as personal injury case awards, he or she is not eligible for medicaid services for one year and until full restitution has been made to HSD. The eligible recipient child maintains medicaid eligibility provided all other eligibility criteria are met.

[8.200.430.14 NMAC - Rp, 8.200.430.14 NMAC, 1-1-14]

8.200.430.15 ELIGIBLE RECIPIENT RESPONSIBILITY TO GIVE PROVIDER PROPER IDENTIFICATION AND NOTICE OF ELIGIBILITY CHANGES:

A. An eligible recipient is responsible for presenting a current medicaid eligibility card and evidence of any other health insurance to a medicaid provider each time service is requested.

(1) An eligible recipient is responsible for any financial liability incurred if he or she fails to furnish current medicaid eligibility identification before the receipt of a service and as a result the provider fails to adhere to MAD rules, such as a failure to request prior approval. If this omission occurs, the settlement of claims for services is between the eligible recipient and the provider. An individual is financially responsible for services received if he or she was not eligible for medicaid services on the date services are furnished.

(2) When a provider bills medicaid and the claim is denied, the provider cannot bill the eligible recipient. Exceptions exist for denials caused by medicaid ineligibility or by an eligible recipient's failure to furnish medicaid identification in a timely manner.

(3) If an eligible recipient fails to notify the provider that he or she has received services that are limited by time or amount, the eligible recipient is responsible for payment of the service prior to rendering the service if the provider made reasonable efforts to verify whether the eligible recipient has already received services.

B. **Notification of providers following retroactive eligibility determinations:** If an eligibility determination is made, the eligible recipient is responsible for notifying providers of this eligibility determination. When an individual receives retro medicaid eligibility, the now-eligible recipient must notify all of his or her medicaid providers of his or her change of eligibility. If the eligible recipient fails to notify the provider and the provider can no longer file a claim for reimbursement, the eligible recipient becomes the responsible payer for those services.

C. **Notification if an eligible recipient has private insurance:** If an eligible recipient is covered under a private health insurance policy or health plan, he or she is required to inform his or her medicaid providers of the private health coverage, including applicable policy numbers and special claim forms.

[8.200.430.15 NMAC - Rp, 8.200.430.15 NMAC, 1-1-14]

8.200.430.16 ELIGIBLE RECIPIENT FINANCIAL RESPONSIBILITIES:

A. A medicaid provider agrees to accept the amount paid as payment in full with the exception of co-payment amounts required in certain medicaid eligibility categories [42 CRF 447.15]. Other than the co-payments, a provider cannot bill an eligible recipient for any unpaid portion of the bill (balance billing) or for a claim that is not paid because of a provider administrative error or failure of multiple providers to communicate eligibility information. A native American eligible recipient is exempt from co-payment requirements.

(1) An eligible recipient is responsible for any financial liability incurred if he or she fails to furnish current medicaid eligibility identification before the receipt of a medicaid service and as a result the provider fails to adhere to medicaid reimbursement rules, such as a failure to request prior approval. If this omission occurs, the settlement of claims for services is between the eligible recipient and the provider. An individual is financially responsible for services received if he or she was not eligible for medicaid services on the date services are furnished.

(2) When a provider bills medicaid and the claim is denied, the provider cannot bill the eligible recipient. Exceptions exist for denials caused by medicaid ineligibility or by an eligible recipient's failure to furnish medicaid identification at the time of service.

(3) If an eligible recipient fails to notify a provider that he or she has received services that are limited by time or amount, the eligible recipient is responsible to pay for services if, before furnishing the services, the provider makes reasonable efforts to verify whether the eligible recipient has already received services.

B. **Failure of an eligible recipient to follow his or her privately held health insurance carrier's requirements:** An eligible recipient must be aware of the physician, pharmacy, hospital, and other providers who

participate in his or her HMO or other managed care plan. An eligible recipient is responsible for payment for services if he or she uses a provider who is not a participant in his or her plan or if he or she receives any services without complying with the rules, policies, and procedures of his or her plan.

C. **Other eligible recipient payment responsibilities:** If all the following conditions are met before a service is furnished, the eligible recipient can be billed directly by a medicaid provider for services and is liable for payment:

(1) the eligible recipient is advised by a provider that the particular service is not covered by medicaid or is advised by a provider that he or she is not a medicaid provider;

(2) the eligible recipient is informed by a provider of the necessity, options, and charges for the services and the option of going to another provider who is a medicaid provider; and

(3) the eligible recipient agrees in writing to have the service provided with full knowledge that he or she is financially responsible for the payment.

D. **Children's health insurance program (CHIP) and working disabled individuals (WDI) co-payments:** It is the eligible recipient's responsibility to pay the co-payment to the medicaid provider.

(1) **WDI co-payment requirements are the following:**

(a) $7 per outpatient physician visit to a physician or other practitioner, dental visit, therapy session, or behavioral health service session;

(b) $20 per ER visit;

(c) $28 for non emergent use of the ER;

(d) $30 per inpatient hospital admission;

(e) $5 per drug item (does not apply if the $8 co-payment for a brand name drug is assessed); and

(f) $8 for a brand name drug when there is a less expensive therapeutically equivalent drug on the Preferred Drug List (PDL) unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.

(2) **CHIP co-payment requirements are the following:**

(a) $5 per outpatient physician visit to a physician or other practitioner, dental visit, therapy session, or behavioral health service session;

(b) $15 per ER visit;

(c) $50 for non emergent use of the ER;

(d) $25 per inpatient hospital admission;

(e) $2 per drug item (does not apply if the $5 co-payment for a brand name drug is assessed); and

(f) $5 for a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.

E. **The following exemptions from co-payment responsibilities for WDI and CHIP eligible recipients apply:**

(1) Native Americans;

(2) family planning services, procedures, drugs, supplies, and devices;

(3) medicare cross over claims including claims from Medicare Advantage Plans;

(4) preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams, etc.);

(5) prenatal and postpartum care and deliveries, and prenatal drug items;

(6) provider preventable conditions;

(7) psychotropic drug items are exempt from the brand name co-payment (only the regular pharmacy co-payment applies);

(8) when the maximum family limit has been exceeded;

(9) all services rendered by an IHS, 638 facility, or Urban Indian facility regardless of race code; and

(10) federal match 3 for categories 071 and 400 through 421 are exempt because these are presumptively eligible children.

F. **Brand Name Drug:** A $3 co-payment for a brand name drug applies to MAD eligible recipients, except for WDI and CHIP, which have higher co-payment amounts, when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.

G. **Non emergent use of the ER:** For non emergent use of the ER, the co-payment varies by the federal poverty level (FPL). These co-payment amounts apply to MAD eligible recipients except for WDI which has a higher co-payment amount. The co-payments for non emergent use of the ER are the following:

(1) $8 if 150% of the FPL or below; and

(2) $50 if greater than 150% of the FPL.

H. **The following are exempt from the non emergent use of the ER and brand name drug co-payment:**

(1) Native Americans;

(2) medicare cross over claims including claims from Medicare Advantage Plans;

(3) psychotropic drug items;

(4) foster care and adoption categories (014, 017, 037, 046, 047, 066, and 086); and

(5) institutional care categories (081, 083, and 084).

I. **Co-payment maximum:** The aggregate amount of cost sharing imposed for all individuals in the family as applied during the monthly period is 5 percent of countable family income.

[8.200.430.16 NMAC - Rp, 8.200.430.16 NMAC, 1-1-14]

8.200.430.17 RESTITUTION:

A. A medicaid recipient must return overpayments or medical payments received from liable third parties to the applicable medical service provider or to MAD. If payments are not returned or received, recoupment proceedings against the recipient will be initiated.

B. The restitution bureau of HSD is responsible for the tracking and collection of overpayments made to medicaid recipients, vendors, and medicaid providers. See Section OIG-940, RESTITUTIONS. The MAD third party liability unit is responsible for monitoring and collecting payments received from liable third parties. See 8.302.3 NMAC.

[8.200.430.17 NMAC - Rp, 8.200.430.17 NMAC, 1-1-14]

8.200.430.18 ELIGIBLE RECIPIENT RESPONSIBILITY TO ENROLL IN AVAILABLE EMPLOYER-BASED GROUP HEALTH PLAN OR OTHER INSURANCE PLANS: Effective July 01, 1998, HSD no longer accepts referrals to the health insurance premium payment (HIPP) program. HIPP is only available to participants active on HIPP as of July 01, 1998 who have continued to maintain their eligibility for the program.

A. **Payments under the health insurance premium payment program:** Under HIPP, HSD will pay premiums, deductibles, co-insurance and other cost-sharing obligations necessary to enroll an applicant or medicaid eligible recipient in an available cost-effective insurance plan.

(1) An applicant or an eligible recipient is required to participate in an employer-based group health plan (EGHP) as a condition of eligibility. If an applicant or an eligible recipient is enrolled in a non-employer-based plan and is also eligible to enroll in a cost-effective EGHP, he or she must enroll in the EGHP to remain eligible for medicaid. If continued enrollment in both plans remains cost-effective, HSD may choose to pay the premiums for the non-employer-based plan. If an applicant or an eligible recipient is eligible for more than one cost-effective EGHP, he or she must enroll in the EGHP which HSD determines to be more cost-effective.

(2) An applicant or an eligible recipient is not required to enroll in a non- employer-based insurance plan as a condition of eligibility. If such plan is cost-effective, HSD may choose to pay the applicable premiums and cost-sharing obligations.

(3) HSD can pay the premiums only for a non-medicaid eligible family member if that member must be enrolled in the EGHP in order for the medicaid eligible family member to receive coverage. The costs of furnishing coverage to the non-medicaid eligible family members are not considered in determining the cost effectiveness of the EGHP or non employer-based plan.

(4) HSD may pay the cost of premiums for a medicare supplemental insurance policy for a dual-eligible MAD recipient if HSD determines that such payment would be cost effective.

(5) Claims submitted by providers for furnishing medical or behavioral health services to an applicant or an eligible recipient covered under the HIPP program are subject to standard third party editing and processing. See 8.302.3 NMAC.

(6) Payments will not be made for premiums used as a deduction to income for purposes of the medicaid eligibility determination.

B. Insurance plans excluded from coverage under the health insurance premium payment program: HSD will not pay premiums or cost-sharing obligations for health insurance plans under the following circumstances:

(1) the EGHP is that of an absent parent;

(2) the EGHP is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy; for instance, the plan pays $50 a day versus 80 percent of the total charges;

(3) the plan is an education policy offered on the basis of attendance or enrollment at an educational facility;

(4) the plan is maintained for the applicant or an eligible recipient through another source, such as maintenance of insurance for a child by the absent parent;

(5) the EGHP is designed to provide coverage for a temporary period only; or

(6) the individual covered under the plan is not medicaid eligible on the date the decision is made for enrollment in the HIPP program.

C. **Application process:** At the time an applicant applies for medicaid or a program that includes medicaid benefits or at the time of the periodic review of the eligible recipient's medicaid eligibility, he or she must complete a health insurance premium payment referral (HIPP) form. The form must be completed during the process and forwarded to MAD third party liability unit (TPLU).

(1) The MAD TPLU determines whether an EGHP is cost-effective using guidelines set forth in the approved state medicaid plan. After a determination is made, the MAD TPLU furnishes notice to the applicant or the eligible recipient and the appropriate ISD, SSI, or CYFD office of the determination within 30 calendar days of the receipt of the HIPP form or as soon as possible. Additional time may be required for the determination if required information cannot be obtained within the 30 calendar day time period.

(2) As a condition of medicaid eligibility, an applicant or an eligible recipient must provide HSD with all necessary information about the plan and report all changes with respect to the plan to HSD within 10 calendar days of that change.

(a) If an applicant or an eligible recipient parent fails to provide the information necessary to make the cost- effectiveness determination, fails to enroll in a cost-effective plan, or disenrolls from such a plan for reasons not described in Subsection E below, he or she is no longer a MAD eligible recipient. MAD benefits to an applicant or eligible recipient child are not terminated if the parent or responsible individual fails to provide information or cooperate with HSD.

(b) Medicaid benefits for the spouse of an employed individual are not terminated due to the employed individual's failure to provide information or cooperate if the spouse cannot enroll in the plan independently.

D. **Effective date:** Premium payments to the cost-effective plan are due on the first of the month in which an applicant's eligibility is established or the month, in which premium payments are due for the applicant or the eligible recipient enrollment in a cost-effective plan, whichever is later.

E. **Disenrollment and discontinuation of premium payments:** Premium payments are discontinued on the first of the month after the date that all members of a household lose medicaid eligibility. If only a portion of the household members lose medicaid eligibility, HSD will conduct a review of the plan to determine whether enrollment in the plan remains cost effective. As a condition of medicaid eligibility, an applicant or an eligible recipient is required to be enrolled in a cost-effective EGHP. Disenrollment is permissible under the following circumstances:

(1) HSD determines that plan enrollment is no longer cost effective; or

(2) the plan is no longer available to the applicant or the eligible recipient for instance, the applicant or the eligible recipient changes employers or the employer no longer offers insurance coverage; or

(3) the applicant or the eligible recipient was enrolled in a plan through a spouse or parent who is no longer willing to enroll him or her.

F. **Review of cost-effectiveness:** HSD reviews the cost-effectiveness for each plan:

(1) at least every six months for an EGHP and annually for non-employer-based insurance plans;

(2) with a change in the predetermined cost or services covered by the plan, such as an increase in a premium rate or elimination of maternity coverage;

(3) when a member of the household loses medicaid eligibility;

(4) when circumstances affecting the availability of the plan occur, such as employment termination, reduction in employment hours; and

(5) when the employer changes insurance carriers.

[8.200.430.18 NMAC - Rp, 8.200.430.18 NMAC, 1-1-14]

8.200.430.19 REPORTING REQUIREMENTS: A medicaid eligible recipient is required to report certain changes which might affect his or her eligibility. The following changes must be reported to ISD within 10 calendar days from the date the change occurred pursuant to 8.200.400 NMAC, 8.200.410 NMAC, and 8.200.420 NMAC.

A. **Living arrangements or change of address**: Any change in where an eligible recipient lives or gets his or her 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 either or both the assistance unit and budget group.

C. **Enumeration:** Any new social security number must be reported.

D. **Income:** Except for continuous eligibility in 8.200.400 NMAC any increase or decrease in the amount of income or change in the source of income must be reported.

E. **Resource:** Any change in what an eligible recipient owns must be reported. This includes any property the eligible recipient owns or has interest in, cash on hand, money in banks or credit unions, stocks, bonds, life insurance policies or any other item of value.

[8.200.430.19 NMAC - N, 1-1-14]

8.200.430.20 MAD ESTATE RECOVERY: HSD is mandated to seek recovery from the estates of certain individuals up to the amount of medical assistance payments made by the HSD on behalf of the individual. See Social Security Act Section 1917 [42 USC 1396p(b) and NMSA 1978, Section 27-2A-1 et seq. "Medicaid Estate Recovery Act".

A. **Definitions used in MAD estate recovery:**

(1) **Estate:** Real and personal property and other assets of an individual subject to probate or administration pursuant to the New Mexico Uniform Probate Code.

(2) **Medical assistance:** Amounts paid by HSD for long term care services including related hospital and prescription drug services.

(3) **Personal representative:** An adult designated in writing who is authorized to represent the estate of the eligible recipient.

B. **Basis for defining the group:** A medicaid eligible recipient who was 55 years of age or older when medical assistance payments were made on his or her behalf for nursing facilities services, home and community based services, and related hospital and prescription drug services are subject to estate recovery.

C. **The following exemptions apply to estate recovery:**

(1) Qualified medicare beneficiaries, specified low-income beneficiaries, qualifying individuals, and qualified disabled and working individuals are exempt from estate recovery for the receipt of hospital and prescription drug services unless they are concurrently in a nursing facility category of eligibility or on a home and community based services waiver; this provision applies to medicare cost-sharing benefits (i.e., Part A and Part B premiums, deductibles, coinsurance, and co-payments) paid under the medicare savings programs.

(2) Certain income, resources, and property are exempted from medicaid estate recovery for native Americans:

(a) interest in and income derived from tribal land and other resources held in trust status and judgment funds from the Indian claims commission and the United States (U.S.) claims court;

(b) ownership interest in trust or non-trust property, including real property and improvements;

(i) located on a reservation or near a reservation as designated and approved by the bureau of Indian affairs of the U.S, department of interior; or

(ii) for any federally-recognized tribe located within the most recent boundaries of a prior federal reservation; and

(iii) protection of non-trust property described in Subparagraphs (a) and (b) is limited to circumstances when it passes from a native American to one or more relatives, including native Americans not enrolled as members of a tribe and non-native Americans such as a spouse and step-children, that their culture would nevertheless protect as family members; to a tribe or tribal organization; or to one or more native Americans;

(c) income left as a remainder in an estate derived from property protected in Paragraph (2) above , that was either collected by a native American, or by a tribe or tribal organization and distributed to native Americans that the individual can clearly trace the income as coming from the protected property;

(d) ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a tribe or tribal organization and distributed to native Americans derived from these sources as long

as the individual can clearly trace the ownership interest as coming from protected sources; and

(e) ownership interest in or usage of rights to items not covered by Subparagraphs (a) through (d) above that have unique religious, spiritual, traditional, and or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

D. **Recovery process:** Recovery from an eligible recipient's estate will be made only after the death of the eligible recipient's surviving spouse, if any, and only at a time that the eligible recipient does not have surviving child who is less than 21 years of age, blind, or who meet the social security administration's definition of disability.

(1) Estate recovery is limited to payments for applicable services received on or after October 1, 1993 except that recovery also is permitted for pre-October 1993 payments for nursing facility services received by medicaid recipient who was 65 years of age or older when such nursing facility services were received.

(2) A recovery notice will be mailed to the personal representative or next of kin upon the eligible recipient's death informing him or her about the amount of claim against the estate and provide information on hardship waivers and hearing rights.

(3) It is the family or personal representative's responsibility to report the eligible recipient's date of death to the ISD office within 10 calendar days after the date of death.

E. **Eligible recipient rights and responsibilities:**

(1) At the time of application or re-certification, a personal representative must be identified or confirmed by the applicant or eligible recipient or his or her designee.

(2) Information explaining estate recovery will be furnished to the applicant or eligible recipient, his or her personal representative, or designee during the application or recertification process. Upon the death of the medicaid eligible recipient, a notice of intent to collect (recovery) letter will be mailed to the eligible recipient's personal representative with the total amount of claims paid by medicaid on behalf of the eligible recipient. The personal representative must acknowledge receipt of this letter in the manner prescribed in the letter within 30 calendar days of the date on the letter.

(3) During the application or recertification process for medicaid eligibility, the local county ISD office will identify the assets of an applicant or the eligible recipient. This includes all real and personal property which belongs in whole or in part to the applicant or eligible recipient and the current fair market value of each asset. Any known encumbrances on the asset should be identified at this time by the applicant or the eligible recipient or his or her personal representative.

(4) MAD, or its designee, will send notice of recovery to the probate court, when applicable, and to the eligible recipient's personal representative or successor in interest. The notice will contain the following information:

(a) statement describing the action MAD, or its designee, intends to take;
(b) reasons for the intended action;
(c) statutory authority for the action;
(d) amount to be recovered;
(e) opportunity to apply for the undue hardship waiver;
(f) procedures for applying for a hardship waiver and the relevant timeframes involved;
(g) explanation of the eligible recipient's personal representative's right to request an administrative hearing; and
(h) the method by which an affected person may obtain a hearing and the applicable timeframes involved.

(5) Once notified by MAD or its designee of the decision to seek recovery, it is the responsibility of the eligible recipient's personal representative or successor in interest to notify other individuals who would be affected by the proposed recovery.

(6) The personal representative will:

(a) remit the amount of medical assistance payments to HSD or its designee;
(b) apply for an undue hardship waiver; (see Paragraph (2) of Subsection F below); or
(c) request an administrative hearing.

F. **Waivers:**

(1) For a general waiver, HSD may compromise, settle, or waive recovery pursuant to the Medicaid Estate Recovery Act if it deems that such action is in the best interest of the state or federal government.

(2) Hardship provision: HSD, or its designee, may waive recovery because recovery would work an undue hardship on the heirs. The following are deemed to be causes for hardship:

(a) the deceased recipient's heir would become eligible for a needs-based assistance program such as medicaid or temporary assistance to needy families (TANF) or be put at risk of serious deprivation without the receipt of the proceeds of the estate;

(b) the deceased eligible recipient's heir would be able to discontinue reliance on a needs-based program (such as medicaid or TANF) if he or she received the inheritance from the estate;

(c) the deceased recipient's assets which are subject to recovery are the sole income source for the heir;

(d) the homestead is worth 50 percent or less than the average price of a home in the county where the home is located based on census data compared to the property tax value of the home; or

(e) there are other compelling circumstances as determined by HSD or its designee.

[8.200.430.20 NMAC - N, 1-1-14]

HISTORY OF 8.200.430 NMAC: The material in this part was derived from that previously filed with the State Records Center:
8 NMAC 4.MAD.430, Recipient Policies, Recipient Rights and Responsibilities, filed 12-30-94.

History of Repealed Material:
8.200.430 NMAC, Recipient Rights and Responsibilities, filed 12-13-2000 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT POLICIES
PART 520 INCOME STANDARDS

8.200.520.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.200.520.1 NMAC – Rp, 8.200.520.1 NMAC, 1-1-14]

8.200.520.2 SCOPE: The rule applies to the general public.
[8.200.520.2 NMAC – Rp, 8.200.520.2 NMAC, 1-1-14]

8.200.520.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.200.520.3 NMAC - Rp, 8.200.520.3 NMAC, 1-1-14]

8.200.520.4 DURATION: Permanent.
[8.200.520.4 NMAC - Rp, 8.200.520.4 NMAC, 1-1-14]

8.200.520.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.200.520.5 NMAC - Rp, 8.200.520.5 NMAC, 1-1-14]

8.200.520.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.200.520.6 NMAC - Rp, 8.200.520.6 NMAC, 1-1-14]

8.200.520.7 DEFINITIONS: [RESERVED]

8.200.520.8 MISSION: 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.
[8.200.520.8 NMAC - N, 1-1-14]

8.200.520.9 GENERAL NEED DETERMINATION: To be MAD eligible, an applicant or a re-determining eligible recipient must meet specific income and as applicable, resource standards.
[8.200.520.9 NMAC - Rp, 8.200.520.9 NMAC, 1-1-14]

8.200.520.10 INCOME STANDARDS: This part contains the federal income poverty rate tables for use with all eligibility categories, cost of living (COLA) disregard calculations, and other applicable income tables.
[8.200.520.10 NMAC - Rp, 8.200.520.10 NMAC, 1-1-14]

8.200.520.11 FEDERAL POVERTY INCOME GUIDELINES:

A. 100% FPL:

Size of budget group	FPL per month
1	$958*
2	$1,293*
3	$1,628
4	$1,963
5	$2,298
6	$2,633
7	$2,968
8	$3,303

Add $335 for each additional person in the budget group.
*Use only these two standards for the qualified medicare beneficiary (QMB) program.

B. 120% 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 $958 per month but no more than $1,149 per month.
2. Couple	At least $1,293per month but no more than $1,551 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. 133% FPL:

Size of budget group	FPL per month
1	$1,274
2	$1,720
3	$2,165
4	$2,611
5	$3,056
6	$3,502
7	$3,974
8	$4,393

Add $446 for each additional person in the budget group.

D. 135% 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 $1,149 per month but no more than $1,293 per month.
2. Couple	At least $1,551 per month but no more than $1,745 per month.

E. 150% FPL: This income level is used only in the determination of the maximum income limit for state coverage insurance (SCI) (category 062) applicant or eligible recipient. Add $502 for each additional person in the budget group. The following income levels apply:

Size of budget group	FPL per month
1	$1,437
2	$1,939
3	$2,442
4	$2,944
5	$3,447
6	$3,949
7	$4,452
8	$4,954

F. 185% FPL:

Size of budget group	FPL per month
1	$1,772
2	$2,392
3	$3,011
4	$3,631
5	$4,251
6	$4,871
7	$5,490
8	$6,110

Add $620 for each additional person in the budget group.

G. 200% FPL:

Size of budget group	FPL per month
1	$1,915
2	$2,585
3	$3,255
4	$3,925
5	$4,595
6	$5,265

7	$5,935
8	$6,605

Add $670 for each additional person in the budget group.

H. 235% FPL:

Size of budget group	FPL per month
1	$2,251
2	$3,038
3	$3,825
4	$4,612
5	$5,400
6	$6,187
7	$6,974
8	$7,761

Add $787 for each additional person in the budget group.

I. 250% FPL:

Size of budget group	FPL per month
1	$2,394
2	$3,232
3	$4,069
4	$4,907
5	$5,744
6	$6,582
7	$7,419
8	$8,257

Add $838 for each additional person in the budget group.

[8.200.520.11 NMAC - Rp, 8.200.520.11 NMAC, 1-1-14]

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	2012 Jan – Dec	1.017	Jan 13
2	2011 Jan – Dec	1.037	Jan 12
3	2010 Jan – Dec	1	Jan 10
4	2009 Jan – Dec	1	Jan 09
5	2008 Jan – Dec	1.058	Jan 08
6	2007 Jan – Dec	1.023	Jan 07
7	2006 Jan – Dec	1.033	Jan 06
8	2005 Jan – Dec	1.041	Jan 05
9	2004 Jan – Dec	1.027	Jan 04
10	2003 Jan – Dec	1.021	Jan 03
11	2002 Jan – Dec	1.014	Jan 02
12	2001 Jan – Dec	1.026	Jan 01
13	2000 Jan – Dec	1.035	Jan 00
14	1999 Jan – Dec	1.025	Jan 99
15	1988 Jan – Dec	1.013	Jan 98

COLA Increase and disregard table			
	Period and year	COLA increase	= benefit before
16	1997 Jan – Dec	1.021	Jan 97
17	1996 Jan – Dec	1.029	Jan 96
18	1995 Jan – Dec	1.026	Jan 95
19	1994 Jan – Dec	1.028	Jan 94
20	1993 Jan – Dec	1.026	Jan 93
21	1992 Jan – Dec	1.03	Jan 92
22	1991 Jan – Dec	1.037	Jan 91
23	1990 Jan – Dec	1.054	Jan 90
24	1989 Jan – Dec	1.047	Jan 89
25	1988 Jan – Dec	1.04	Jan 88
26	1987 Jan – Dec	1.042	Jan 87
27	1986 Jan – Dec	1.013	Jan 86
28	1985 Jan – Dec	1.031	Jan 85
29	1984 Jan – Dec	1.035	Jan 84
30	1982 Jul – 1983 Dec	1.035	Jul 82
31	1981 Jul – 1982 Jun	1.074	Jul 81
32	1980 Jul – 1981 Jun	1.112	Jul 80
33	1979 Jul – 1980 Jun	1.143	Jul 79
34	1978 Jul – 1979 Jun	1.099	Jul 78
35	1977 Jul – 1978 Jun	1.065	Jul 77
36	1977 Apr – 1977 Jun	1.059	Apr 77

[8.200.520.12 NMAC - Rp, 8.200.520.12 NMAC, 1-1-14]

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

Year	Individual FBR	Institution FBR	Individual VTR	Couple FBR	Institution FBR	Couple 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

A. Ineligible child deeming allocation is $350.00

B. Part B premium is $104.90 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 his or her 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, 1-1-14]

8.200.520.14 UNISEX LIFE ESTATE AND REMAINDER INTEREST TABLES

Age	Life Estate	Remainder
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95243	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145

44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36690
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.42095	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514

100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

[8.200.520.14 NMAC - Rp, 8.200.520.14 NMAC, 1-1-14]

8.200.520.15 SUPPLEMENTAL SECURITY INCOME (SSI) LIVING ARRANGEMENTS:

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

Payment amount: $$710 Individual
$1,066 Couple

B. **Individual receiving support and maintenance payments:** For an individual or couple living in his or her 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: $710 - $237 = $473 Individual
$1,066 - $355 = $711 Couple

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

Payment amount: $710 - $237 = $473 Individual
$1,066 - $355 = $711 couple

D. **Child living in home with his or her parent:**

Payment amount: $710

E. **Individual in institution:**

Payment amount: $30.00

[8.200.520.15 NMAC - Rp, 8.200.520.15 NMAC, 1-1-14]

8.200.520.16 MAXIMUM COUNTABLE INCOME FOR INSTITUTIONAL CARE MEDICAID AND HOME AND COMMUNITY BASED WAIVER SERVICES (HCBS) CATEGORIES: Effective January 1, 2013, the maximum countable monthly income standard for institutional care medicaid and the home and community based waiver categories is $2,130.
[8.200.520.16 NMAC - Rp, 8.200.520.16 NMAC, 1-1-14]

8.200.520.17 MAXIMUM COUNTABLE INCOME FOR CHILDREN YOUTH AND FAMILIES (CYFD): Effective July 1, 1995, the maximum countable monthly income standard for CYFD medicaid is $231.00.
[8.200.520.17 NMAC - Rp, 8.200.520.17 NMAC, 1-1-14]

8.200.520.18 SSI RELATED CATEGORIES - DEEMING INCOME WHEN AN APPLICANT CHILD IS LIVING WITH INELIGIBLE PARENT:

A. Monthly computation:

(1) total gross unearned income of parent;

(2) deduct living allowance for ineligible child and/or SSI-eligible sponsored alien (one half of the monthly SSI FBR LA code A*) for each ineligible child/SSI-eligible sponsored alien);

(3) subtotal;

(4) deduct $20.00 general income exclusion - 20.00;

(5) unearned income subtotal;

(6) total gross earned income of parent;

(7) deduct any remaining allocation for ineligible child and/or SSI-eligible sponsored alien; see Paragraph (2) above;

(8) subtotal;

(9) deduct any remaining portion of the $20.00 general income exclusion only if not already totally deducted in Paragraph (4) above;

(10) subtotal;
(11) deduct $65.00; do not apply this deduction if the only income is unearned - 65.00;
(12) subtotal;
(13) subtract one-half of Paragraph (12); do not apply this deduction if the only income is unearned;
(14) earned income subtotal;
(15) total of Paragraph (5) plus Paragraph (14);
(16) deduct parental allocation (1 parent = SSI FBR for an individual LA code A*) (2 parents = SSI FBR for an eligible couple LA code A*);
(17) income deemed to applicant child; if there is more than one applicant child, divide this amount equally between the children: * LA Code A = the full SSI FBR for an individual or a couple.

B. If the deemed income plus the applicant child's separate income exceeds the income standard for an individual, the applicant child is not eligible for that month.

[8.200.520.18 NMAC - Rp, 8.200.520.18 NMAC, 1-1-14]

8.200.520.19 LIFE EXPECTANCY TABLES

A. **Males:**

Age	Life expectancy	Age	Life expectancy	Age	Life expectancy
0	71.80	40	35.05	80	6.98
1	71.53	41	34.15	81	6.59
2	70.58	42	33.26	82	6.21
3	69.62	43	32.37	83	5.85
4	68.65	44	31.49	84	5.51
5	67.67	45	30.61	85	5.19
6	66.69	46	29.74	86	4.89
7	65.71	47	28.88	87	4.61
8	64.73	48	28.02	88	4.34
9	63.74	49	27.17	89	4.09
10	62.75	50	26.32	90	3.86
11	61.76	51	25.48	91	3.64
12	60.78	52	24.65	92	3.43
13	59.79	53	23.82	93	3.24
14	58.82	54	23.01	94	3.06
15	57.85	55	22.21	95	2.90
16	56.91	56	21.43	96	2.74
17	55.97	57	20.66	97	2.60
18	55.05	58	19.90	98	2.47
19	54.13	59	19.15	99	2.34
20	53.21	60	18.42	100	2.22
21	52.29	61	17.70	101	2.11
22	51.38	62	16.99	102	1.99
23	50.46	63	16.30	103	1.89
24	49.55	64	15.62	104	1.78
25	48.63	65	14.96	105	1.68
26	47.72	66	14.32	106	1.59
27	46.80	67	13.70	107	1.50
28	45.88	68	13.09	108	1.41
29	44.97	69	12.50	109	1.33
30	44.06	70	11.92	110	1.25
31	43.15	71	11.35	111	1.17
32	42.24	72	10.80	112	1.10
33	41.33	73	10.27	113	1.02
34	40.23	74	9.27	114	0.96
35	39.52	75	9.24	115	0.89
36	38.62	76	8.76	116	0.83
37	37.73	77	8.29	117	0.77

38	36.83	78	7.83	118	0.71
39	35.94	79	7.40	119	0.66

B. **Females:**

Age	Life expectancy	Age	Life expectancy	Age	Life expectancy
0	78.79	40	40.61	80	9.11
1	78.42	41	39.66	81	8.58
2	77.48	42	38.72	82	8.06
3	76.51	43	37.78	83	7.56
4	75.54	44	36.85	84	7.08
5	74.56	45	35.92	85	6.63
6	73.57	46	35.00	86	6.20
7	72.59	47	34.08	87	5.79
8	71.60	48	33.17	88	5.41
9	70.61	49	32.27	89	5.05
10	69.62	50	31.37	90	4.71
11	68.63	51	30.48	91	4.40
12	67.64	52	29.60	92	4.11
13	66.65	53	28.72	93	3.84
14	65.67	54	27.86	94	3.59
15	64.68	55	27.00	95	3.36
16	63.71	56	26.15	96	3.16
17	62.74	57	25.31	97	2.97
18	61.77	58	24.48	98	2.80
19	60.80	59	23.67	99	2.64
20	59.83	60	22.86	100	2.48
21	58.86	61	22.06	101	2.34
22	57.89	62	21.27	102	2.20
23	56.92	63	20.49	103	2.06
24	55.95	64	19.72	104	1.93
25	54.98	65	18.96	105	1.81
26	54.02	66	18.21	106	1.69
27	53.05	67	17.48	107	1.58
28	52.08	68	16.76	108	1.48
29	51.12	69	16.04	109	1.38
30	50.15	70	15.35	110	1.28
31	49.19	71	14.66	111	1.19
32	48.23	72	13.99	112	1.10
33	47.27	73	13.33	113	1.02
34	46.31	74	12.68	114	0.96
35	45.35	75	12.05	115	0.89
36	44.40	76	11.43	116	0.83
37	43.45	77	10.83	117	0.77
38	42.50	78	10.24	118	0.71
39	41.55	79	9.67	119	0.66

[8.200.520.19 NMAC - Rp, 8.200.520.19 NMAC, 1-1-14]

8.200.520.20 COVERED QUARTER INCOME STANDARD:

Date	Calendar Quarter Amount
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, 1-1-14]

8.200.520.21 STANDARD OF NEED (SON):

Budget group size	Gross income test		Net income test	
	85% Federal poverty limit (FPL)	AFDC July 16, 1996 185% Standard of need	Standard of need	
	072 JUL and 049/059 Refugee	030 Pregnant women	072 JUL and 049/059 Refugee	AFDC July 16, 1996 030 Pregnant woman
1	$791	$427	$266	$231
2	$1,072	$574	$357	$310
3	$1,352	$720	$447	$389
4	$1,633	$868	$539	$469
5	$1,913	$1,014	$630	$548
6	$2,194	$1,160	$721	$627
7	$2,474	$1,306	$812	$706
8	$2,755	$1,452	$922	$785
+1	+ $281	+ $147	+ $91	+ $79

[8.200.520.21 NMAC - N, 1-1-14]

HISTORY OF 8.200.520 NMAC: The material in this part was derived from that previously filed with the State Records Center:
8 NMAC 4.MAD.500, Eligibility Policies, Income and Resource Standards, filed 12-30-94.
8 NMAC 4.MAD.500, Eligibility Policies, Income and Resource Standards, 6-20-95.

History of Repealed Material:
8.200.520 NMAC, Income Standard, filed 12-18-00 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 202 MEDICAID ELIGIBILITY - JUL MEDICAID
PART 400 RECIPIENT REQUIREMENTS

8.202.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.202.400.1 NMAC - Rp, 8.202.400.1 NMAC, 1-1-14]

8.202.400.2 SCOPE: The rule applies to the general public.
[8.202.400.2 NMAC - Rp, 8.202.400.2 NMAC, 1-1-14]

8.202.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.202.400.3 NMAC - Rp, 8.202.400.3 NMAC, 1-1-14]

8.202.400.4 DURATION: Permanent.
[8.202.400.4 NMAC - Rp, 8.202.400.4 NMAC, 1-1-14]

8.202.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.202.400.5 NMAC - Rp, 8.202.400.5 NMAC, 1-1-14]

8.202.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.202.400.6 NMAC - Rp, 8.202.400.6 NMAC, 1-1-14]

8.202.400.7 DEFINITIONS: [RESERVED]

8.202.400.8 MISSION: 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.
[8.202.400.8 NMAC - Rp, 8.202.400.8 NMAC, 1-1-14]

8.202.400.9 WHO CAN BE AN ELIGIBLE RECIPIENT:

A. An applicant or an eligible recipient must meet specific eligibility requirements. These include:

(1) a child under 19 years of age;

(2) a natural or adoptive parent of the child, provided he or she lives with the eligible recipient child; there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process;

(3) when the parent does not live with the child, one specified relative caretaker, within the fifth degree of relationship by blood, marriage or adoption; refer to the relationship section at the end of this chapter for more information;

(4) a woman whose third trimester pregnancy has been medically verified through documentary evidence;

(5) an individual who meets the following eligibility requirements pursuant to 8.200.410 NMAC and 8.200.420 NMAC of citizenship or alien status: enumeration; residence; non-concurrent receipt of assistance; and applications for other benefits;

(6) an applicant or eligible recipient must assign medical support rights to HSD and agree to cooperate with third party liability responsibilities pursuant to 8.200.430 NMAC; and

(7) appropriate to the size of the budget group (not including the ineligible parent due to citizenship or alien status or enumeration), countable gross income must be less than 85 percent of the federal poverty limit (FPL); and the countable net income must be less than the standard of need (SON) pursuant to 8.200.520 NMAC, and 8.202.500 NMAC.

B. An applicant or an eligible recipient may have other creditable health insurance coverage.

C. An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.

D. For medical assistance program applicants or re-determining recipients who are recipients of another type of ISD benefits, the following will not be used in as automatic disqualification from medical assistance programs enrollment:

(1) New Mexico works (NMW) cash assistance eligibility;

(2) disqualifications for dual state public assistance benefits resulting in a conviction of fraud; or

(3) disqualifications for fugitive and probation parole violators.

[8.202.400.9 NMAC - Rp, 8.202.400.9 NMAC, 1-1-14]

8.202.400.10 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP:

A. At time of application, an applicant and a re-determining eligible recipient and ISD shall identify everyone who is to be considered for inclusion in the assistance unit and budget group. The composition of the assistance unit and budget group is based on the relationship of the household members to the dependent child for whom the application is being made. Each member of the assistance unit and budget group, including an unborn child, is counted as one in the household size.

B. The budget group includes all members of the assistance unit. Additional budget group members include individuals who live in the household with the assistance unit and have a financial obligation of support.

(1) Except for a supplemental security income (SSI) recipient, the following individuals have a financial obligation of support for medicaid eligibility:

(a) spouses: married individuals as defined under applicable New Mexico state law (New Mexico recognizes common law and same sex marriages established in other states); and

(b) parents for children: there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process.

(2) The following individuals do not have a financial obligation of support for medicaid eligibility:

(a) an SSI recipient to the assistance unit;

(b) a father of the unborn child who is not married to the pregnant woman;

(c) a stepparent to a stepchild;

(d) a grandparent to a grandchild;

(e) a legal guardian or conservator of a child;

(f) an alien sponsor to the assistance unit; and

(g) a sibling to a sibling.

[8.202.400.10 NMAC - Rp, 8.202.400.10 NMAC, 1-1-14]

8.202.400.11 ELIGIBLE MEMBERS: The assistance unit includes individuals who apply and who are determined eligible.

A. **The dependent child assistance unit:** Certain individuals may be included in the assistance unit, provided they live together and meet eligibility requirements. Those individuals are:

(1) the dependent child and full, half, step or adoptive siblings;

(2) the natural or adoptive parents of a child; there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process; and

(3) when the parent does not live with the child, one specified relative caretaker, within the fifth degree of relationship by blood, marriage or adoption, refer to Section 13 of this rule.

B. **The adult-only assistance unit:**

(1) When the dependent child is receiving supplemental security insurance (SSI), the eligible parent or a specified relative when the parents are not living with the child, may constitute an adult-only assistance unit. The spouse of a parent (step-parent) and the spouse of the specified relative are not eligible to be included in the assistance unit. Spouse refers to a person who is married to the individual under applicable state law.

(2) A pregnant woman in her third trimester who has no dependent child living with her may constitute an adult only assistance unit when:

(a) each unborn child is counted as one as if the child was born and living with the mother; and

(b) the child is born, regardless of marital status, the father, if living with the assistance unit, may be a member of the assistance unit.

[8.202.400.11 NMAC - Rp, 8.202.400.11 NMAC, 1-1-14]

8.202.400.12 SANCTIONED MEMBERS: New Mexico works', child support enforcement division (CSED), and work sanctions do not apply to JUL medicaid eligibility.
[8.202.400.12 NMAC - Rp, 8.202.400.12 NMAC, 1-1-14]

8.202.400.13 LIVING ARRANGEMENTS:

A. **Living in the home with a relative:** To be included in the assistance unit, a child must be living, or considered to be living, in the home of:

(1) a natural or an adoptive parent; there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process; or

(2) a specified relative who is related within the fifth degree of relationship by blood, marriage or adoption and assumes responsibility for the day-to-day care and control of the child; the determination of whether an individual functions as the specified relative shall be made by the specified relative unless other information known to the worker clearly indicates otherwise.

B. **A child considered to be living in the home:** A child is considered to be part of the assistance unit as evidenced by the child's customary physical presence in the home. If a child is living with more than one household, the following applies:

(1) when the child is actually spending more time with one household than the other, the child would be determined to be living with the household with whom the child spends the most time; or

(2) when the child is actually spending equal amounts of time with each household, the child shall be considered to be living with the household who first applies for medicaid enrollment.

C. **Extended living in the home:** An individual may be physically absent from the home for longer or shorter periods of time and be a member of the assistance unit and budget group. Extended living in the home includes:

(1) an individual attending college or a boarding school; or

(2) an individual receiving treatment in a Title XIX medicaid facility including institutions that meet a nursing facility (NF) level of care (LOC) and intermediate care facilities for individuals with an intellectual disability (ICF-IID) LOC; when an individual has been a member of the assistance unit, eligibility for another medicaid eligibility category, such as long term care medicaid, should be evaluated; until a determination of eligibility for another category can be made, the individual is considered to be living with the budget group.

D. **Temporary absence - extended living in the home:** An individual may be physically absent from the home and be a member of the assistance unit and budget group. These other temporary absences include:

(1) an individual not living in the home due to an emergency who is expected to return to the household within 60 calendar days, continues to be a member of the household;

(2) a child removed from the home of a parent or a specified relative by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and families department), until an adjudicatory custody hearing takes place. If the adjudicatory hearing results in custody being granted to some other entity, the child will be removed from the assistance unit; or

(3) a child residing in a detention center:

(a) continues to be a member of the household if he or she resides fewer than 60 calendar days, regardless of any adjudication as an inmate of a public institution; or

(b) the individual is not eligible for medicaid enrollment if he or she resides 60 calendar days or more as an adjudicated inmate of a public institution pursuant to 8.200.410 NMAC.

E. **Relationships:**

(1) The following relatives are within the fifth degree of relationship to the dependent child:

(a) a father (biological or adoptive);

(b) a mother (biological or adoptive);

(c) a grandfather, great grandfather, great great grandfather, great great great grandfather;

(d) a grandmother, great grandmother, great great grandmother, great great great grandmother;

(e) a spouse of child's parent (stepparent);

(f) a spouse of child's grandparent, great grandparent, great great grandparent, great great great grandparent (step grandparent);

(g) a brother, half-brother, brother-in-law, step-brother;

(h) a sister, half-sister, sister-in-law, step-sister;

(i) an uncle of the whole or half-blood, uncle-in-law, great uncle, great great uncle;

(j) an aunt of the whole or half-blood, aunt-in-law, great aunt, great great aunt;

(k) a first cousin and spouse of first cousin;

(l) a son or daughter of first cousin (first cousin once removed);
(m) a son or daughter of great aunt or great uncle (first cousin once removed) and spouse; and
(n) a nephew or niece and spouses.

(2) A second cousin is a child of a first cousin once removed or child of a child of a great aunt or uncle and is not within the fifth degree of relationship.

(3) **Effect of divorce or death on relationship:** A relationship based upon marriage, such as the "in-law" or "step" relationships, continues to exist following the dissolution of the marriage by divorce or death.

(4) **Table of relationships:** Below is the table of relationship based on the uniform probate code, see NMSA 1978, Section 45-1-101 et. seq. The relationships marked through with an "X" are not within the fifth degree of relationship.

					5 Great-great-great grandparents
				4 Great-great grandparents	X
			3 Great grandparents	5 Great-grand uncles and aunts	
		2 Grandparents	4 Great aunt great uncle	X	
	1 Parents	3 Aunt or uncle	5 First cousin once-removed		
Dependent child	2 Siblings	4 First cousins	X		
X	3 Nephew or niece	5 First cousin once-removed			
	4 Grand nephew grand niece	X			
	5 Great grand nephew or niece				
	X				

[8.202.400.13 NMAC - Rp, 8.202.400.13 NMAC, 1-1-14]

8.202.400.14 GENERAL RECIPIENT REQUIREMENTS: Refer to 8.202.400.9 NMAC.
[8.202.400.14 NMAC - Rp, 8.202.400.14 NMAC, 1-1-14]

8.202.400.15 CITIZENSHIP: Refer to 8.200.410.11 NMAC.
[8.202.400.15 NMAC - Rp, 8.202.400.15 NMAC, 1-1-14]

8.202.400.16 WORK PROGRAMS - GENERAL: Refer to 8.202.400.9 NMAC.
[8.202.400.16 NMAC - Rp, 8.202.400.16 NMAC, 1-1-14]

8.202.400.17 [RESERVED]

8.202.400.18 PROGRAM DISQUALIFICATIONS:

A. **Dual state benefits:** Any individual who has been convicted of fraud for receiving temporary assistance for needy families (TANF), food stamps, medicaid, or SSI in more than one state at the same time is not eligible for inclusion in the JUL medicaid assistance group for a period of 10 years following such conviction. The conviction must have occurred on or after August 22, 1996.

B. **Fugitive and probation and parole violators:** An individual who is a fugitive felon or who has been determined to be in violation of conditions of probation or parole is not eligible for inclusion in the JUL medicaid assistance group.

[8.202.400.18 NMAC - Rp, 8.202.400.18 NMAC, 1-1-14]

8.202.400.19 TERM LIMITATIONS: TANF term limits are not applicable to JUL medicaid. Individuals who meet all criteria for JUL medicaid eligibility, but who are ineligible for NMW solely on the basis of TANF term limits, may continue to receive JUL medicaid.
[8.202.400.19 NMAC - Rp, 8.202.400.19 NMAC, 1-1-14]

8.202.400.20 SPECIAL RECIPIENT REQUIREMENTS:

A. **Age:** Refer to 8.202.400.9 NMAC.

B. **Continuing eligibility on the factor of age:** When an individual has been determined eligible on the condition of age, he or she remains eligible on the condition until the applicable upper age limit is reached. An individual who exceeds the age limit during a given month is eligible for that month, unless the birthday is the first day of the month.

[8.202.400.20 NMAC - Rp, 8.202.400.20 NMAC, 1-1-14]

8.202.400.21 SCHOOL ATTENDANCE - REQUIREMENT: School attendance is required for children who are 18 years of age. There is no school requirement for children under age 18. A child 18 years of age must be a full-time student at a certified educational facility or participating and fully complying with a home-schooling program approved by the New Mexico public education department. Whether a child is considered a full-time student and meeting full-time attendance requirements is based on the standards of the educational facility or program in which the child is enrolled. Children who have received a general equivalency development (GED) certificate or are early high school graduates are considered to have met school attendance requirements and continue to be JUL medicaid eligible until age 19. School attendance requirements are evaluated only at the time of JUL medicaid application or recertification.
[8.202.400.21 NMAC - Rp, 8.202.400.21 NMAC, 1-1-14]

8.202.400.22 [RESERVED]

8.202.400.23 ALIEN SPONSORSHIP: Alien sponsor deeming provisions are set forth in manual section 8.200.410.11 NMAC.
[8.202.400.23 NMAC - Rp, 8.202.400.23 NMAC, 1-1-14]

8.202.400.24 LIVING IN A PUBLIC INSTITUTION: Refer to 8.200.410.15 NMAC.
[8.202.400.24 NMAC - Rp, 8.202.400.24 NMAC, 1-1-14]

8.202.400.25 RECIPIENT RIGHTS AND RESPONSIBILITIES: Refer to 8.200.430 NMAC.
[8.202.400.25 NMAC - Rp, 8.202.400.25 NMAC, 1-1-14]

8.202.400.26 ASSIGNMENT OF MEDICAL SUPPORT: Refer to 8.200.420.12 NMAC.
[8.202.400.26 NMAC - Rp, 8.202.400.26 NMAC, 1-1-14]

8.202.400.27 REPORTING REQUIREMENTS: Refer to 8.200.430.19 NMAC.
[8.202.400.27 NMAC - Rp, 8.202.400.27 NMAC, 1-1-14]

HISTORY OF 8.202.400 NMAC:

History of Repealed Material:
8.202.400 NMAC, Recipient Policies, filed 6-14-01 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 202 MEDICAID ELIGIBILITY - JUL MEDICAID
PART 500 INCOME AND RESOURCE STANDARDS

8.202.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.202.500.1 NMAC - Rp, 8.202.500.1 NMAC, 1-1-14]

8.202.500.2 SCOPE: The rule applies to the general public.
[8.202.500.2 NMAC - Rp, 8.202.500.2 NMAC, 1-1-14]

8.202.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.202.500.3 NMAC - Rp, 8.202.500.3 NMAC, 1-1-14]

8.202.500.4 DURATION: Permanent.
[8.202.500.4 NMAC - Rp, 8.202.500.4 NMAC, 1-1-14]

8.202.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.202.500.5 NMAC - Rp, 8.202.500.5 NMAC, 1-1-14]

8.202.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.202.500.6 NMAC - Rp, 8.202.500.6 NMAC, 1-1-14]

8.202.500.7 DEFINITIONS: [RESERVED]

8.202.500.8 MISSION: 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.
[8.202.500.8 NMAC - N, 1-1-14]

8.202.500.9 ESTABLISHING NEED - GENERAL REQUIREMENTS:

A. **Financial need:** An individual's eligibility is based on financial need pursuant to section 1931 of the Social Security Act, NMSA 1978, Section 27-2B-15(B), the rules in this chapter and 8.200.520 NMAC.

B. **Financial eligibility:** Pursuant to Section 1931 of the Social Security Act, enacted by Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), a new medicaid financial eligibility standard was created.

(1) Income eligibility criteria: The income eligibility criteria are based on New Mexico's aid to families with dependent children (AFDC) program as of July 16, 1996. This is defined as the standard of need (SON) used in AFDC as of July 16, 1996.

(a) As a state option, New Mexico ~~could~~ *may* increase income and resource eligibility criteria in medicaid over a period (beginning after July 16, 1996) by a percentage that does not exceed the percentage increase in the consumer price index for all urban consumers all items, United States city average over such period.

(b) Pursuant to NMSA 1978, Section 27-2B-15(B), income eligibility criteria for JUL medicaid shall be the same as the New Mexico temporary assistance to needy families (TANF) program. The SON for TANF has increased since July 16, 1996; therefore the SON for JUL medicaid has increased to match TANF.

(2) Less restrictive income and resource methodology: Pursuant to Section 1931 of the Social Security Act, as a state option, New Mexico ~~could~~ *may* use income and resource eligibility methodologies that are less restrictive than the AFDC methodologies used as of July 16, 1996. This chapter defines less restrictive methodologies used by New Mexico for resources, countable and excluded earned or unearned income, available or unavailable income and income deductions or disregards.

C. **Determining need is a two-step process:** When the countable gross or net income is exactly equal to the income eligibility standards, eligibility does not exist.

(1) Gross income test: The first step is determining the countable gross income of the budget group. Gross income includes all countable income before taking taxes or deductions. Only self employment deductions are allowed in the gross income test. The calculated gross income must be less than 85 percent of the federal poverty limit (FPL) for the size of the budget group (not including the ineligible parent due to citizenship or alien status or enumeration). If the budget group's income is more than 85 percent FPL, the assistance unit is not eligible.

(2) Net income test: The second step is determining the countable net income of the budget group. From the countable gross income in step one, deduct all allowable work related expenses (WRE) and unearned income deductions or disregards. The countable net income must be less than the SON appropriate to ~~for~~ the size of the budget group (not including the ineligible parent due to citizenship or alien status or enumeration). If the budget group's income is more than the SON, the assistance unit is not eligible.

[8.202.500.9 NMAC - Rp, 8.202.500.9 NMAC, 1-1-14]

8.202.500.10 RESOURCES/PROPERTY - RESOURCE STANDARDS: There are no resource standards.

[8.202.500.10 NMAC - Rp, 8.202.500.10 NMAC, 1-1-14]

8.202.500.11 INCOME - GENERAL - Income eligibility: Income consists of money received by a person whose income is considered available to the budget group as described in this chapter.

A. Income from a 30 calendar day period: Income from a 30 calendar day period is used to determine eligibility. The 30 calendar day period may be any consecutive 30-day period that is prior to the date of the application through the date of timely disposition. The applicant or the eligible recipient and the caseworker must agree on the 30 calendar day period. Income from a terminated source is not counted.

B. Income received less frequently than monthly: If an amount of gross income is received less frequently than monthly, that amount is converted to a monthly amount to determine financial eligibility. The conversion is dividing the total income by the number of months the income is intended to cover. For the purposes of this calculation, a partial month is considered to be one full month. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It includes contract income as well as income for a tenured teacher who may not have a contract.

C. Use of conversion factors: Whenever a full month's income is received on a weekly or biweekly basis, the income is converted to a monthly amount. Income is rounded down to the nearest whole dollar prior to application of the conversion factor. Weekly income is multiplied by four and biweekly income is multiplied by two.

[8.202.500.11 NMAC - Rp, 8.202.500.11 NMAC, 1-1-14]

8.202.500.12 AVAILABLE INCOME:

A. Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined using allowable income exemptions, deductions, and disregards.

B. Available income includes:

(1) the income of an ineligible member due to citizenship or alien status or enumeration must be prorated and deemed available to the assistance unit; income is prorated and deemed as follows:

(a) from the countable gross earned and unearned income, allow all income exemptions, deductions and disregards. The result is the individual's net income;

(b) divide the individual's net income by the number of individuals in the budget group; the result is the prorated income amount that is deemed to each eligible assistance group member; and

(c) multiply the prorated income amount by the number of eligible assistance group members; the result is the total countable prorated income that is deemed to the assistance unit;

(2) income received and made available by someone not included in the budget group (payee) for someone included in the budget group;

(3) income that is withheld as a result of a garnishment or wage withholding; and

(4) income withheld by a source at the budget group's request.

[8.202.500.12 NMAC - N, 1-1-14]

8.202.500.13 UNAVAILABLE INCOME:

A. Individuals included in the budget group may have a legal right to income but not access to it. The following are not counted as available income:

(1) received by someone for the budget group and not made available to the budget group; or

(2) income that is not listed as available in this chapter where the budget group cannot gain access to the income; this includes wages withheld by an employer that refuses to pay.

B. Individuals may receive payment of funds "passed through" the individual for the benefit of someone other than themselves. Such pass through payments are not considered available.

C. A recipient of supplemental security income (SSI) is not part of the budget group. This income is not available to the budget group.

D. The income of a step-parent or spouse of a specified relative is not counted to the assistance unit.

E. Alien sponsor deeming is not applicable pursuant to 8.200.410 NMAC.

[8.202.500.13 NMAC - N, 1-1-14]

8.202.500.14 EARNED INCOME: Earned income includes wages, salaries, tips, and other employee pay from employment and net earnings from self-employment. Earned income of a dependent child is not counted.

[8.202.500.14 NMAC - N, 1-1-14]

8.202.500.15 EARNED INCOME DEDUCTIONS/DISREGARDS:

A. Self employment: Certain self-employment deductions allowed by the federal internal revenue service (IRS) are allowed in the net and gross income test.

(1) Self-employment income will be annualized for income projection purposes. If the IRS Form 1040 form has been filed, the previous year's tax return is used to anticipate future income, if no significant changes in circumstances have occurred. An alternative method of income anticipation should be used when the amount of self-employment income reported on tax returns would no longer be a good indicator of expected income, i.e., loss of cattle or crops due to disease.

(2) If tax returns are used for annualized projected income, self-employment expenses listed on the return are allowable except for:

(a) the mileage allowance is the New Mexico department of finance and administration (DFA) rate as detailed in 2.42.2 NMAC unless proof that the actual expense is greater; and

(b) no deduction is allowed for rent or purchase of the place of business if the individual operates the business out of his or her residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines;

(c) the following deductions are not allowed: (i) depreciation; (ii) personal business and entertainment expenses; (iii) personal transportation to and from work; (iv) purchase of capital equipment; and (v) payments on the principal of loans for capital assets or durable goods.

B. WRE income disregards: The WRE is disregarded from countable earned income for each earner during the net income test as follows:

(1) single parent: $125.00 and one-half of the remainder (not including the ineligible parent due to citizenship or alien status or enumeration);

(2) two parents: $225.00 and one-half of the remainder for each parent, step-parent or spouse of a specified relative (not including ineligible individuals due to citizenship, alien status or enumeration); or

(3) ineligible parent due to citizenship/alien status or enumeration: $125.00 only (income is subject to proration).

C. Child care expenses: Out of pocket expenses for child care that are necessary due to employment of an assistance unit member shall be allowed as follows:

(1) from earned income remaining after allowing the WRE, deduct an amount not to exceed $200.00 per month for a child under the age two and $175.00 per month for a child age two or older;

(2) if more than one parent is working, costs of child care shall be allocated to maximize the available deduction to the benefit group; and

(3) the total amount deducted per child, regardless of the number of assistance unit members who are employed, shall not exceed the applicable limits set forth.

[8.202.500.15 NMAC - N, 1-1-14]

8.202.500.16 UNEARNED INCOME: Unearned income includes benefits, pensions, etc.

A. The following types of unearned income are counted:

(1) old age, survivors, and disability insurance (OASDI);

(2) railroad retirement benefits (RRB);
(3) veterans administration (VA) benefits:
(a) income available to veterans and their dependents from the VA as compensation for service-connected disability;
(b) pension for non-service connected disability;
(c) dependency and indemnity compensation; and
(d) death benefits paid from a government issue (GI) life insurance;
(4) unemployment compensation benefits (UCB);
(5) military allotments;
(6) worker's compensation;
(7) pension, annuity, and retirement benefits;
(8) union benefits;
(9) lodge or fraternal benefits;
(10) real property income that is not earned income;
(11) shared shelter and utility payments when the budget group shares shelter with others:
(a) payments which exceed the budget group's cost are considered income;
(b) payments which are less than the budget group's cost are not considered; these are the others' share of the shelter cost and are treated as pass-through payments;
(12) income from the sale of goods or property which are obtained in finished condition;
(13) child support payments received directly by the budget group and retained for its use;
(14) settlement payments which are received from worker's compensation settlements, insurance claims, damage claims, litigation, trust distributions which are made on a recurring basis;
(15) individual Indian monies (IIM) payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual member of a tribe; and
(16) bureau of Indian affairs (BIA) or tribal general assistance (GA) payments; and
(17) lump sum payments are considered income in the month received, unless specifically excludable under medicaid regulations; lump sum payments are considered as a resource, if retained, as of the first moment of the first day of the following month.

B. The following types of unearned income are not considered in determining eligibility:
(1) cash assistance from HSD or a tribal entity;
(2) supplemental nutritional assistance program (SNAP);
(3) low income home energy assistance program (LIHEAP);
(4) foster care or adoption subsidy;
(5) supplemental security income (SSI);
(6) Child Nutrition and National School Lunch Act;
(7) nutrition programs for the elderly, including meals on wheels and lunches at senior citizen's centers;
(8) bona fide loans from private individuals and commercial institutions as well as loans for the purpose of educational assistance;
(9) work study funds paid by an educational institution, when the purpose is to assist with educational expenses, regardless of the actual use of the funds;
(10) domestic volunteers compensation or any other payments made to or on behalf of volunteers under the Domestic Volunteers Services Act of 1973 including:
(a) volunteers in service to America (VISTA);
(b) university year for action (UYA);
(c) special volunteer programs (SVP);
(d) retired senior volunteer program (RSVP);
(e) foster grandparents program (FGP);
(f) older American community service program (OACSP);
(g) service corps of retired executives (SCORE); and
(h) active corps of executives (ACE);
(11) state and federal income tax returns;
(12) American Indian and Alaskan native payments including:
(a) per capita payments distribution of tribal funds to an American Indian or Alaskan native tribal member by the tribe or by the secretary of the US department of the interior;
(b) interest derived from retained per capita payments (if kept separately identifiable); and

(c) tribal land claims payments settled by means of case payments;

(13) Job Training Partnership Act of 1982 (JTPA) payments made to dependent children;

(14) Title II Uniform Relocation Assistance and Real Property Acquisition Act of 1970 payments;

(15) supportive service payments made for reimbursement of transportation, child care, or training related expenses under New Mexico works (NMW) work programs, tribal work programs, and other employment assistance programs;

(16) division of vocational rehabilitation (DVR) training payments made by the for training expenses;

(17) gifts, donations or contribution from other agencies which are intended to meet needs not covered as a medicaid benefit; to be exempt, the payment must:

(a) be paid under the auspices of an organization or non-profit entity; and

(b) be for a specific identified purpose, to supplement not duplicate medicaid covered benefits for the intended beneficiary of the donation or contribution;

(18) educational loans and grants intended for educational expenses regardless of actual utilization of the funds;

(19) agent orange settlement fund payments or any fund established pursuant to the agent orange product liability litigation settlement;

(20) radiation exposure compensation settlement fund payments;

(21) Nazi victim payments made to individuals per Public Law 103-286, August 1, 1994;

(22) vendor payments made on behalf of a budget group member when an individual or organization outside the budget group uses its own funds to make a direct payment to a budget group's service provider.

[8.202.500.16 NMAC - N, 1-1-14]

8.202.500.17 UNEARNED INCOME DEDUCTIONS/DISREGARDS: For an eligible recipient of TANF or New Mexico works (NMW), the child support enforcement division (CSED) pass-through payment of up to $100.00 is disregarded for the purposes of determining medicaid eligibility.

[8.202.500.17 NMAC - N, 1-1-14]

HISTORY OF 8.202.500 NMAC:

History of Repealed Material:

8.202.500 NMAC, Income and Resource Standards, filed 9-17-01 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 202 MEDICAID ELIGIBILITY - JUL MEDICAID
PART 600 BENEFIT DESCRIPTION

8.202.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.202.600.1 NMAC - Rp, 8.202.600.1 NMAC, 1-1-14]

8.202.600.2 SCOPE: The rule applies to the general public.
[8.202.600.2 NMAC - Rp, 8.202.600.2 NMAC, 1-1-14]

8.202.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.202.600.3 NMAC - Rp, 8.202.600.3 NMAC, 1-1-14]

8.202.600.4 DURATION: Permanent.
[8.202.600.4 NMAC - Rp, 8.202.600.4 NMAC, 1-1-14]

8.202.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.202.600.5 NMAC - Rp, 8.202.600.5 NMAC, 1-1-14]

8.202.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.202.600.6 NMAC - Rp, 8.202.600.6 NMAC, 1-1-14]

8.202.600.7 DEFINITIONS: [RESERVED]

8.202.600.8 MISSION: 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.
[8.202.600.8 NMAC - N, 1-1-14]

8.202.600.9 BENEFIT DESCRIPTION: JUL medicaid eligibility provides medicaid services for families with a dependent eligible child. An eligible recipient under this category is eligible for full medicaid services. Applications received on or after January 1, 2014 for JUL medicaid eligibility will be evaluated for an Affordable Care Act category.
[8.202.600.9 NMAC - Rp, 8.202.600.9 NMAC, 1-1-14]

8.202.600.10 BENEFIT DETERMINATION: ISD determines initial and ongoing eligibility.

A. Up to three months of retroactive medicaid coverage is provided to an applicant who has received a medicaid covered service during the retroactive period and who would have met applicable eligibility criteria had he or she applied. Eligibility for each retroactive month is determined separately. Application for retroactive medicaid must be made within 180 calendar days from the date of the medicaid application.

B. If income changes result in ineligibility for a pregnant woman enrolled in JUL medicaid, the pregnant woman remains eligible for medicaid under pregnancy related services or family planning services, without a new eligibility determination or application.
[8.202.600.10 NMAC - Rp, 8.202.600.10 NMAC, 1-1-14]

8.202.600.11 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A re-determination of eligibility is made every 12 months.

B. Continuous eligibility for a child establishes a 12-month period of eligibility for a child under age 19. Changes in family income are disregarded for the child but not the adult assistance unit members. Refer to 8.200.400.14 NMAC.

C. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change as detailed in 8.200.430 NMAC.

D. Recipients of JUL medicaid with a re-determination date of March 31, 2014 or prior will be re-determined for this category using exisiting JUL medicaid eligibility policy. Recipients with a determination date of April 1, 2014 or later will be re-determined for an Affordable Care Act category of medicaid eligibility. JUL medicaid ends March 31, 2015.

[8.202.600.11 NMAC - Rp, 8.202.600.11 NMAC, 1-1-14]

8.202.600.12 RETROACTIVE BENEFIT COVERAGE: Refer to 8.202.600.10 NMAC.

[8.202.600.12 NMAC - Rp, 8.202.600.12 NMAC, 1-1-14]

HISTORY OF 8.202.600 NMAC:

History of Repealed Material:

8.202.600 NMAC, Benefit Description, filed 9-17-01 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 206 MEDICAID ELIGIBILITY - RECIPIENTS FOR WHOM CYFD HAS FULL OR PARTIAL RESPONSIBILITY
PART 400 RECIPIENT REQUIREMENTS

8.206.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.206.400.1 NMAC - Rp, 8.206.400.1 NMAC, 1-1-14]

8.206.400.2 SCOPE: The rule applies to the general public.
[8.206.400.2 NMAC - Rp, 8.206.400.2 NMAC, 1-1-14]

8.206.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.206.400.3 NMAC - Rp, 8.206.400.3 NMAC, 1-1-14]

8.206.400.4 DURATION: Permanent.
[8.206.400.4 NMAC - Rp, 8.206.400.4 NMAC, 1-1-14]

8.206.400.5 EFFECTIVE DATE: Janaury 1, 2014, unless a later date is cited at the end of a section.
[8.206.400.5 NMAC - Rp, 8.206.400.5 NMAC, 1-1-14]

8.206.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.206.400.6 NMAC - Rp, 8.206.400.6 NMAC, 1-1-14]

8.206.400.7 DEFINITIONS:

A. "Full or partial financial responsibility" means children, youth and families department (CYFD) has made a payment on behalf of the eligible recipient during each month for which MAD eligibility is sought. The nature of CYFD's financial responsibility must be documented. Documentation must include either the court-ordered placement or custody award and CYFD payments made on behalf of the eligible recipient at the time of application and each subsequent periodic review.

B. "Private institutions" includes accredited and non-accredited residential treatment centers and group homes, and treatment foster care. Institutions specifically excluded from this definition are the youth diagnostic development center, New Mexico boys and girls schools, and reintegration centers which are not certified to furnish medical care. A child placed in one of these facilities is not eligible for medical assistance program services.

C. "Substitute care placement" includes placement in foster homes or private institutions.
[8.206.400.7 NMAC - N, 1-1-14]

8.206.400.8 MISSION: 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.
[8.206.400.8 NMAC - N, 1-1-14]

8.206.400.9 MEDICAID FOR RECIPIENTS UNDER EIGHTEEN YEARS OF AGE FOR WHOM THE CHILDREN, YOUTH, AND FAMILIES DEPARTMENT HAS FULL OR PARTIAL FINANCIAL RESPONSIBILITY - CATEGORIES 017, 037, 046, 047, 066, AND 086 - AND EXTENDED MEDICAID FOR CERTAIN INDIVIDUALS RECEIVING CHAFEE INDEPENDENT LIVING ASSISTANCE:

A. MAD is required to furnish coverage to eligible recipients under 18 years of age for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act (SSA) [42 CFR Section 436.118].

B. MAD has opted to furnish coverage to eligible recipients under 18 years of age who meet all the aid to families with dependent children (AFDC) eligibility criteria except for the definition of "dependent child" for whom the state of New Mexico, through CYFD, has assumed full or partial financial responsibility [42 CFR Section 436.222].

C. MAD furnishes extended coverage to eligible recipients over 18 years of age but under 21 years of age who are receiving Chafee independent living assistance.

D. MAD furnishes extended coverage to former foster care eligible recipients up to 26 years of age under Category 066 as required by the Affordable Care Act.

[8.206.400.9 NMAC - Rp, 8.206.400.9 NMAC, 1-1-14]

8.206.400.10 BASIS FOR DEFINING THE GROUP: An eligible recipient 18 years of age or under can be eligible for CYFD medicaid if the state bears full or partial responsibility for him or her and makes a payment on behalf of him or her. An eligible recipient 18 year or under will be assigned one of the following MAD categories of eligibility.

A. Category 017: The eligible recipient resides in New Mexico and receives a Title IV-E adoptive subsidy from another state.

B. Category 037: The eligible recipient resides in New Mexico and receives a Title IV-E adoptive subsidy from New Mexico.

C. Category 046: The eligible recipient resides out-of-state and receives a Title IV-E foster care payment from New Mexico. A medicaid card is issued by the state in which the eligible recipient resides.

D. Category 047: The eligible recipient currently resides out-of-state and receives a Title IV-E adoption subsidy payment. A medicaid card is issued by the state in which the eligible recipient resides.

E. Category 066: The eligible recipient is in the child protective service component of CYFD and is IV-E eligible or is from a home that meets AFDC eligibility criteria.

F. Category 086: The eligible recipient resides in New Mexico, is in the custody of another state and receives Title IV-E foster care payment from that state.

[8.206.400.10 NMAC - Rp, 8.206.400.10 NMAC, 1-1-14]

8.206.400.11 LIVING ARRANGEMENTS: To be eligible for CYFD medicaid, an individual under 18 years of age must be in a substitute care placement or temporarily in a medical facility with an ultimate plan to be placed in substitute care arrangement.

A. **Removal from home:** An individual who is in the custody of his or her parent or guardian is not eligible for CYFD medicaid. When a CYFD medicaid eligible recipient is returned to his or her parent or guardian's custody, CYFD medicaid is terminated.

B. **Release from jurisdiction of non-Title XIX facility:** An eligible recipient who is released from the jurisdiction and control of the correctional system for whom CYFD has full or partial financial responsibility and is in a substitute care placement can be eligible for CYFD medicaid beginning the first of the month after release from the correctional system if all other eligibility criteria are met.

(1) **Permanent release from jurisdiction requirements:** An individual living in a correctional facility or under the jurisdiction and control of the correctional system is not eligible for MAD services. This includes an individual temporarily released from a correctional facility for the sole purpose of receiving medical treatment.

(2) **Documentation of release:** To document that the individual is no longer under the jurisdiction and control of the correctional system, the individual must be permanently released from the correction facility and the court or parole order must specify the following:

(a) the individual is in the custody of CYFD; or

(b) CYFD is required to make monthly payment for the care, maintenance and medical treatment of the individual; in addition, the individual must receive or be evaluated for (or both) the receipt of long-term medical treatment.

C. **Independent living arrangements:** MAD furnishes extended coverage to an eligible recipient between 18 years and 21 years of age who is considered to be in an independent living arrangement if foster care payment is made to the eligible recipient and he or she meets all other MAD eligibility criteria.

[8.206.400.11 NMAC - Rp, 8.206.400.11 NMAC, 1-1-14]

8.206.400.12 [RESERVED]

8.206.400.13 ENUMERATION: See 8.200.410.10 NMAC.
[8.206.400.13 NMAC - Rp, 8.206.400.13 NMAC, 1-1-14]

8.206.400.14 CITIZENSHIP: See 8.200.410.11 NMAC.
[8.206.400.14 NMAC - Rp, 8.206.400.14 NMAC, 1-1-14]

8.206.400.15 RESIDENCE: See 8.200.410.12 NMAC.
[8.206.400.15 NMAC - Rp, 8.206.400.15 NMAC, 1-1-14]

8.206.400.16 NON-CONCURRENT RECEIPT OF ASSISTANCE: An applicant or re-determining recipient is not eligible for CYFD medicaid if he or she is eligible under another MAD category of eligibility, or if he or she receives supplemental security income (SSI). An applicant or re-determining recipient receiving SSI can qualify for and receive MAD services under an alternate category of eligibility.
[8.206.400.16 NMAC - Rp, 8.206.400.16 NMAC, 1-1-14]

8.206.400.17 [RESERVED]

8.206.400.18 AGE: To be eligible for CYFD medicaid, an applicant or a re-determining recipient must be under 18 years of age, except as outlined in Subsection D of 8.206.200.9 NMAC.

A. **Students under nineteen:** When an eligible recipient reaches 18 years of age, he or she loses medical assistance program eligibility unless: (1) he or she is a full-time student in a secondary school or its equivalent and (2) he or she is expected to complete the program before reaching 19 years of age. In such cases, eligibility is terminated when he or she leaves school or upon his or her 19th birthday, whichever comes first. School attendance must be verified each semester as part of CYFD's re-determination process.

B. **Proof of age:** The following documents constitute primary evidence of age:

(1) birth certificate;
(2) adoption papers or records;
(3) hospital or clinic records;
(4) church or baptismal records;
(5) bureau of vital statistics or local government records;
(6) United States passports or immigration and naturalization services records;
(7) Indian census reports; or
(8) birth records maintained by the social security administration (SSA).

C. If the age of the applicant or re-determining recipient cannot be established using primary evidence, a minimum of two pieces of corroborating secondary evidence must be used, such as school records, census records, court support order not generated by CYFD, physician statement, juvenile court records not generated by CYFD, child welfare records not generated by CYFD, voluntary social services agency records, insurance policies, minister's signed statement, affidavits or military records.
[8.206.400.18 NMAC - Rp, 8.206.400.18 NMAC, 1-1-14]

8.206.400.19 ASSIGNMENT OF MEDICAL SUPPORT: MAD has established special requirement rules. See 8.200.420 NMAC.

A. **CYFD requirements:** The authorized representative of CYFD who signs the MAD eligibility application on behalf of the applicant or re-determining recipient must notify MAD of any available third party medical coverage.

B. **CYFD responsibilities for cooperation with HSD child support enforcement division (CSED):** CYFD is responsible for cooperating with CSED activities which include:

(1) identifying and locating the absent parent(s) of the eligible recipients receiving MAD services;
(2) establishing paternity of children born out of wedlock;
(3) obtaining child and medical support for the child;
(4) identifying and providing information necessary to pursue third party health coverage; and
(5) developing procedures for referrals and determination of good cause for not pursuing child support or not requiring cooperation in pursuing such support.
[8.206.400.19 NMAC - Rp, 8.206.400.19 NMAC, 1-1-14]

8.206.400.20 REPORTING REQUIREMENTS: For all eligible recipients who receive medical assistance program services through CYFD, any change in an eligible recipient's circumstances which affect his or her eligibility must be documented and acted upon by the CYFD authorized representative within 10 calendar days of CYFD receiving notice of the change.
[8.206.400.20 NMAC - Rp, 8.206.400.20 NMAC, 1-1-14]

HISTORY OF 8.206.400 NMAC:

History of Repealed Material:
8 NMAC 4.CYM.430 Recipient Rights and Responsibilities, filed 10-1-94 - Repealed effective 7-1-03.
8.206.400 NMAC, Recipient Policies, filed 6-11-03 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 227 TRANSITIONAL MEDICAID ELIGIBILITY - LOSS OF JUL FAMILY MEDICAID DUE TO CHILD OR SPOUSAL SUPPORT
PART 400 RECIPIENT REQUIREMENTS

8.227.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.227.400.1 NMAC - Rp, 8.227.400.1 NMAC, 1-1-14]

8.227.400.2 SCOPE: The rule applies to the general public.
[8.227.400.2 NMAC - Rp, 8.227.400.2 NMAC, 1-1-14]

8.227.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.227.400.3 NMAC - Rp, 8 227.400.3 NMAC, 1-1-14]

8.227.400.4 DURATION: Permanent.
[8.227.400.4 NMAC - Rp, 8.227.400.4 NMAC, 1-1-14]

8.227.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.227.400.5 NMAC - Rp, 8.227.400.5 NMAC, 1-1-14]

8.227.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility – General Recipient Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.227.400.6 NMAC - Rp, 8.227.400.6 NMAC, 1-1-14]

8.227.400.7 DEFINITIONS: [RESERVED]

8.227.400.8 MISSION: 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.
[8.227.400.8 NMAC - N, 1-1-14]

8.227.400.9 CASES CLOSED DUE TO CHILD OR SPOUSAL SUPPORT: When a JUL medicaid assistance unit loses medicaid eligibility, wholly or in part, due to new or increased child or spousal support, the assistance unit is eligible for transitional medicaid eligibility under Category 027 for four calendar months. Eligibility begins the first month immediately following JUL medicaid ineligibility.

A. To be a medicaid eligible recipient, the assistance unit must have:

(1) received JUL medicaid in three of the most recent six month period prior to the ineligibility for JUL medicaid;

(2) lost JUL medicaid wholly or in part due to new or increased child or spousal support;

(3) at least one eligible dependent recipient living in the home;

(4) assigned medical support rights to HSD and agree to cooperate with third party liability responsibilities pursuant to 8.200.430 NMAC.

B. A recipient must meet all the eligibility requirements in 8.200.410 NMAC and 8.200.420 NMAC.

C. Applicant or a re-determining eligible recipient may have other creditable health insurance coverage.

D. An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.
[8.227.400.9 - Rp, 8.227.400.9 NMAC, 1-1-14]

8.227.400.10 [RESERVED]

8.227.400.11 ENUMERATION: Refer to 8.200.410.10 NMAC.

[8.227.400.11 NMAC - Rp, 8.227.400.11 NMAC, 1-1-14]

8.227.400.12 CITIZENSHIP: Refer to 8.200.410.11 NMAC.
[8.227.400.12 NMAC - Rp, 8.227.400.12 NMAC, 1-1-14]

8.227.400.13 RESIDENCE: Refer to 8.200.410.12 NMAC.
[8.227.400.13 NMAC - Rp, 8.227.400.13 NMAC, 1-1-14]

8.227.400.14 [RESERVED]

8.227.400.15 [RESERVED]

8.227.400.16 RECIPIENT RIGHTS AND RESPONSIBILITIES: Refer to 8.200.430 NMAC.
[8.227.400.16 NMAC - Rp, 8.227.400.16 NMAC, 1-1-14]

8.227.400.17 ASSIGNMENTS OF MEDICAL SUPPORT: Refer to 8.200.430.13 NMAC.
[8.227.400.17 NMAC - Rp, 8.227.400.17 NMAC, 1-1-14]

8.227.400.18 REPORTING REQUIREMENTS: Refer to 8.200.430.19 NMAC.
[8.227.400.18 NMAC - Rp, 8.227.400.18 NMAC, 1-1-14]

HISTORY OF 8.227.400 NMAC:

History of Repealed Material:
8.227.400 NMAC, Recipient Policies, filed 6-11-03 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 227 MEDICAID ELIGIBILITY - LOSS OF JUL FAMILY MEDICAID DUE TO CHILD OR SPOUSAL SUPPORT
PART 500 INCOME AND RESOURCE STANDARDS

8.227.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.227.500.1 NMAC - Rp, 8.227.500.1 NMAC, 1-1-14]

8.227.500.2 SCOPE: The rule applies to the general public.
[8.227.500.2 NMAC - Rp, 8.227.500.2 NMAC, 1-1-14]

8.227.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.227.500.3 NMAC - Rp, 8.227.500.3 NMAC, 1-1-14]

8.227.500.4 DURATION: Permanent.
[8.227.500.4 NMAC - Rp, 8.227.500.4 NMAC, 1-1-14]

8.227.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.227.500.5 NMAC - Rp, 8.227.500.5 NMAC, 1-1-14]

8.227.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining medical assistance eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.227.500.6 NMAC - Rp, 8.227.500.6 NMAC, 1-1-14]

8.227.500.7 DEFINITIONS: [RESERVED]

8.227.500.8 MISSION: 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.
[8.227.500.8 NMAC - N, 1-1-14]

8.227.500.9 NEED DETERMINATION AND INCOME STANDARDS: There are no income standards.
[8.227.500.9 NMAC - Rp, 8.227.500.9 NMAC, 1-1-14]

8.227.500.10 RESOURCE STANDARDS: Resources are not an eligibility factor.
[8.227.500.10 NMAC - Rp, 8.227.500.10 NMAC, 1-1-14]

8.227.500.11 INCOME STANDARDS: Income is not an eligibility factor.
[8.227.500.11 NMAC - Rp, 8.227.500.11 NMAC, 1-1-14]

HISTORY OF 8.227.500 NMAC:

History of Repeal Material:
8.227.500 NMAC, Income and Resource Standards, filed 3-25-10 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 227 MEDICAID ELIGIBILITY - LOSS OF JUL FAMILY MEDICAID DUE TO CHILD OR SPOUSAL SUPPORT
PART 600 BENEFIT DESCRIPTION

8.227.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.227.600.1 NMAC - Rp, 8.227.600.1 NMAC, 1-1-14]

8.227.600.2 SCOPE: The rule applies to the general public.
[8.227.600.2 NMAC - Rp, 8.227.600.2 NMAC, 1-1-14]

8.227.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.227.600.3 NMAC - Rp, 8.227.600.3 NMAC, 1-1-14]

8.227.600.4 DURATION: Permanent.
[8.227.600.4 NMAC - Rp, 8.227.600.4 NMAC, 1-1-14]

8.227.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.227.600.5 NMAC - Rp, 8.227.600.5 NMAC, 1-1-14]

8.227.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.227.600.6 NMAC - Rp, 8.227.600.6 NMAC, 1-1-14]

8.227.600.7 DEFINITIONS: [RESERVED]

8.227.600.8 MISSION: 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.
[8.227.600.8 NMAC - N, 1-1-14]

8.227.600.9 BENEFIT DESCRIPTION: When a JUL medicaid assistance unit receives medicaid in three of the most recent six months, and loses medicaid wholly or in part due to new or increased child or spousal support, the assistance unit is eligible for transitional medicaid for four calendar months. A medicaid eligible recipient under this category is eligible to receive the full range of medicaid covered services. Effective January 1, 2014, the loss of JUL family medicaid from increased child or spousal support will not qualify recipients for transitional medicaid. The eligibility requirements for transitional medicaid effective January 1, 2014 can be found in 8.297.400 NMAC.
[8.227.600.9 NMAC - Rp, 8.227.600.9 NMAC, 1-1-14]

8.227.600.10 BENEFIT DETERMINATION: ISD determines initial and ongoing eligibility.
[8.227.600.10 NMAC - Rp, 8.227.600.10 NMAC, 1-1-14]

8.227.600.11 INITIAL BENEFITS: Notice of the ineligibility for JUL medicaid and eligibility for Category 027 medicaid benefits for four months is generated and mailed to recipients.
[8.227.600.11 NMAC - Rp, 8.227.600.11 NMAC, 1-1-14]

8.227.600.12 ONGOING BENEFITS: At the end of the four month period, notice of the case closure is mailed to the recipient. If the JUL medicaid case with child support income is closed because of loss of the earned income disregard but eligiblity would have continued if the earned income disregard were allowed, the recipient may be eligible for transitional medicaid. A separate application for transitional medicaid must be submitted.
[8.227.600.12 NMAC - Rp, 8.227.600.12 NMAC, 1-1-14]

8.227.600.13 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. Redetermination of eligibility is not applicable. A four month period of eligibility following JUL medicaid is established, without a new eligibility determination or application. Increases in income are disregarded. Refer to 8.227.400 NMAC.

B If the combined certification period for JUL medicaid and Category 027 is fewer than 12 months, the remaining months within the 12-month continuous eligibility period for a child is extended through the child's Category 032 program without a new eligibility determination or application.

C. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change as detailed in 8.200.430 NMAC.

[8.227.600.13 NMAC - N, 1-1-14]

HISTORY OF 8.227.600 NMAC:

History of Repealed Material:

8.227.600 NMAC, Benefit Description, filed 9-1-15 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 228 TRANSITIONAL MEDICAID ELIGIBILITY - LOSS OF JUL FAMILY MEDICAID
PART 400 RECIPIENT REQUIREMENTS

8.228.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.228.400.1 NMAC - Rp, 8.228.400.1 NMAC, 1-1-14]

8.228.400.2 SCOPE: The rule applies to the general public.
[8.228.400.2 NMAC - Rp, 8.228.400.2 NMAC, 1-1-14]

8.228.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.228.400.3 NMAC - Rp, 8.228.400.3 NMAC, 1-1-14]

8.228.400.4 DURATION: Permanent.
[8.228.400.4 NMAC - Rp, 8.228.400.4 NMAC, 1-1-14]

8.228.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.228.400.5 NMAC - Rp, 8.228.400.5 NMAC, 1-1-14]

8.228.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions for determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility – General Recipient Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.228.400.6 NMAC - Rp, 8.228.400.6 NMAC, 1-1-14]

8.228.400.7 DEFINITIONS: [RESERVED]

8.228.400.8 MISSION: 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.
[8.228.400.8 NMAC - N, 1-1-14]

8.228.400.9 TRANSITIONAL MEDICAID - CATEGORY 028: When a JUL family medicaid assistance unit loses medicaid, due to earnings, the assistance unit is eligible for transitional medicaid under Category 028 for 12 calendar months. Eligibility begins the first month following JUL family medicaid ineligibility.

A. An eligible recipient or the assistance unit must have:
(1) received JUL medicaid in one of the preceding six months;
(2) lost JUL family medicaid due to countable earnings;
(3) at least one eligible dependent child living in the home;
(4) an individual who meets the eligibility requirements pursuant to 8.200.410 NMAC and 8.200.420 NMAC citizenship or alien status; enumeration; residence; non-concurrent receipt of assistance; and applications for other benefits; and
(5) assigned medical support rights to HSD and agreed to cooperate with third party liability responsibilities pursuant to 8.200.430 NMAC.

B. An eligible recipient may have other creditable health insurance coverage.

C. An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.
[8.228.400.9 NMAC - Rp, 8.228.200.9 NMAC, 1-1-14]

8.228.400.10 BASIS FOR DEFINING THE GROUP: The following individuals are not included in the assistance unit in the determination of eligibility for transitional medicaid:

A. individuals who enter the assistance unit after the transitional benefit period begins;

B. children who no longer meet the age requirements for JUL medicaid. For JUL medicaid, a child must be less than 19 years of age; or

C. an assistance unit or individuals who were ineligible for assistance in any one or more of the six month prior to losing JUL benefits because they committed fraud.
[8.228.400.10 NMAC - Rp, 8.228.400.10 NMAC, 1-1-14]

8.228.400.11 [RESERVED]

8.228.400.12 ENUMERATION: Refer to 8.200.410.10 NMAC.
[8.228.400.12 NMAC - Rp, 8.228.400.12 NMAC, 1-1-14]

8.228.400.13 CITIZENSHIP: Refer to 8.200.410.11 NMAC.
[8.228.400.13 NMAC - Rp, 8.228.400.13 NMAC, 1-1-14]

8.228.400.14 RESIDENCE: Refer to 8.200.410.12 NMAC.
[8.228.400.14 NMAC - Rp, 8.228.400.14 NMAC, 1-1-14]

8.228.400.15 [RESERVED]

8.228.400.16 AGE: The JUL age requirements apply to this category. Refer to 8.202.400.20 NMAC.
[8.228.400.16 NMAC - Rp, 8.228.400.16 NMAC, 1-1-14]

8.228.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: Refer to 8.200.430 NMAC.
[8.228.400.17 NMAC - Rp, 8.228.400.17 NMAC, 1-1-14]

8.228.400.18 ASSIGNMENTS OF MEDICAL SUPPORT: Refer to 8.200.420.12 NMAC.
[8.228.400.18 NMAC - Rp, 8.228.400.18 NMAC, 1-1-14]

8.228.400.19 REPORTING REQUIREMENTS: Refer to 8.200.430.19 NMAC.
[8.228.400.19 NMAC - Rp, 8.228.400.19 NMAC, 1-1-14]

HISTORY OF 8.228.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 290.1000, Medical Assistance for Woman and Children, filed 11-13-84.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.
MAD Rule 837, Transitional Medicaid - Extended Medicaid Benefits to Families Who Lose AFDC Because of Earnings from Employment or Loss of Earned Income Disregard (EID), filed 9-26-94.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
MAD Rule 837, Transitional Medicaid - Extended Medicaid Benefits to Families Who Lose AFDC Because of Earnings from Employment or Loss of Earned Income Disregard (EID), filed 9-26-94 - Repealed effective 2-1-95.
8.228.400 NMAC, Recipient Policies, filed 6-13-03 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 228 TRANSITIONAL MEDICAID ELIGIBILITY - LOSS OF JUL FAMILY MEDICAID DUE TO EARNED INCOME
PART 500 INCOME AND RESOURCE STANDARDS

8.228.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.228.500.1 NMAC - Rp, 8.228.500.1 NMAC, 1-1-14]

8.228.500.2 SCOPE: The rule applies to the general public.
[8.228.500.2 NMAC - Rp, 8.228.500.2 NMAC, 1-1-14]

8.228.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.228.500.3 NMAC - Rp, 8.228.500.3 NMAC, 1-1-14]

8.228.500.4 DURATION: Permanent.
[8.228.500.4 NMAC - Rp, 8.228.500.4 NMAC, 1-1-14]

8.228.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.228.500.5 NMAC - Rp, 8.228.500.5 NMAC, 1-1-14]

8.228.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions policy manual, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.228.500.5 NMAC - N, 1-1-14]

8.228.500.7 DEFINITIONS: [RESERVED]

8.228.500.8 MISSION: 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.
[8.228.500.8 NMAC – Rp, 8.228.500.6 NMAC, 1-1-14]

8.228.500.9 NEED DETERMINATION: Income is not an eligibility factor.
[8.228.500.9 NMAC - Rp, 8.228.500.9 NMAC, 1-1-14]

8.228.500.10 RESOURCE STANDARDS: Resources are not an eligibility factor.
[8.228.500.10 NMAC - Rp, 8.228.500.10 NMAC, 1-1-14]

8.228.500.11 INCOME STANDARDS: Income is not an eligibility factor.
[8.228.500.11 NMAC - Rp, 8.228.500.11 NMAC, 1-1-14]

HISTORY OF 8.228.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records:
ISD 290.1000, Medical Assistance for Woman and Children, filed 11-13-84.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.
MAD Rule 837, Transitional Medicaid - Extended Medicaid Benefits to Families Who Lose AFDC Because of Earnings from Employment or Loss of Earned Income Disregard (EID), filed 9-26-94.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
MAD Rule 837, Transitional Medicaid - Extended Medicaid Benefits to Families Who Lose AFDC Because of Earnings from Employment or Loss of Earned Income Disregard (EID), filed 9-26-94 - Repealed effective 2-1-95.
8.228.500 NMAC, Income and Resource Standards, filed 9-15-13 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 228 MEDICAID ELIGIBILITY - LOSS OF JUL FAMILY MEDICAID DUE TO EARNED INCOME
PART 600 BENEFIT DESCRIPTION

8.228.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.228.600.1 NMAC - Rp, 8.228.600.1 NMAC, 1-1-14]

8.228.600.2 SCOPE: The rule applies to the general public.
[8.228.600.2 NMAC - Rp, 8.228.600.2 NMAC, 1-1-14]

8.228.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.228.600.3 NMAC - Rp, 8.228.600.3 NMAC, 1-1-14]

8.228.600.4 DURATION: Permanent
[8.228.600.4 NMAC - Rp, 8.228.600.4 NMAC, 1-1-14]

8.228.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.228.600.5 NMAC - Rp, 8.228.600.5 NMAC, 1-1-14]

8.228.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.228.600.6 NMAC - Rp, 8.228.600.6 NMAC, 1-1-14]

8.228.600.7 DEFINITIONS: [RESERVED]

8.228.600.8 MISSION: 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.
[8.228.600.8 NMAC - N, 1-1-14]

8.228.600.9 BENEFIT DESCRIPTION: When a JUL medicaid assistance unit loses medicaid due to earnings, the assistance unit is eligible for transitional medicaid for 12 calendar months. A medicaid eligible recipient under this category is eligible to receive the full range of medicaid covered services. Effective January 1, 2014 the loss of JUL medicaid from increased earnings from employment does not qualify recipients for transitional medicaid. The eligibility requirements for transitional medicaid effective January 1, 2014 can be found in 8.298.400 NMAC.
[8.228.600.9 NMAC - Rp, 8.228.600.9 NMAC, 1-1-14]

8.228.600.10 BENEFIT DETERMINATION: ISD determines initial and ongoing eligibility. If an assistance unit becomes ineligible for JUL medicaid because countable earned income exceeds the standard, the caseworker opens a Category 028 for the assistance unit. To be eligible for Category 028, an assistance unit must meet all of the following conditions:

A. the assistance unit was eligible for and received JUL medicaid benefits in New Mexico in one of the six months immediately preceding the month the assistance unit became ineligible for benefits; and

B. the assistance unit lost eligibility for JUL medicaid because the parent or caretaker relative increased earnings.

[8.228.600.10 NMAC - Rp, 8.228.600.10 NMAC, 1-1-14]

8.228.600.11 CALCULATING THE BENEFIT: Eligibility during the 12 month transition period.

A. To receive transitional medicaid throughout the first 12-month period a dependent child must live in the home. If a dependent child does not live in the home, coverage for the assistance unit ends the last day of the month the assistance unit no longer includes a dependent child. This provision includes assistance units where a dependent child leaves the home of the caretaker relative, or where a child turns 19 years of age or otherwise no longer meets the age or school attendance requirement.

B. All conditions listed in 8.228.600.10 NMAC must also be met.

[8.228.600.11 NMAC - Rp, 8.228.600.11 NMAC, 1-1-14]

8.228.600.12 NOTICE REQUIREMENTS: Advance notice of closure is not required in any of the following instances:

A. assistance unit no longer contains dependent children; or

B. assistance unit moves out of state.

[8.228.600.12 NMAC - Rp, 8.228.600.12 NMAC, 1-1-14]

8.228.600.13 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. Redetermination of eligibility is not applicable. A 12-month period of eligibility following JUL medicaid is established, without a new eligibility determination or application. A new application is required after the 12 month period has expired. Increases in income are disregarded. Refer to 8.227.400 NMAC.

B. All changes that may affect eligibility must be reported within 10-calendar days from the date of the change as detailed in 8.200.430 NMAC.

[8.228.600.13 NMAC - N, 1-1-14]

HISTORY OF 8.228.600 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 290.1000, Medical Assistance for Woman and Children, filed 11-13-84.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.
MAD Rule 837, Transitional Medicaid - Extended Medicaid Benefits to Families Who Lose AFDC Because of Earnings from Employment or Loss of Earned Income Disregard (EID), filed 9-26-94.

History of Repealed Material:

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
MAD Rule 837, Transitional Medicaid - Extended Medicaid Benefits to Families Who Lose AFDC Because of Earnings from Employment or Loss of Earned Income Disregard (EID), filed 9/26/94 - Repealed effective 2-1-95.
8.228.600 Benefit Description, filed 9-15-13 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 230 MEDICAID ELIGIBILITY - FULL COVERAGE FOR PREGNANT WOMEN
PART 400 RECIPIENT REQUIREMENTS

8.230.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.230.400.1 NMAC - Rp, 8.230.400.1 NMAC, 1-1-14]

8.230.400.2 SCOPE: The rule applies to the general public.
[8.230.400.2 NMAC - Rp, 8.230.400.2 NMAC, 1-1-14]

8.230.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.230.400.3 NMAC - Rp, 8.230.400.3 NMAC, 1-1-14]

8.230.400.4 DURATION: Permanent.
[8.230.400.4 NMAC - Rp, 8.230.400.4 NMAC, 1-1-14]

8.230.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.230.400.5 NMAC - Rp, 8.230.400.5 NMAC, 1-1-14]

8.230.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions for determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility – General Recipient Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.230.400.6 NMAC - Rp, 8.230.400.6 NMAC, 1-1-14]

8.230.400.7 DEFINITIONS: [RESERVED]

8.230.400.8 MISSION: 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.
[8.230.400.8 NMAC - N, 1-1-14]

8.230.400.9 FULL MEDICAID COVERAGE FOR PREGNANT WOMEN - CATEGORY 030:

A. To be eligible an individual must meet the following eligibility requirements:

(1) a woman whose pregnancy has been medically verified through documentary evidence, who does not have a minor child living with her;

(2) a woman who meets eligibility requirements pursuant to 8.200.410 NMAC and 8.200.420 NMAC;

(3) an applicant or eligible recipient must assign medical support rights to HSD and agree to cooperate with third party liability responsibilities pursuant to 8.200.430 NMAC; and

(4) appropriate to the budget group size the countable gross income must be less than 185 percent of the federal poverty level. The standard of need (SON) and the countable net income must be less than the SON pursuant to 8.200.520 NMAC, and 8.230.500 NMAC.

B. Individuals may have other creditable health insurance.

C. An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.

D. For MAD applicants or re-determining recipients who are recipients of another type of ISD benefits, the following will not be used in as automatic disqualification from medical assistance programs enrollment:

(1) New Mexico works (NMW) cash assistance eligibility;

(2) disqualifications for dual state public assistance benefits resulting in a conviction of fraud; or

(3) disqualifications for fugitive and probation parole violators.

[8.230.400.9 NMAC - Rp, 8.230.400.9 NMAC, 1-1-14]

8.230.400.10 BASIS FOR DEFINING THE GROUP: The assistance unit is the pregnant woman who applies for medicaid and who is determined eligible and each unborn child is counted as one as if the child was born and living with the mother.
[8.230.400.10 NMAC - Rp, 8.230.400.10 NMAC, 1-1-14]

8.230.400.11 [RESERVED]

8.230.400.12 ENUMERATION: Refer to 8.200.410.10 NMAC.
[8.230.400.12 NMAC - Rp, 8.230.400.12 NMAC, 1-1-14]

8.230.400.13 CITIZENSHIP: Refer to 8.200.410.11 NMAC.
[8.230.400.13 NMAC - Rp, 8.230.400.13 NMAC, 1-1-14]

8.230.400.14 RESIDENCE: Refer to 8.200.410.12 NMAC.
[8.230.400.14 NMAC - Rp, 8.230.400.14 NMAC, 1-1-14]

8.230.400.15 EMPLOYMENT, TRAINING AND WORK: Registration or participation in employment assistance programs are not an eligibility factor.
[8.230.400.15 NMAC - Rp, 8.230.400.15 NMAC, 1-1-14]

8.230.400.16 [RESERVED]

8.230.400.17 AGE: There are no age requirements for this eligibility category.
[8.230.400.17 NMAC - Rp, 8.230.400.17 NMAC, 1-1-14]

8.230.400.18 PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN: Refer to 8.200.400.11 NMAC
[8.230.400.18 NMAC - Rp, 8.230.400.18 NMAC, 1-1-14]

8.230.400.19 RECIPIENT RIGHTS AND RESPONSIBILITIES: Refer to 8.200.430 NMAC.
[8.230.400.19 NMAC - Rp, 8.230.400.19 NMAC, 1-1-14]

8.230.400.20 ASSIGNMENTS OF MEDICAL SUPPORT: Refer to 8.200.420.12 NMAC.
[8.230.400.20 NMAC - Rp, 8.230.400.20 NMAC, 1-1-14]

8.230.400.21 REPORTING REQUIREMENTS: Refer to 8.200.430.19 NMAC.
[8.230.400.21 NMAC - Rp, 8.230.400.21 NMAC, 1-1-14]

8.230.400.22 BUDGET GROUP: The budget group includes all members of the assistance unit. Additional budget group members include individuals who live in the household with the assistance unit and have a financial obligation of support.

A. Except for a supplemental security income (SSI) recipient, the following individuals have a financial obligation of support for medicaid eligibility:

(1) the spouse of the pregnant woman; New Mexico recognizes common law and same sex marriages established in other states; and

(2) there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process.

B. The following individuals do not have a financial obligation of support for medicaid eligibility:

(1) a SSI recipient to the assistance unit;
(2) a father of the unborn child who is not married to the pregnant woman;
(3) a stepparent to a stepchild;
(4) a grandparent to a grandchild;
(5) a legal guardian or conservator of a child;
(6) an alien sponsor to the assistance unit; or
(7) a sibling to a sibling.

[8.230.400.23 NMAC - N, 1-1-14]

8.230.400.23 LIVING IN THE HOME:

A. **Extended living in the home:** An individual may be physically absent from the home and be a member of the assistance unit and budget group.

(1) Extended living in the home includes:

(a) an individual attending college or a boarding school; or

(b) an individual receiving treatment in a Title XIX medicaid facility (including institutionalized when meeting a nursing facility (NF) level of care (LOC) and intermediate care facilities for individuals with an intellectual disability (ICF-IID) LOC.

(2) When an individual has been a member of the assistance unit, eligibility for another medicaid eligibility category, such as long term care medicaid, should be evaluated. Until a determination of eligibility for another category can be made, the individual is considered to be living with the budget group.

B. **Temporary absence - extended living in the home:** An individual may be physically absent from the home and be a member of the assistance unit and budget group. These other temporary absences include:

(1) an individual not living in the home due to an emergency who is expected to return to the household within 60 calendar days;

(2) a child removed from the home of a parent or a specified relative by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and families department), until an adjudicatory custody hearing takes place; if the adjudicatory hearing results in custody being granted to some other person or entity, the child will be removed from the assistance unit; or

(3) a child residing in a detention center:

(a) continues to be a member of the household if he or she resides fewer than 60 consecutive calendar days, regardless of adjudication as an inmate of a public institution; or

(b) the individual is not eligible for medicaid enrollment if he or she resides 60 consecutive calendar days or more as an adjudicated inmate of a public institution pursuant to 8.200.410 NMAC.

[8.230.400.23 NMAC - N, 1-1-14]

HISTORY OF 8.230.400 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 290.1000, Medical Assistance for Woman and Children, filed 11-13-84.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.

History of Repealed Material:

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
8.230.400 NMAC, Recipient Policies, filed 6-13-03 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 230 MEDICAID ELIGIBILITY - FULL COVERAGE FOR PREGNANT WOMEN
PART 500 INCOME AND RESOURCE STANDARDS

8.230.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.230.500.1 NMAC - Rp, 8.230.500.1 NMAC, 1-1-14]

8.230.500.2 SCOPE: The rule applies to the general public.
[8.230.500.2 NMAC - Rp, 8.230.500.2 NMAC, 1-1-14]

8.230.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.230.500.3 NMAC - Rp, 8.230.500.3 NMAC, 1-1-14]

8.230.500.4 DURATION: Permanent.
[8.230.500.4 NMAC - Rp, 8.230.500.4 NMAC, 1-1-14]

8.230.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.230.500.5 NMAC - Rp, 8.230.500.5 NMAC, 1-1-14]

8.230.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.230.500.6 NMAC - Rp, 8.230.500.6 NMAC, 1-1-14]

8.230.500.7 DEFINITIONS: [RESERVED]

8.230.500.8 MISSION: 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.
[8.230.500.8 NMAC - N, 1-1-14]

8.230.500.9 NEED DETERMINATION:

A. Financial need: An individual's eligibility is based on financial need pursuant to Section 1931 of the Social Security Act, the rules in this chapter and in 8.200.520 NMAC.

B. Financial eligibility: Pursuant to Section 1931 of the Social Security Act, enacted by Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), a new medicaid financial eligibility standard was created.

(1) Income eligibility criteria: The income eligibility criteria are based on New Mexico's aid to families with dependent children (AFDC) program as of July 16, 1996. This is defined as the standard of need (SON) used in AFDC as of July 16, 1996.

(2) Less restrictive income and resource methodology: Pursuant to Section 1931 of the Social Security Act, as a state option, New Mexico may use income and resource eligibility methodologies that are less restrictive than the AFDC methodologies used as of July 16, 1996. This chapter defines less restrictive methodologies used in New Mexico for resources, countable and excluded earned and unearned income, available and unavailable income and income deductions and disregards.

C. Gross and net income tests: Determining financial need is a two-step process. When the countable gross or net income is exactly equal to the income eligibility standards, eligibility does not exist.

(1) Gross income test: the first step is determining the countable gross income of the budget group. Gross income includes all countable income before taking taxes or deductions. Only self employment deductions are allowed in the gross income test. The calculated gross income must be less than 185 percent of the SON. If the budget group's income is more than 185 percent of the SON, the assistance unit is not eligible.

(2) Net income test: the second step is determining the countable net income of the budget group. From the countable gross income in step one, deduct all allowable work related expenses (WRE), unearned income deductions and disregards. The countable net income must be less than the SON appropriate to the budget group size. If the budget group's income is more than the SON, the assistance unit is not eligible.
[8.230.500.9 NMAC - Rp. 8.230.500.9 NMAC, 1-1-14]

8.230.500.10 RESOURCE STANDARDS: The applicant or re-determining recipient's assistance unit must meet the resource standards established for AFDC.
[8.230.500.10 NMAC - Rp, 8.230.500.10 NMAC, 1-1-14]

8.230.500.11 RESOURCE EXCLUSIONS: Refer to Section 13 of this part.
[8.230.500.11 NMAC - Rp, 8.230.500.11 NMAC, 1-1-14]

8.230.500.12 INCOME ELIGIBILITY: Income consists of money received by a person whose income is considered available to the budget group as described in this rule.

A. Income from a 30 calendar day period is used to determine eligibility. The 30 calendar day period may be any consecutive 30 calendar day period that is prior to the date of the application through the date of timely disposition. The applicant and the caseworker must agree on the 30 calendar day period. Income from a terminated source is not counted.

B. Income received less frequently than monthly: If an amount of gross income is received less frequently than monthly, that amount is converted to a monthly amount to determine financial eligibility. The conversion is dividing the total income by the number of months the income is intended to cover. For the purposes of this calculation, a partial month is considered to be one full month. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It includes contract income as well as income for a tenured teacher who may not have a contract.

C. Use of conversion factors: Whenever a full month's income is received on a weekly or biweekly basis, the income is converted to a monthly amount. Income is rounded down to the nearest whole dollar prior to application of the conversion factor. Weekly income is multiplied by four and biweekly income is multiplied by two.
[8.230.500.12 NMAC - Rp, 8.230.500.12 NMAC, 1-1-14]

8.230.500.13 EARNED INCOME:

A. **Income exclusions:** The income of a stepparent of a minor pregnant woman and the income of a sponsor of a pregnant alien are not considered available, unless the following apply:

(1) income is actually available to the pregnant woman; or

(2) pregnant woman is a sponsored alien and the sponsor is her spouse.

B. **Earned income deductions and disregards:** Countable earned income is determined by subtracting all earned income deductions allowable for AFDC, and for which the pregnant woman qualifies, from gross earnings. The following deductions are allowed per wage earner:

(1) deductions for work-related expenses of $90.00; and

(2) earned income disregards (EIDs) of $30 and one third.
[8.230.500.13 NMAC - Rp, 8.230.500.13 NMAC, 1-1-14]

8.230.500.14 DEEMED INCOME: The gross income of the ineligible parent(s) of a minor women who is pregnant is considered available to the minor women if she resides in the parent(s)' household. If the assistance unit to which the minor pregnant woman belongs includes her siblings, the applicable amounts of the ineligible parent's income is deemed to the care of those siblings. Income deemed available to a minor woman is considered available to the assistance unit to which she belongs.
[8.230.500.14 NMAC - Rp, 8.230.500.14 NMAC, 1-1-14]

8.230.500.15 TOTAL COUNTABLE INCOME: The earned income which remains after subtracting all appropriate deductions and exclusions and the gross amount of any unearned income received by the assistance unit, is compared to the appropriate percentage of the federal income poverty guidelines (FPL) to determine eligibility.
[8.230.500.15 NMAC - Rp, 8.230.500.15 NMAC, 1-1-14]

8.230.500.16 LUMP SUM PAYMENTS: Lump sum payments are considered income in the month received, unless specifically excludable under medicaid regulations. Lump sum payments are considered as a resource, if retained, as of the first moment of the first day of the following month.
[8.230.500.16 NMAC - Rp, 8.230.500.16 NMAC, 1-1-14]

8.230.500.17 AVAILABLE INCOME:

A. Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined using allowable income exemptions, deductions and disregards. The income of a budget group member who is not included in the assistance unit is deemed available to the assistance unit.

B. Available income includes:

(1) income received by the budget group;

(2) income received by someone not included in the budget group for someone included in the budget group and which is available to the budget group;

(3) income that is withheld as a result of a garnishment or wage withholding; and

(4) income withheld by a source at the budget group's request.

[8.230.500.17 NMAC - N, 1-1-14]

8.230.500.18 UNAVAILABLE INCOME:

A. Individuals included in the budget group may have a legal right to income but that income is considered unavailable. Income is not counted as available income when:

(1) it is received by someone for the budget group and not made available to the budget group; or

(2) the income that is not listed as available in this rule where the budget group cannot gain access to the income; this includes wages withheld by an employer that refuses to pay.

B. Individuals may receive payment of funds "passed through" the individual for the benefit of someone other than themselves. Such pass through payments are not considered available.

C. A recipient of supplemental security income (SSI) is not part of the budget group. His income is not available to the budget group.

D. Alien sponsor deeming is not applicable pursuant to 8.200.410 NMAC.

[8.230.500.18 NMAC - N, 1-1-14]

8.230.500.19 EARNED INCOME: Earned income includes wages, salaries, tips, other employee pay from employment, and net earnings from self-employment.
[8.230.500.19 NMAC - N, 1-1-14]

8.230.500.20 EARNED INCOME DEDUCTIONS/DISREGARDS:

A. Self employment: Certain self-employment deductions allowed by the federal internal revenue service (IRS) are allowed in the net and gross income test.

(1) Self-employment income will be annualized for income projection purposes. If the IRS Form 1040 has been filed, the previous year's tax return is used to anticipate future income if no significant changes in circumstances have occurred. An alternative method of income anticipation should be used when the amount of self employment income reported on tax returns would no longer be a good indicator of expected income, i.e., loss of cattle or crops due to disease.

(2) If tax returns are used for annualized projected income, self-employment expenses listed on the return are allowable except for:

(a) when mileage allowance is the New Mexico department of finance and administration (DFA) rate as detailed in 2.42.2 NMAC unless proof that the actual expense is greater;

(b) when no deduction is allowed for rent or purchase of the place of business if the individual operates the business out of his or her residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines; and

(c) depreciation, personal business and entertainment expenses, personal transportation to and from work, the purchase of capital equipment; and payments on the principal of loans for capital assets or durable goods.

B. Work related expense deductions of $90 and earned income disregards of $30 and one third of the remaining balance is disregarded from countable earned income for each employed individual during the net income test.

[8.230.500.20 NMAC - N, 1-1-14]

8.230.500.21 UNEARNED INCOME: Unearned income includes benefits, pensions, etc.

A. The following types of unearned income are counted:

(1) old age, survivors, and disability insurance (OASDI);

(2) railroad retirement benefits (RRB);

(3) veterans administration (VA) benefits:

(a) income available to veterans and their dependents from the VA as compensation for service-connected disability;

(b) pension for non-service connected disability;

(c) dependency and indemnity compensation; and

(d) death benefits paid from a government issue (GI) life insurance;

(4) unemployment compensation benefits (UCB);

(5) military allotments;

(6) worker's compensation;

(7) pension, annuity, and retirement benefits;

(8) union benefits;

(9) lodge or fraternal benefits;

(10) real property income that is not earned income;

(11) shared shelter and utility payments, when the budget group shares shelter with others:

(a) payments which exceed the budget group's cost are considered income; and

(b) payments which are less than the budget group's cost are not considered; these are the others' share of the shelter cost and are treated as pass-through payments;

(12) income from the sale of goods or property which are obtained in finished condition;

(13) child support payments received directly by the budget group and retained for its use;

(14) settlement payments which are received from worker's compensation settlements, insurance claims, damage claims, litigation, trust distributions which are made on a recurring basis;

(15) individual Indian monies (IIM) payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual member of a tribe; and

(16) bureau of Indian affairs (BIA) or tribal general assistance (GA) payments.

B. The following types of unearned income are not considered in determining eligibility:

(1) cash assistance from HSD or a tribal entity;

(2) supplemental nutritional assistance program (SNAP);

(3) low income home energy assistance program (LIHEAP);

(4) foster care or adoption subsidy;

(5) supplemental security income (SSI);

(6) Child Nutrition and National School Lunch Act;

(7) nutrition programs for the elderly, including meals on wheels and lunches at senior citizen's centers;

(8) bona fide loans from private individuals and commercial institutions as well as loans for the purpose of educational assistance;

(9) work study funds paid by an educational institution when the purpose is to assist with educational expenses, regardless of the actual use of the funds;

(10) domestic volunteers compensation or any other payments made to or on behalf of volunteers under the Domestic Volunteers Services Act of 1973 including:

(a) volunteers in service to America (VISTA);

(b) university year for action (UYA);

(c) special volunteer programs (SVP);

(d) retired senior volunteer program (RSVP);

(e) foster grandparents program (FGP);

(f) older American community service program (OACSP);

(g) service corps of retired executives (SCORE); and

(h) active corps of executives (ACE);

(11) state and federal income tax returns;

(12) American Indian or Alaskan native payments including:

(a) per capita payments distribution of tribal funds to an American Indian or Alaskan native tribal member by the tribe or by the secretary of the United States (U.S.) department of the interior;

(b) interest derived from retained per capita payments (if kept separately identifiable); and

(c) tribal land claims payments settled by means of case payments;

(13) Job Training Partnership Act of 1982 (JTPA) payments made to dependent children;

(14) Title II Uniform Relocation Assistance and Real Property Acquisition Act of 1970 payments;

(15) supportive service payments made for reimbursement of transportation, child care, or training related expenses under NMW work programs, tribal work programs and other employment assistance programs;

(16) division of vocational rehabilitation (DVR) training payments made by the for training expenses;

(17) gifts, donations or contribution from other agencies which are intended to meet needs not covered as a medicaid benefit; to be exempt, the payment must:

(a) be paid under the auspices of an organization or non-profit entity; and

(b) be for a specific identified purpose, to supplement not duplicate medicaid covered benefits for the intended beneficiary of the donation/contribution;

(18) educational loans and grants intended for educational expenses regardless of actual utilization of the funds;

(19) agent orange settlement fund payments or any fund established pursuant to the agent orange product liability litigation settlement;

(20) radiation exposure compensation settlement fund payments;

(21) Nazi victim payments made to individuals per P.L. 103-286, August 1, 1994; and

(22) vendor payments made on behalf of a budget group member when an individual or organization outside the budget group uses its own funds to make a direct payment to a budget group's service provider.

[8.230.500.21 NMAC - N, 1-1-14]

HISTORY OF 8.230.500 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 290.1000, Medical Assistance for Woman and Children, filed 11-13-84.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.

History of Repealed Material:

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
8.230.500 NMAC, Income and Resource Standards, filed 3-25-10 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 230 MEDICAID ELIGIBILITY - FULL COVERAGE FOR PREGNANT WOMEN
PART 600 BENEFIT DESCRIPTION

8.230.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.230.600.1 NMAC - Rp, 8.230.600.1 NMAC, 1-1-14]

8.230.600.2 SCOPE: The rule applies to the general public.
[8.230.600.2 NMAC - Rp, 8.230.600.2 NMAC, 1-1-14]

8.230.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.230.600.3 NMAC - Rp, 8.230.600.3 NMAC, 1-1-14

8.230.600.4 DURATION: Permanent.
[8.230.600.4 NMAC - Rp, 8.230.600.4 NMAC, 1-1-14]

8.230.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.230.600.5 NMAC - Rp, 8.230.600.5 NMAC, 1-1-14]

8.230.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.230.600.6 NMAC - Rp, 8.230.600.6 NMAC, 1-1-14]

8.230.600.7 DEFINITIONS: [RESERVED]

8.230.600.8 MISSION: 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.
[8.230.600.8 NMAC - N, 1-1-14]

8.230.600.9 BENEFIT DESCRIPTION: A medicaid eligible recipient under this category is eligible to receive the full range of medicaid covered services. Applications received on or after January 1, 2014 will be evaluated for an Affordable Care Act category.
[8.230.600.9 NMAC - Rp, 8.230.600.9 NMAC, 1-1-14]

8.230.600.10 BENEFIT DETERMINATION: ISD determines initial and ongoing eligibility.

A. A pregnant woman may have one presumptive eligibility determination made per pregnancy by an approved provider. Presumptive eligibility determinations made after January 1, 2014, will be evaluated per Affordable Care Act rules.

B. An eligible recipient remains eligible throughout her pregnancy and for two months after the month of delivery or after the month in which the pregnancy terminated.

C. After the two-month postpartum period, medicaid coverage will be converted to Category 035 family planning services for 12 months. Periodic eligibility reviews are not required during this period.
[8.230.600.10 NMAC - Rp, 8.230.600.10 NMAC, 1-1-14]

8.230.600.11 INITIAL BENEFITS:

A. **Move during eligibility determination:** If an applicant moves to another county while the eligibility determination is pending, the county ISD office in which the application was originally registered shall transfer the case to the new responsible ISD office.

B. **Delays in eligibility determination:** If an eligibility determination is not made within the time limit, the applicant is notified in writing of the reason for the delay. This notice also informs the applicant of the right to request an administrative hearing.
[8.230.600.11 NMAC - Rp, 8.230.600.11 NMAC, 1-1-14]

8.230.600.12 [RESERVED]

8.230.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three months of retroactive medicaid coverage can be provided 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 months prior to the month of application [42 CFR Section 435.914].

A. **Application for retroactive benefit coverage:** Applications for retroactive coverage can be submitted even after a pregnancy ends. If the mother was not eligible for and receiving medicaid at the time of delivery or when the pregnancy terminated, retroactive coverage for Category 030 can only be extended through the month the pregnancy ended. Application for retroactive medicaid can be made by indicating the existence of unpaid medical expenses in the three months prior to the month of application on the application form. Applications for retroactive medicaid benefits must be made by 180 days from the date of application for assistance.

B. **Approval requirements:** To establish retroactive eligibility, the caseworker must verify that all conditions of eligibility were met for each of the three retroactive months in which the applicant received medicaid-covered services. Each month must be approved or denied on its own merit. Retroactive eligibility can be approved on either the ISD eligibility system (for categories programmed on that system) or on the retroactive medicaid eligibility authorization MAD 333 form.

C. **Notice:**

(1) **Notice to applicant:** The applicant must be informed of the reason(s) for denial of eligibility for any retroactive months.

(2) **Recipient responsibility to notify provider:** After the retroactive eligibility has been established, the caseworker must notify the recipient that he or she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient fails to inform all providers and furnish verification of eligibility which can be used for billing and the provider consequently does not submit the billing within the timeframes referenced in 8.302.2.11 NMAC the recipient is responsible for payment of the bill.
[8.230.600.13 NMAC - Rp, 8.230.600.13 NMAC, 1-1-14]

8.230.600.14 CHANGES IN ELIGIBILITY: If a pregnant woman who is eligible for medicaid under Category 030 loses eligibility because of a change in family income, she automatically remains eligible for medicaid under Category 035, pregnancy related services or family planning services, without a new application. The pregnancy related services only remain effective for the two months following the month in which the child is born or the pregnancy ends. Coverage is limited to pregnancy related services only. The family planning services for 12 months remain effective subsequent to the two month post-partum period.
[8.230.600.14 NMAC - Rp, 8.230.600.14 NMAC, 1-1-14]

8.230.600.15 PERIODIC REDETERMATIONS OF ELIGIBILITY:

A. A redetermination of eligibility is not required.

B. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change as detailed in 8.200.430 NMAC.
[8.230.600.15 NMAC - N, 1-1-14]

HISTORY OF 8.230.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center.
ISD 290.1000, Medical Assistance for Woman and Children, filed 11-13-84.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
8.230.600 NMAC, Benefit Description, filed 6-13-12 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 231 MEDICAID ELIGIBILITY - INFANTS OF MOTHERS WHO ARE MEDICAID OR MEDICAL ASSISTANCE PROGRAM ELIGIBLE
PART 600 BENEFIT DESCRIPTION

8.231.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.231.600.1 NMAC - Rp, 8.231.600.1 NMAC, 1-1-14]

8.231.600.2 SCOPE: The rule applies to the general public.
[8.231.600.2 NMAC - Rp, 8.231.600.2 NMAC, 1-1-14]

8.231.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.231.600.3 NMAC - Rp, 8.231.600.3 NMAC, 1-1-14]

8.231.600.4 DURATION: Permanent.
[8.231.600.4 NMAC - Rp, 8.231.600.4 NMAC, 1-1-14]

8.231.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.231.600.5 NMAC - Rp, 8.231.600.5 NMAC, 1-1-14]

8.231.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.231.600.6 NMAC - Rp, 8.231.600.6 NMAC, 1-1-14]

8.231.600.7 DEFINITIONS: [RESERVED]

8.231.600.8 MISSION: 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.
[8.231.600.8 NMAC - Rp, 8.231.600.8 NMAC, 1-1-14]

8.231.600.9 BENEFIT DESCRIPTION: An applicant or recipient who is eligible for medicaid under this category is eligible to receive the full range of medicaid services.
[8.231.600.9 NMAC - Rp, 8.231.600.9 NMAC, 1-1-14]

8.231.600.10 BENEFIT DETERMINATION:

A. Medical service providers must give the name and case number of the New Mexico medicaid eligible mother and the name, birth date, sex of the newborn, and the name of the hospital where the birth occurred to local county ISD office. Within three days after receipt of this information, the income support specialist (ISS):

(1) determines if the mother was eligible for New Mexico medicaid at the time of birth or if the birth and delivery was covered by emergency medical services to undocumented aliens (EMSA);

(2) registers the newborn for medicaid on the system; a signed application is not required;

(3) provides eligibility information to the hospital; and

(4) notifies the mother that a signed application is necessary to establish the newborn's eligibility for TANF, if applicable.

B. **Processing time limit:** All applications must be processed within 45 days from the date of application. The time limit begins on the day the signed application is received. Applications must be acted upon and notice of approval, denial or delay sent out within the required time limit. The ISS explains the time limit and that the applicant may request an administrative hearing if the application pends longer than the time limit allows.
[8.231.600.10 NMAC - Rp, 8.231.600.10 NMAC, 1-1-14]

8.231.600.11 INITIAL BENEFITS: Notices of eligibility determinations are automatically generated and mailed to applicants or recipients.

A. **Move during eligibility determination:** If an applicant moves to another county while the eligibility determination is pending, the county ISD office in which the application was originally registered transfers the case to the new responsible office.

B. **Delays in eligibility determination:** If an eligibility determination is not made within the time limit, the applicant is notified in writing of the reason for the delay. This notice also informs the applicant or recipient of the right to request an administrative hearing.

[8.231.600.11 NMAC - Rp, 8.231.600.11 NMAC, 1-1-14]

8.231.600.12 ONGOING BENEFITS: A newborn remains eligible for assistance under Category 031 for up to 12 months, as long as the newborn remains in New Mexico.

[8.231.600.12 NMAC - Rp, 8.231.600.12 NMAC, 1-1-14]

8.231.600.13 RETROACTIVE BENEFIT COVERAGE: A woman who applies for New Mexico medicaid after the birth of her newborn and is determined retroactively eligible for the month of the newborn's birth, or for a prior month within the three month retroactive period, is deemed to have been eligible for and receiving medicaid at the time of the birth. Her newborn qualifies for New Mexico medicaid for 12 months beginning with the month of birth, providing the criteria listed above apply. Up to three 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 months prior to the month of application [42 CFR Section 435.914].

A. **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 medicaid assistance (MAD 381) form or by checking "yes" to the question "does anyone in your household have unpaid medical expenses in the last three months?" on the application for assistance (ISD S) form. Applications for retroactive medicaid benefits must be made no later than 180 days from the date of application for assistance. Medicaid covered services which were furnished more than two years prior to application are not covered.

B. **Approval requirements:** To establish retroactive eligibility, the ISS must verify that all conditions of eligibility were met for each of the three retroactive months and that the applicant received medicaid-covered services. Each month must be approved or denied on its own merits. Retroactive eligibility can be approved on either the eligibility system (for categories programmed on that system) or on the retroactive medicaid eligibility authorization (MAD 333) form.

C. **Notice:**

(1) Notice to applicant: The applicant must be informed if eligibility for any of the retroactive months is denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISD worker must notify the recipient that he is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient fails to 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.

[8.231.600.13 NMAC - Rp, 8.231.600.13 NMAC, 1-1-14]

8.231.600.14 CHANGE IN ELIGIBILITY: If the newborn is placed on MAD Category 400 or 420 and then loses eligibility for either of these categories, the newborn can still be eligible for Category 031 if he meets Category 031 requirements for the remainder of the 12 month period. A new application is not required.

[8.231.600.14 NMAC - Rp, 8.231.600.14 NMAC, 1-1-14]

HISTORY OF 8.231.600 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 290.1000, Medical Assistance for Woman and Children, filed 11-13-84.

ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
8.231.600 NMAC, Benefit Description, filed 12-10-07 - Repealed 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 232 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - CHILDREN UNDER 19 - UP TO 235 PERCENT OR LOWER OF FEDERAL POVERTY GUIDELINES
PART 400 RECIPIENT REQUIREMENTS

8.232.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.232.400.1 NMAC - Rp, 8.232.400.1 NMAC, 1-1-14]

8.232.400.2 SCOPE: The rule applies to the general public.
[8.232.400.2 NMAC - Rp, 8.232.400.2 NMAC, 1-1-14]

8.232.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.232.400.3 NMAC - Rp, 8.232.400.3 NMAC, 1-1-14]

8.232.400.4 DURATION: Permanent.
[8.232.400.4 NMAC - Rp, 8.232.400.4 NMAC, 1-1-14]

8.232.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.232.400.5 NMAC - Rp, 8.232.400.5 NMAC, 1-1-14]

8.232.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions for determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility – General Recipient Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.232.400.6 NMAC - Rp, 8.232.400.6 NMAC, 1-1-14]

8.232.400.7 DEFINITIONS: [RESERVED]

8.232.400.8 MISSION: 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.
[8.232.400.8 NMAC - Rp, 8.232.400.8 NMAC, 1-1-14]

8.232.400.9 MEDICAID COVERAGE FOR CHILDREN - CATEGORY 032:

A. To be eligible, a child must meet the following specific eligibility requirements:

(1) be under 19 years of age;

(2) an individual who meets the following eligibility requirements pursuant to 8.200.410 NMAC and 8.200.420 NMAC citizenship or alien status, enumeration, residence, non-concurrent receipt of assistance, and applications for other benefits;

(3) an applicant/recipient must assign medical support rights to HSD and agree to cooperate with third party liability responsibilities pursuant to 8.200.430 NMAC;

(4) pursuant to 8.200.520 NMAC and 8.200.500 NMAC and appropriate to the budget group size, income must be:

(a) less than 185 percent of the federal poverty level (FPL) guidelines; no copayments are required at this level; or

(b) between 185-235 percent of the FPL guidelines; copayments are required for this level, referred to as the children's health insurance program (CHIP).

B. Other creditable health insurance coverage:

(1) less than 185 percent FPL, the child may have other creditable health insurance coverage; and

(2) between 185 percent to 235 percent FPL (CHIP), the child is not eligible when he or she has other creditable health insurance.

C. An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.

[8.232.400.9 NMAC - Rp, 8.232.400.9 NMAC, 1-1-14]

8.232.400.10 GENERAL RECIPIENT REQUIREMENTS:

A. **Enumeration:** Refer to 8.200.410.10 NMAC.

B. **Citizenship:** Refer to 8.200.410.11 NMAC.

C. **Residence:** Refer to 8.200.410.12 NMAC.

[8.232.400.10 NMAC - Rp, 8.232.400.10 NMAC, 1-1-14]

8.232.400.11 SPECIAL RECIPIENT REQUIREMENTS: Presumptive eligibility for children: Refer to 8.200.400.12 NMAC.

[8.232.400.11 NMAC - Rp, 8.232.400.11 NMAC, 1-1-14]

8.232.400.12 RECIPIENT RIGHTS AND RESPONSIBILITIES:

A. Refer to 8.200.430 NMAC.

B. **Assignments of medical support:** Refer to 8.200.420.12 NMAC.

[8.232.400.12 NMAC - Rp, 8.232.400.12 NMAC, 1-1-14]

8.232.400.13 REPORTING REQUIREMENTS: Refer to 8.200.430.19 NMAC.

[8.232.400.13 NMAC - Rp, 8.232.400.13 NMAC, 1-1-14]

8.232.400.14 BASIS FOR DEFINING THE ASSISTANCE UNITS AND BUDGET GROUP: At the time of application, HSD shall identify everyone who is to be considered for inclusion. The applicant or the eligible recipient may choose to include or to exclude a child in the assistance unit. Each member of the assistance unit and budget group, including each unborn child, is counted as one in the household size.

[8.232.400.14 NMAC - N, 1-1-14]

8.232.400.15 ELIGIBLE ASSISTANCE UNITS: An assistance unit includes the dependent child for whom medicaid eligibility is being requested and may include other children living in the same home.

A. Depending on the age of the child and the related earned income disregards and child care deductions, the child may be eligible pursuant to 8.200.510 NMAC and 8.232.500 NMAC when the assistance unit's income is less than 185 percent FPL; or the income is between 185 percent to 235 percent FPL for CHIP.

B. A child receiving supplemental security income (SSI), foster care or adoption subsidy payments is excluded from the assistance unit.

[8.232.400.15 NMAC - N, 1-1-14]

8.232.400.16 BUDGET GROUP: The budget group includes all members of the assistance unit. Additional budget group members include individuals who live in the household with the assistance unit and have a financial obligation of support.

A. Except for an SSI recipient, the following individuals have a financial obligation of support for medicaid eligibility:

(1) spouses: married individuals as defined under applicable New Mexico state law (New Mexico recognizes common law and same sex marriages established in other states); and

(2) parents for children: there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process.

B. The following individuals do not have a financial obligation of support for medicaid eligibility:

(1) a SSI recipient to the assistance unit;

(2) a father of the unborn child who is not married to the pregnant woman;

(3) a stepparent to a stepchild;

(4) a grandparent to a grandchild;

(5) a legal guardian or conservator of a child;

(6) an alien sponsor to the assistance unit; and

(7) a sibling to a sibling.

C. Budget group earned income disregards and child care deductions vary based on the age group of the child. Refer to 8.232.500 NMAC.

[8.232.400.16 NMAC - N, 1-1-14]

8.232.400.17 LIVING IN THE HOME:

A. **Living in the home with a relative:** To be included in the assistance unit, a child must be living, or considered to be living, in the home of:

(1) a natural or an adoptive parent; there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process; or

(2) a specified relative who is related within the fifth degree of relationship by blood, marriage or adoption and assumes responsibility for the day-to-day care and control of the child; the determination of whether an individual functions as the specified relative shall be made by the specified relative unless other information known to HSD clearly indicates otherwise.

B. **A child considered to be living in the home:** A child is considered to be part of the assistance unit as evidenced by the child's customary physical presence in the home. If a child is living with more than one household, the following applies:

(1) when the child is actually spending more time with one household than the other, the child would be determined to be living with the household with whom the child spends the most time; and

(2) when the child is actually spending equal amounts of time with each household, the child shall be considered to be living with the household which first applies for medicaid enrollment.

C. **Extended living in the home:** An individual may be physically absent from the home for longer or shorter periods of time and be a member of the assistance unit and budget group.

(1) Extended living in the home includes:

(a) an individual attending college or a boarding school; or

(b) an individual receiving treatment in a Title XIX medicaid facility (including institutionalized when meeting a nursing facility (NF) level of care (LOC) and intermediate care facilities for individuals with an intellectual disability (ICF-IID) LOC.

(2) When an individual has been a member of the assistance unit, eligibility for another medicaid eligibility category, such as long term care medicaid, should be evaluated. Until a determination of eligibility for another category can be made, the individual is considered to be living with the budget group.

D. **Temporary absence - extended living in the home:** An individual may be physically absent from the home and be a member of the assistance unit and budget group. These other temporary absences include:

(1) an individual not living in the home due to an emergency who is expected to return to the household within 60 calendar days;

(2) a child removed from the home of a parent or a specified relative by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and families department), until an adjudicatory custody hearing takes place; if the adjudicatory hearing results in custody being granted to some other person or entity, the child will be removed from the assistance unit; or

(3) a child residing in a detention center:

(a) continues to be a member of the household if he or she resides fewer than 60 consecutive calendar days, regardless of adjudication as an inmate of a public institution; or

(b) the individual is not eligible for medicaid enrollment if he or she resides 60 consecutive calendar days or more as an adjudicated inmate of a public institution pursuant to 8.200.410 NMAC.

[8.232.400.17 NMAC - N, 1-1-14]

HISTORY OF 8.232.400 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, 6-5-92.

History of Repealed Material:
MAD Rule 830 Medical Assistance for Women and Children and AFDC - Related Groups, filed 6-5-92 - Repealed effective 12-30-94.
8.232.400 NMAC, Recipient Policies, filed 6-15-01 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 232 MEDICAID ELIGIBILITY - CHILDREN UNDER 19 - 235 PERCENT OR LOWER OF FEDERAL POVERTY GUIDELINES
PART 500 INCOME AND RESOURCE STANDARDS

8.232.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.232.500.1 NMAC - Rp, 8.232.500.1 NMAC, 1-1-14]

8.232.500.2 SCOPE: The rule applies to the general public
[8.232.500.2 NMAC - Rp, 8.232.500.2 NMAC, 1-1-14]

8.232.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.232.500.3 NMAC - Rp, 8.232.500.3 NMAC, 1-1-14]

8.232.500.4 DURATION: Permanent.
[8.232.500.4 NMAC - Rp, 8.232.500.4 NMAC, 1-1-14]

8.232.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.232.500.5 NMAC - Rp, 8.232.500.5 NMAC, 1-1-14]

8.232.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.232.500.6 NMAC - Rp, 8.232.500.6 NMAC, 1-1-14]

8.232.500.7 DEFINITIONS: [RESERVED]

8.232.500.8 MISSION: 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.
[8.232.500.8 NMAC - N, 1-1-14]

8.232.500.9 NEED DETERMINATION: An individual's eligibility is based on financial need. Pursuant to 8.200.520 NMAC and 8.235.500 NMAC and appropriate to the budget group size, countable income must be:

A. when the income is less than 185 percent of the federal poverty limit (FPL), no copayments are required at this level; or

B. when the income is between 185-235 percent of the FPL, copayments are required for this level, referred to as the children's health insurance program (CHIP).

[8.232.500.9 NMAC - Rp, 8.232.500.9 NMAC, 1-1-14]

8.232.500.10 RESOURCE STANDARDS: Resources are not an eligibility factor.
[8.232.500.10 NMAC - Rp, 8.232.500.10 NMAC, 1-1-14]

8.232.500.11 INCOME STANDARDS: An individual's eligibility is based on financial need. Pursuant to 8.200.520 NMAC, 8.235.500 NMAC and appropriate to the budget group size, countable income must be:

A. when the income is less than 185 percent of FPL, no copayments are required at this level; or

B. when the income is between 185-235 percent of the FPL, copayments are required for this level; referred to as CHIP.

[8.232.500.11 NMAC - Rp, 8.232.500.11 NMAC, 1-1-14]

8.232.500.12 EARNED INCOME: Earned income includes wages from employment and profit from self-employment. A dependent child's income is not counted as earned income.

[8.232.500.12 NMAC - Rp, 8.232.500.12 NMAC, 1-1-14]

8.232.500.13 UNAVAILABLE INCOME

A. Individuals included in the budget group may have a legal right to income but not access to it; such income is not counted as available income when:

(1) it is received by someone for the budget group and not made available to the budget group; or

(2) the income is not listed as available in this part where the budget group cannot gain access to the income; this includes wages withheld by an employer that refuses to pay.

B. Individuals may receive payment of funds "passed through" the individual for the benefit of someone other than themselves. Such pass through payments are not considered available.

C. A recipient of supplemental security income (SSI) is not part of the budget group. His or her income is not available to the budget group.

D. Alien sponsor deeming is not applicable pursuant to 8.200.410 NMAC.

[8.232.500.13 NMAC - Rp, 8.232.500.13 NMAC, 1-1-14]

8.232.500.14 LUMP SUM PAYMENTS: Lump sum payments are considered income in the month received, unless specifically excluded under medicaid regulations. Lump sum payments are considered resources, if retained, as of the first of the moment of the first day of the following month. Refer to 8.232.500.10 NMAC.

[8.232.500.14 NMAC - Rp, 8.232.500.14 NMAC, 1-1-14]

8.232.500.15 INCOME ELIGIBILITY: Income consists of money received by a person whose income is considered available to the budget group as described in this part.

A. Income from a 30 calendar day period is used to determine eligibility. The 30 calendar day period may be any consecutive 30 calendar day period that is prior to the date of the application through the date of timely disposition. The applicant or re-certifying eligible recipient and the caseworker must agree on the 30 calendar day period. Income from a terminated source is not counted.

B. Income received less frequently than monthly: If an amount of gross income is received less frequently than monthly, that amount is converted to a monthly amount to determine financial eligibility. The conversion is dividing the total income by the number of months the income is intended to cover. For the purposes of this calculation, a partial month is considered to be one full month. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It includes contract income as well as income for a tenured teacher who may not have a contract.

C. Use of conversion factors: Whenever a full month's income is received on a weekly or biweekly basis, the income is converted to a monthly amount. Income is rounded down to the nearest whole dollar prior to application of the conversion factor. Weekly income is multiplied by four; biweekly income is multiplied by two.

[8.232.500.15 NMAC - N, 1-1-14]

8.232.500.16 [RESERVED]

8.232.500.17 EARNED INCOME DEDUCTIONS:

A. Self employment: Certain self-employment deductions allowed by the federal internal revenue service (IRS) are allowed.

(1) Self-employment income will be annualized for income projection purposes. If the IRS Form 1040 has been filed, the previous year's tax return is used to anticipate future income if no significant changes in circumstances have occurred. An alternative method of income anticipation should be used when the amount of self employment income reported on tax returns would no longer be a good indicator of expected income, i.e., loss of cattle or crops due to disease.

(2) If tax returns are used for annualized projected income, self-employment expenses listed on the return are allowable except for:

(a) mileage allowance is the New Mexico department of finance and administration (DFA) rate as detailed in 2.42.2 NMAC unless proof that the actual expense is greater;

(b) rent or purchase of the place of business if the individual operates the business out of his or her residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines;

(c) depreciation;

(d) personal business and entertainment expenses;

(e) personal transportation to and from work;
(f) purchase of capital equipment; and
(g) payments on the principal of loans for capital assets or durable goods.

B. Work related expense (WRE) income disregards: WRE disregards are allowed based on the age of the child. WRE disregards may not exceed the amount of an individual's gross earned income.

(1) Disregards are $750.00 per month for a child birth through five years of age.

(2) Disregard are $120.00 and 1/3 of the remainder per month per employed parent for a child six through 19 years of age.

C. Child care: To be eligible for a child care deduction, the child receiving the care must be a dependent of the employed person, under the age 13; and is included in the budget group.

D. Child care deduction:

(1) deduct an amount equal to the actual cost of child care per child birth through five years of age, but not less than $375.00 total cost per month; or

(2) deduct the actual amount up to $175.00 per month per child for a wage earner employed full time with a child six through 12 years of age; if the wage earner is employed part time deduct $87.50 per month per child.

E. Third party child care payments: Child care costs paid by third parties directly to the child care provider cannot be used as child care deductions. Such payments are classified as vendor payments and are not counted as income. If such payments do not meet the full cost of child care, the difference between the deduction and the vendor payment is the amount allowed, up to the stated child care deductions in subsection D of this section. If the third party child care payments are made to the budget group, the payments would be treated as pass through payments and not counted.

[8.232.500.17 NMAC - Rp, 8.232.500.12 NMAC, 1-1-14]

8.232.500.18 UNEARNED INCOME:

A. The following types of unearned income are considered in determining eligibility:

(1) old age, survivors, and disability insurance (OASDI);

(2) railroad retirement benefits (RRB);

(3) veterans administration (VA) benefits:

(a) income available to veterans and their dependents from the VA as compensation for service-connected disability;

(b) pension for non-service connected disability;

(c) dependency and indemnity compensation; and

(d) death benefits paid from a government issue (GI) life insurance;

(4) unemployment compensation benefits (UCB);

(5) military allotments;

(6) worker's compensation;

(7) pension, annuity, and retirement benefits;

(8) union benefits;

(9) lodge or fraternal benefits;

(10) real property income that is not earned income;

(11) shared shelter and utility payments that exceed the budget group's cost are considered income, when the budget group shares shelter with others;

(12) income from the sale of goods or property which are obtained in finished condition;

(13) child support payments received directly by the budget group and retained for its use;

(14) settlement payments which are received from worker's compensation settlements, insurance claims, damage claims, litigation, trust distributions which are made on a recurring basis;

(15) American Indian individual Indian monies (IIM) for payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual member of a tribe; and

(16) bureau of Indian affairs (BIA) or tribal general assistance (GA) payments.

B. The following types of unearned income are excluded:

(1) cash assistance from HSD or a tribal entity;

(2) supplemental nutritional assistance program (SNAP);

(3) low income home energy assistance program (LIHEAP);

(4) foster care or adoption subsidy;

(5) SSI;

(6) Child Nutrition and National School Lunch Act;

(7) nutrition programs for the elderly, including meals on wheels and lunches at senior citizen's centers;

(8) bona fide loans from private individuals and commercial institutions as well as loans for the purpose of educational assistance;

(9) work study funds paid by an educational institution, when the purpose is to assist with educational expenses regardless of the actual use of the funds;

(10) domestic volunteers compensation or any other payments made to or on behalf of volunteers under the Domestic Volunteers Services Act of 1973 including:

(a) volunteers in service to America (VISTA);
(b) university year for action (UYA);
(c) special volunteer programs (SVP);
(d) retired senior volunteer program (RSVP);
(e) foster grandparents program (FGP);
(f) older American community service program (OACSP);
(g) service corps of retired executives (SCORE); and
(h) active corps of executives (ACE);

(11) state and federal income tax returns;

(12) American Indian and Alaskan native payments including:

(a) per capita payments distribution of tribal funds to an American Indian or Alaskan native tribal member by the tribe or by the secretary of the United States (U.S.) department of the interior;
(b) interest derived from retained per capita payments (if kept separately identifiable); and
(c) tribal land claims payments settled by means of case payments;

(13) Job Training Partnership Act of 1982 (JTPA) payments made to dependent children;

(14) Title II Uniform Relocation Assistance and Real Property Acquisition Act of 1970 payments;

(15) supportive service payments made for reimbursement of transportation, child care, or training related expenses under the New Mexico work programs (NMW), tribal work programs, and other employment assistance programs;

(16) division of vocational rehabilitation (DVR) training payments made by the for training expenses;

(17) gifts, donations or contributions from other agencies which are intended to meet needs not covered as a medicaid service when the payment is paid under the auspices of an organization or non-profit entity and utilized for a specific identified purpose to supplement not duplicate medicaid covered services that are for the intended beneficiary of the donation or contribution;

(18) educational loans and grants intended for educational expenses regardless of actual utilization of the funds;

(19) agent orange settlement fund payments or any fund established pursuant to the agent orange product liability litigation settlement;

(20) radiation exposure compensation settlement fund payments;

(21) Nazi victim payments made to individuals per Public Law (PL) 103-286, August 1, 1994;

(22) vendor payments made on behalf of a budget group member when an individual or organization outside the budget group uses its own funds to make a direct payment to a budget group's service provider;

(23) shared shelter and utility payments that are less than the budget group's cost when the budget group shares shelter with others; these are the other individual's share of the shelter cost and are treated as pass-through payments; and

(24) other income excluded pursuant to federal law.

[8.232.500.18 NMAC - N, 1-1-14]

8.232.500.19 UNEARNED INCOME DEDUCTIONS/DISREGARDS: For recipients of temporary assistance to needy families (TANF) or New Mexico works' (NMW), the child support enforcement division's (CSED) pass-through payment up to $100 is disregarded for the purposes of determining medicaid eligibility.
[8.232.500.19 NMAC - N, 1-1-14]

HISTORY OF 8.232.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 290.1000, Medical Assistance for Woman and Children, filed 11-13-84.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
8 NMAC 4.KID.500, Income and Resource Standards, filed 7-25-95 - Repealed effective 8-1-06.
8.232.500 NMAC, Income and Recourse Standards, filed 7-18-06 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 232 MEDICAID ELIGIBILITY - CHILDREN UNDER 19 - 235 PERCENT OR LOWER OF FEDERAL POVERTY GUIDELINES
PART 600 BENEFIT DESCRIPTION

8.232.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.232.600.1 NMAC - Rp, 8.232.600.1 NMAC, 1-1-14]

8.232.600.2 SCOPE: The rule applies to the general public
[8.232.600.2 NMAC - Rp, 8.232.600.2 NMAC, 1-1-14]

8.232.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.232.600.3 NMAC - Rp, 8.232.600.3 NMAC, 1-1-14]

8.232.600.4 DURATION: Permanent.
[8.232.600.4 NMAC - Rp, 8.232.600.4 NMAC, 1-1-14]

8.232.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.232.600.5 NMAC - Rp, 8.232.600.5 NMAC, 1-1-14]

8.232.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.232.600.6 NMAC - Rp, 8.232.600.6 NMAC, 1-1-14]

8.232.600.7 DEFINITIONS: [RESERVED]

8.232.600.8 MISSION: 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.
[8.232.600.8 NMAC - Rp, 8.232.600.8 NMAC, 1-1-14]

8.232.600.9 BENEFIT DESCRIPTION:

A. An eligible recipient child of an assistance unit with income less than 185 percent federal poverty level (FPL) guidelines receives the full range of medicaid services. No copayments are required of this eligibility category.

B. An eligible recipient child of an assistance unit with income that is greater than 185 percent and less than 235 percent of the FPL receives the full range of medicaid services. This eligibility category is known as the children's health insurance program (CHIP). Copayments are required for this eligibility category pursuant to 8.200.430 NMAC.

C. Applications received on or after January 1, 2014 for Category 032 will be evaluated for an Affordable Care Act category.
[8.232.600.9 NMAC - Rp, 8.232.600.9 NMAC, 1-1-14]

8.232.600.10 BENEFIT DETERMINATION:

A. A child may have a presumptive eligibility determination made by a MAD approved provider. Refer to 8.200.400.12 NMAC.

B. ISD determines initial and ongoing eligibility.
[8.232.600.10 NMAC - Rp, 8.232.600.10 NMAC, 1-1-14]

8.232.600.11 INITIAL BENEFITS:

A. **Move during eligibility determination:** If an applicant moves to another county while the eligibility determination is pending, the county ISD office in which the application was originally registered shall transfer the case to the new responsible office.

B. **Delays in eligibility determination:** If an eligibility determination is not made within the time limit, the applicant is notified in writing of the reason for the delay. This notice also informs the applicant or re-determining recipient of the right to request an administrative hearing.

[8.232.600.11 NMAC - Rp, 8.232.600.11 NMAC, 1-1-14]

8.232.600.12 ONGOING BENEFITS:

A. A redetermination of eligibility is made every 12 months.

B Continuous eligibility for a child is established at a 12-month period of eligibility for a child under age 19. Changes in family income are disregarded.

C. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change as detailed in 8.200.430 NMAC.

D. Recipients of Category 032 with a re-determination date of March 31, 2014 or prior will be re-determined for this category using existing Category 032 policy. Recipients with a re-determination date of April 1, 2014 or later will be re-determined for an Affordable Care Act category. Category 032 ends March 31, 2015.

[8.232.600.12 NMAC - Rp, 8.232.600.12 NMAC, 1-1-14]

8.232.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three months of retroactive medicaid coverage can be furnished to an applicant or recipient who has received medicaid-covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three months prior to the month of application [42 CFR Section 435.914].

A. **Application for retroactive benefit coverage:** Application for retroactive medicaid can be made by checking "yes" to the question "does anyone in your household have unpaid medical expenses in the last three months?" on the application for assistance (ISD 100 or ISDSP 101) form or by checking "yes" to the question "does anyone have any unpaid medical bills from the past three months?" on the application for medical assistance for children and pregnant women (MAD 023 or MADSP 048) form. Applications for retroactive medicaid benefits must be made no later than 180 days from the date of application for assistance. Medicaid covered services which were furnished more than two years prior to application are not covered.

B. **Approval requirements:** To establish retroactive eligibility, the income support division worker must verify that all conditions of eligibility were met for each of the three retroactive months and that the applicant received medicaid-covered services. Each month must be approved or denied on its own merits. Retroactive eligibility can be approved on either the eligibility system or on the retroactive medicaid eligibility authorization (MAD 333) form.

C. **Notice to applicant:** The income support division worker must inform the applicant if eligibility for any of the retroactive months is denied. Recipient responsibility to notify provider: After the retroactive eligibility has been established, the income support division worker must notify the recipient that he or 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.

[8.232.600.13 NMAC - Rp, 8.232.600.13 NMAC, 1-1-14]

8.232.600.14 CHANGES IN ELIGIBILITY:

A. **Eligibility termination when age limit reached:** If a recipient's eligibility ends because he or she turns 19 years of age and the recipient is receiving inpatient services in an acute care hospital on the date he or she turns 19 years of age, the recipient's eligibility continues until the end of that admission. If the recipient is an inpatient in a free-standing psychiatric facility or other residential facility, the recipient's eligibility continues until the end of the month in which the recipient turns 19 years of age. The ISD worker verifies that the closure is caused by the recipient's turning 19 years of age and terminates medicaid eligibility at the end of the applicable time period.

B. **Ongoing eligibility:** A re-determination of eligibility is made every 12 months. Changes in eligibility status will be effective the first day of the following month.

C. **Continuous eligibility:** Eligibility will continue for the 12-month certification period, regardless of changes in income. This provision applies even if it is reported that the family income exceeds the applicable FPL guidelines. The 12 months of continuous medicaid starts with the month of approval or re-determination and is

separate from any months of presumptive or retroactive eligibility. This provision does not apply when there is a death of a household member, the member or the family moves out of state or the child turns 19 years of age. [8.232.600.14 NMAC - Rp, 8.232.600.14 NMAC, 1-1-14]

HISTORY OF 8.232.600 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

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ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.

History of Repealed Material:

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
8.232.600 NMAC, Benefit Description, filed 6-16-04 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 234 MEDICAID ELIGIBILITY - LOSS OF SSI - INCOME OR RESOURCES AVAILABLE FROM AN ALIEN SPONSOR
PART 400 RECIPIENT REQUIREMENTS

8.234.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.234.400.1 NMAC - Rp, 8.234.400.1 NMAC, 1-1-14]

8.234.400.2 SCOPE: The rule applies to the general public.
[8.234.400.2 NMAC - Rp, 8.234.400.2 NMAC, 1-1-14]

8.234.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.234.400.3 NMAC - Rp, 8.234.400.3 NMAC, 1-1-14]

8.234.400.4 DURATION: Permanent.
[8.234.400.4 NMAC - Rp, 8.234.400.4 NMAC, 1-1-14]

8.234.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.234.400.5 NMAC - Rp, 8.234.400.5 NMAC, 1-1-14]

8.234.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility – General Recipient Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.234.400.6 NMAC - Rp, 8.234.400.6 NMAC, 1-1-14]

8.234.400.7 DEFINITIONS: [RESERVED]

8.234.400.8 MISSION: 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.
[8.200.400.8 NMAC - N, 1-1-14]

8.234.400.9 MEDICAID ELIGIBILITY FOR INDIVIDUALS INELIGIBILE FOR SSI DUE TO DEEMED INCOME OR RESOURCES FROM AN ALIEN SPONSOR - CATEGORY 034:

A. An individual must meet specific eligibility requirements. These include:

(1) an individual meets the social security administration (SSA) definitions of: aged; blind; or disabled and is ineligible for supplemental security income (SSI) solely because of deemed income or resource considered available from an alien sponsor;

(2) an individual who meets the eligibility requirements pursuant to 8.200.410 NMAC and 8.200.420 NMAC for citizenship or alien status, enumeration, residence; non-concurrent receipt of assistance, and applications for other benefits;

(3) an applicant or recipient must assign medical support rights to HSD and agree to cooperate with third party liability responsibilities pursuant to 8.200.430 NMAC; and

(4) appropriate to the budget group size, countable income must be less than the SSI federal benefit rate (FBR) income pursuant to 8.200.520 NMAC, 8.215 NMAC and 8.234.500 NMAC.

B. Individuals may have other creditable health insurance coverage.

C An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.
[8.234.400.9 NMAC - Rp, 8.234.400.9 NMAC, 1-1-14]

8.234.400.10 [RESERVED]

8.234.400.11 ENUMERATION: Refer to 8.200.410.10 NMAC.

[8.234.400.11 NMAC - Rp, 8.234.400.11 NMAC, 1-1-14]

8.234.400.12 CITIZENSHIP: Refer to 8.200.410.11 NMAC.
[8.234.400.12 NMAC - Rp, 8.234.400.12 NMAC, 1-1-14]

8.234.400.13 RESIDENCE: Refer to 8.200.410.12 NMAC.
[8.234.400.13 NMAC - Rp, 8.234.400.13 NMAC, 1-1-14]

8.234.400.14 [RESERVED]

8.234.400.15 SSI STATUS:

A. An applicant or re-determining recipient for Category 034 must meet all other SSI eligibility standards, including:

(1) applicant or re-determining recipient's own income and resources must be below SSI standards;
(2) nonconcurrent receipt of assistance;
(3) residence;
(4) aged, blind, or disabled status; and
(5) citizenship or permanent alien status.

B. See 8.215.500.11 NMAC and 8.215.500.18 NMAC for information on SSI income and resource standards.

[8.234.400.15 NMAC - Rp, 8.234.400.15 NMAC, 1-1-14]

8.234.400.16 RECIPIENT RIGHTS AND RESPONSIBILITIES: Refer to 8.200.430 NMAC.
[8.234.400.16 NMAC - Rp, 8.234.400.16 NMAC, 1-1-14]

8.234.400.17 BASIS FOR DEFINING THE ASSISTANCE UNIT AND BUDGET GROUP: At the time of application, an applicant shall identify everyone who is to be considered for inclusion in the assistance unit and budget group. The composition of the assistance unit and budget group is based on the relationship of the household members. Each member of the assistance unit and budget group, including an unborn child, is counted as one in the household size.
[8.234.400.17 NMAC - N, 1-1-14]

8.234.400.18 ASSISTANCE UNIT: The assistance unit includes the applicant and may include others in the household who are determined eligible.
[8.234.400.18 NMAC - N, 1-1-14]

8.234.400.19 BUDGET GROUP: The budget group includes all members of the assistance unit. Additional budget group members include individuals who live in the household with the assistance unit and have a financial obligation of support.

A. Except for an SSI recipient, the following individuals have a financial obligation of support for medicaid eligibility:

(1) spouses: married individuals as defined under applicable New Mexico state law (New Mexico recognizes common law and same sex marriages established in other states); and
(2) parents for children: there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process.

B. The following individuals do not have a financial obligation of support for medicaid eligibility:

(1) an SSI recipient to the assistance unit;
(2) a father of the unborn child who is not married to the pregnant woman;
(3) a stepparent to a stepchild;
(4) a grandparent to a grandchild;
(5) a legal guardian or conservator of a child;
(6) an alien sponsor to the assistance unit; and
(7) a sibling to a sibling.

[8.234.400.19 NMAC - N, 1-1-14]

8.234.400.20 LIVING IN THE HOME:

A. **Living in the home with a relative:** To be included in the assistance unit, a child must be living, or considered to be living, in the home of:

(1) a natural or an adoptive parent; there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process; or

(2) a specified relative who is related within the fifth degree of relationship by blood, marriage or adoption and assumes responsibility for the day-to-day care and control of the child; the determination of whether an individual functions as the specified relative shall be made by the specified relative unless other information known to the worker clearly indicates otherwise.

B. **A child considered to be living in the home:** A child is considered to be part of the assistance unit as evidenced by the child's customary physical presence in the home. If a child is living with more than one household, the following applies:

(1) when the child is actually spending more time with one household than the other, the child would be determined to be living with the household with whom the child spends the most time; and

(2) when the child is actually spending equal amounts of time with each household, the child shall be considered to be living with the household who first applies for medicaid enrollment.

C. **Extended living in the home:** An individual may be physically absent from the home for longer or shorter periods of time and be a member of the assistance unit and budget group.

(1) Extended living in the home includes:

(a) when an individual is attending college or a boarding school; or

(b) when an individual is receiving treatment in a Title XIX medicaid facility (including institutionalized when meeting a nursing facility (NF) level of care (LOC) and intermediate care facilities for individuals with an intellectual disability (ICF-IID) LOC.

(2) When an individual has been a member of the assistance unit, eligibility for another medicaid eligibility category, such as long term care medicaid, should be evaluated. Until a determination of eligibility for another category can be made, the individual is considered to be living with the budget group.

D. **Temporary absence - extended living in the home:** An individual may be physically absent from the home and be a member of the assistance unit and budget group. These other temporary absences include:

(1) an individual not living in the home due to an emergency who is expected to return to the household within 60 calendar days, continues to be a member of the household;

(2) a child removed from the home of a parent or a specified relative by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and families department), until an adjudicatory custody hearing takes place; if the adjudicatory hearing results in custody being granted to some other entity, the child will be removed from the assistance unit; or

(3) a child residing in a detention center:

(a) continues to be a member of the household if he or she resides fewer than 60 calendar days who is either adjudicated or not adjudicated as an inmate of a public institution; or

(b) the individual is not eligible for medicaid enrollment if he or she resides 60 calendar days or more as an adjudicated inmate of a public institution pursuant to 8.200.410 NMAC.

[8.234.400.20 NMAC - N, 1-1-14]

HISTORY OF 8.234.400 NMAC:

History of Repealed Material:

8.234.400 NMAC, Recipient Policies, filed 9-15-13 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 234 MEDICAID ELIGIBILITY - LOSS OF SSI - INCOME OR RESOURCES AVAILABLE FROM A STEPPARENT
PART 500 INCOME AND RESOURCE STANDARDS

8.234.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.234.500.1 NMAC - Rp, 8.234.500.1 NMAC, 1-1-14]

8.234.500.2 SCOPE: The rule applies to the general public.
[8.234.500.2 NMAC - Rp, 8.234.500.2 NMAC, 1-1-14]

8.234.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.234.500.3 NMAC - Rp, 8.234.500.3 NMAC, 1-1-14]

8.234.500.4 DURATION: Permanent.
[8.234.500.4 NMAC - Rp, 8.234.500.4 NMAC, 1-1-14]

8.234.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.234.500.5 NMAC - Rp, 8.234.500.5 NMAC, 1-1-14]

8.234.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200 400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions policy manual, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.234.500.6 NMAC - Rp, 8.234.500.6 NMAC, 1-1-14]

8.234.500.7 DEFINITIONS: [RESERVED]

8.234.500.8 MISSION: 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.
[8.234.500.8 NMAC - N, 1-1-14]

8.234.500.9 NEED DETERMINATION: An individual's financial need is based on meeting supplemental security income (SSI) federal benefit rate (FBR) income and resource methodology pursuant to 8.215.500 NMAC.
[8.234.500.9 NMAC - Rp, 8.234.500.9 NMAC, 1-1-14]

8.234.500.10 RESOURCE STANDARDS: The resource standards for establishing eligibility are described in 8.215.500 NMAC. The resources of an alien sponsor are not considered when determining eligibility.
[8.234.500.10 NMAC - Rp, 8.234.500.10 NMAC, 1-1-14]

8.234.500.11 INCOME STANDARDS: The income standards for establishing eligibility are described in 8.215.500 NMAC. The income of an alien sponsor is not considered when determining eligibility.
[8.234.500.11 NMAC - Rp, 8.234.500.11 NMAC, 1-1-14]

HISTORY OF 8.234.500 NMAC:

History of Repealed Material:
8.234.500 NMAC, Income and Resource Standards, filed 9-15-13 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 234 MEDICAID ELIGIBILITY - LOSS OF SSI - INCOME OR RESOURCES AVAILABLE FROM A STEPPARENT
PART 600 BENEFIT DESCRIPTION

8.234.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.234.600.1 NMAC - Rp, 8.234.600.1 NMAC, 1-1-14]

8.234.600.2 SCOPE: The rule applies to the general public.
[8.234.600.2 NMAC - Rp, 8.234.600.2 NMAC, 1-1-14]

8.234.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.234.600.3 NMAC - Rp, 8.234.600.3 NMAC, 1-1-14]

8.234.600.4 DURATION: Permanent.
[8.234.600.4 NMAC - Rp, 8.234.600.4 NMAC, 1-1-14]

8.234.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.234.600.5 NMAC - Rp, 8.234.600.5 NMAC, 1-1-14]

8.234.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions Chapter 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.234.600.6 NMAC - Rp, 8.234.600.6 NMAC, 1-1-14]

8.234.600.7 DEFINITIONS: [RESERVED]

8.234.600.8 MISSION: 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.
[8.234.600.8 NMAC - N, 1-1-14]

8.234.600.9 BENEFIT DESCRIPTION: Under the eligibility Category 034, an eligible recipient receives the full range of medicaid covered services.
[8.234.600.9 NMAC - Rp, 8.234.600.9 NMAC, 1-1-14]

8.234.600.10 BENEFIT DETERMINATION:

A. ISD determines initial and ongoing eligibility.

B. Up to three months of retroactive medicaid coverage is provided to an applicant who has received a medicaid covered service during the retroactive period and who would have met applicable eligibility criteria had they applied earlier. Eligibility for each retroactive month is determined separately. An application for retroactive medicaid enrollment must be made within 180 calendar days from the date of the medicaid application.
[8.234.600.10 NMAC - Rp, 8.234.600.10 NMAC, 1-1-14]

8.234.600.11 INITIAL BENEFITS:

A. **Move during eligibility determination:** If an applicant moves to another county while the eligibility determination is pending, the county ISD office in which the application was originally registered shall transfer the case to the new responsible office.

B. **Delays in eligibility determination:** If an eligibility determination is not made within the time limit, the applicant is notified in writing of the reason for the delay. This notice also informs the applicant or re-determining recipient of the right to request an administrative hearing.
[8.234.600.11 NMAC - Rp, 8.234.600.11 NMAC, 1-1-14]

8.234.600.12 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A re-determination of eligibility is made every 12 months.

B. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change as detailed in 8.200.430 NMAC.

[8.234.600.12 NMAC - Rp, 8.234.600.12 NMAC, 1-1-14]

8.234.600.13 SSI RETROACTIVE BENEFIT COVERAGE: Up to three 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 months prior to the month of application [42 CFR 435.914].

A. **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 or re-determination 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 months?" on the application for assistance (ISD 100 S) form. Applications for retroactive supplemental security income (SSI) medicaid benefits for recipients of SSI must be made by 180 days from the date of approval for SSI. Medicaid covered services which were furnished more than two years prior to approval are not covered.

B. **Approval requirements:** To establish retroactive eligibility, the income support specialist (ISS) must verify that all conditions of eligibility were met for each of the three retroactive months and that the applicant received medicaid covered services. Eligibility for each month is approved or denied on its own merits.

(1) 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 8.200.520.10 NMAC. 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 months in the retroactive period.

(2) Disability determination required: If a determination is needed of the date of onset of blindness or disability, the ISS must send a referral to disability determination services (ISD 305) to the disability determination unit.

C. **Notice:**

(1) Notice to applicant: The applicant must be informed if any of the retroactive months are denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISS must notify the recipient that he or 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.

[8.234.600.13 NMAC - Rp, 8.234.600.13 NMAC, 1-1-14]

HISTORY OF 8.234.600 NMAC:

History of Repealed Material:

8.234.600 NMAC, Benefit Description, filed 9-15-13 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 235 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - PREGNANCY OR FAMILY PLANNING SERVICES
PART 400 RECIPIENT REQUIREMENTS

8.235.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.235.400.1 NMAC - Rp, 8.235.400.1 NMAC, 1-1-14]

8.235.400.2 SCOPE: The rule applies to the general public.
[8.235.400.2 NMAC - Rp, 8.235.400.2 NMAC, 1-1-14]

8.235.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.235.400.3 NMAC - Rp, 8.235.400.3 NMAC, 1-1-14]

8.235.400.4 DURATION: Permanent.
[8.235.400.4 NMAC - Rp, 8.235.400.4 NMAC, 1-1-14]

8.235.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.235.400.5 NMAC - Rp, 8.235.400.5 NMAC, 1-1-14]

8.235.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility – General Recipient Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.235.400.6 NMAC - Rp, 8.235.400.6 NMAC, 1-1-14]

8.235.400.7 DEFINITIONS: [RESERVED]

8.235.400.8 MISSION: 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.
[8.235.400.8 NMAC - N, 1-1-14]

8.235.400.9 WHO IS AN ELIGIBLE RECIPIENT:

A. To be eligible, an individual must meet specific eligibility requirements:

(1) for pregnancy or family planning medicaid services requirements pursuant to 8.200.410 NMAC and 8.200.420 NMAC for citizenship or alien status, enumeration, residence, non-concurrent receipt of assistance, and applications for other benefits;

(2) an individual must assign medical support rights to HSD and agrees to cooperate with third party liability responsibilities pursuant to 8.200.430 NMAC; and

(3) appropriate to the size of the budget group countable gross income must be less than 185 percent of the federal poverty limit pursuant to 8.200.520 NMAC and 8.235.500 NMAC.

B. Individuals may have other creditable health insurance coverage.

C. An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.
[8.235.400.9 NMAC - Rp, 8.235.400.9 NMAC, 1-1-14]

8.235.400.10 BASIS FOR DEFINING THE GROUP: At the time of application, an applicant or a re-determining eligible recipient and ISD shall identify everyone who is to be considered for inclusion in the assistance unit and budget group. The composition of the assistance unit and budget group is based on the relationship of the household members to the dependent child for whom the application is being made. Each member of the assistance unit and budget group, including an unborn child, is counted as one in the household size.
[8.235.400.10 NMAC - Rp, 8.235.400.10 NMAC, 1-1-14]

8.235.400.11 [RESERVED]

8.235.400.12 ENUMERATION: Refer to 8.200.410.10 NMAC.
[8.235.400.12 NMAC - Rp, 8.235.400.12 NMAC, 1-1-14]

8.235.400.13 CITIZENSHIP: Refer to 8.200.410.11 NMAC.
[8.235.400.13 NMAC - Rp, 8.235.400.13 NMAC, 1-1-14]

8.235.400.14 RESIDENCE: Refer to 8.200.410.12 NMAC.
[8.235.400.14 NMAC - Rp, 8.235.400.14 NMAC, 1-1-14]

8.235.400.15 EMPLOYMENT, TRAINING AND WORK REGISTRATION: Registration or participation in employment assistance programs are not an eligibility factor.
[8.235.400.15 NMAC - Rp, 8.235.400.15 NMAC, 1-1-14]

8.235.400.16 SPECIAL RECIPIENT REQUIREMENTS: Refer to 8.235.400.9 NMAC.
[8.235.400.16 NMAC - Rp, 8.235.400.16 NMAC, 1-1-14]

8.235.400.17 AGE: To be eligible for pregnancy-related medicaid, specific age requirements are not a factor. For family planning and related services medicaid there is not an age limit for men and women.
[8.235.400.17 NMAC - Rp, 8.235.400.17 NMAC, 1-1-14]

8.235.400.18 PRESUMPTIVE ELIGIBILITY: Refer to 8.200.400.11 NMAC.
[8.235.400.18 NMAC - Rp, 8.235.400.18 NMAC, 1-1-14]

8.235.400.19 RECIPIENT RIGHTS AND RESPONSIBILITIES: Refer to 8.200.430 NMAC.
[8.235.400.19 NMAC - Rp, 8.235.400.19 NMAC, 1-1-14]

8.235.400.20 ASSIGNMENTS OF MEDICAL SUPPORT: Refer to 8.200.420.12 NMAC.
[8.235.400.20 NMAC - Rp, 8.235.400.20 NMAC, 1-1-14]

8.235.400.21 ELIGIBLE ASSISTANCE UNIT:

A. The assistance unit includes an individual who applies and who is determined eligible.

B. Each unborn child is counted as one in the eligibility determination process as if the child was born and living with the mother.

[8.235.400.21 NMAC - N, 1-1-14]

8.235.400.22 BUDGET GROUP: The budget group includes all members of the assistance unit. Additional budget group members include individuals who live in the household with the assistance unit and have a financial obligation of support.

A. Except for an supplemental security income (SSI) recipient, the following individuals have a financial obligation of support for medicaid eligibility:

(1) spouses: married individuals as defined under applicable New Mexico state law (New Mexico recognizes common law and same sex marriages established in other states); and

(2) parents for children: there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process.

B. The following individuals do not have a financial obligation of support for medicaid eligibility:

(1) an SSI recipient to the assistance unit;

(2) a father of the unborn child who is not married to the pregnant woman;

(3) a stepparent to a stepchild;

(4) a grandparent to a grandchild;

(5) a legal guardian or conservator of a child;

(6) an alien sponsor to the assistance unit; and

(7) a sibling to a sibling.

[8.235.400.22 NMAC - N, 1-1-14]

8.235.400.23 LIVING IN THE HOME:

A. **Living in the home with a relative:** To be included in the assistance unit, a child must be living, or considered to be living, in the home of:

(1) a natural or an adoptive parent; there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process; or

(2) a specified relative who is related within the fifth degree of relationship by blood, marriage or adoption and assumes responsibility for the day-to-day care and control of the child; the determination of whether an individual functions as the specified relative shall be made by the specified relative unless other information known to the worker clearly indicates otherwise.

B. **A child considered to be living in the home:** A child is considered to be part of the assistance unit as evidenced by the child's customary physical presence in the home. If a child is living with more than one household, the following applies:

(1) when the child is actually spending more time with one household than the other, the child would be determined to be living with the household with whom the child spends the most time; and

(2) when the child is actually spending equal amounts of time with each household, the child shall be considered to be living with the household who first applies for medicaid enrollment.

C. **Extended living in the home:** An individual may be physically absent from the home for longer or shorter periods of time and be a member of the assistance unit and budget group.

(1) Extended living in the home includes:

(a) an individual attending college or a boarding school; or

(b) an individual receiving treatment in a Title XIX medicaid facility (including institutionalized when meeting a nursing facility (NF) level of care (LOC) and intermediate care facilities for individuals with an intellectual disability (ICF-IID) LOC.

(2) When an individual has been a member of the assistance unit, eligibility for another medicaid eligibility category, such as long term care medicaid, should be evaluated; until a determination of eligibility for another category can be made, the individual is considered to be living with the budget group.

D. **Temporary absence - extended living in the home:** An individual may be physically absent from the home and be a member of the assistance unit and budget group. These other temporary absences include:

(1) an individual not living in the home due to an emergency who is expected to return to the household within 60 calendar days, continues to be a member of the household;

(2) a child removed from the home of a parent or a specified relative by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and families department), until an adjudicatory custody hearing takes place; if the adjudicatory hearing results in custody being granted to some other entity, the child will be removed from the assistance unit; or

(3) a child residing in a detention center:

(a) continues to be a member of the household if he or she resides fewer than 60 calendar days, regardless of adjudication as an inmate of a public institution; or

(b) the individual is not eligible for medicaid enrollment if he or she resides 60 calendar days or more as an adjudicated inmate of a public institution pursuant to 8.200.410 NMAC.

[8.235.400.23 NMAC - N, 1-1-14]

HISTORY OF 8.235.400 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 290.1000, Medical Assistance for Woman and Children, filed 11-13-84.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
8.235.400 NMAC, Recipient Policies, filed 6-13-03 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 235 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - PREGNANCY OR FAMILY PLANNING SERVICES
PART 500 INCOME AND RESOURCE STANDARDS

8.235.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.235.500.1 NMAC - Rp, 8.235.500.1 NMAC, 1-1-14]

8.235.500.2 SCOPE: The rule applies to the general public.
[8.235.500.2 NMAC - Rp, 8.235.500.2 NMAC, 1-1-14

8.235.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.235.500.3 NMAC - Rp, 8.235.500.3 NMAC, 1-1-14]

8.235.500.4 DURATION: Permanent.
[8.235.500.4 NMAC - Rp, 8.235.500.4 NMAC, 1-1-14]

8.235.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.235.500.5 NMAC - Rp, 8.235.500.5 NMAC, 1-1-14]

8.235.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200 400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.235.500.6 NMAC - Rp, 8.235.500.6 NMAC, 1-1-14]

8.235.500.7 DEFINITIONS: [RESERVED]

8.235.500.8 MISSION: 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.
[8.235.500.8 NMAC - N, 1-1-14]

8.235.500.9 NEED DETERMINATION: An individual's eligibility is based on financial need. Pursuant to 8.200.520 NMAC, and appropriate to the budget group size, countable income must be less than:

A. 185 percent of the federal poverty limit (FPL); or

B. the difference between 185 percent FPL and 235 percent FPL may be disregarded from earned income.

[8.235.500.9 NMAC - Rp, 8.235.500.9 NMAC, 1-1-14]

8.235.500.10 RESOURCE STANDARDS: Resources are not an eligibility factor.
[8.235.500.10 NMAC - Rp, 8.235.500.10 NMAC, 1-1-14]

8.235.500.11 INCOME STANDARDS: Income consists of money received by a person whose income is considered available to the budget group as described in this chapter.

A. Income from a 30 calendar day period is used to determine eligibility. The 30 calendar day period may be any consecutive 30 calendar day period that is prior to the date of the application through the date of timely disposition. The applicant and the caseworker must agree on the 30 calendar day period. Income from a terminated source is not counted.

B. Income received less frequently than monthly: If an amount of gross income is received less frequently than monthly, that amount is converted to a monthly amount to determine financial eligibility. The conversion is dividing the total income by the number of months the income is intended to cover. For the purposes of this calculation, a partial month is considered to be one full month. This includes, but is not limited to, income

from sharecropping, farming, and self-employment. It includes contract income as well as income for a tenured teacher who may not have a contract.

C. Use of conversion factors: Whenever a full month's income is received on a weekly or biweekly basis, the income is converted to a monthly amount. Income is rounded down to the nearest whole dollar prior to application of the conversion factor. Weekly income is multiplied by four and biweekly income is multiplied by two.

[8.235.500.11 NMAC - Rp, 8.235.500.11 NMAC, 1-1-14]

8.235.500.12 AVAILABLE INCOME:

A. Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined using allowable income exemptions, deductions and disregards. The income of a budget group member who is not included in the assistance unit is deemed available to the assistance unit.

B. Available income includes:

(1) income received by the budget group;

(2) income received by someone not included in the budget group for someone included in the budget group and which is available to the budget group;

(3) income that is withheld as a result of a garnishment or wage withholding; and

(4) income withheld by a source at the budget group's request

[8.235.500.12 NMAC - Rp, 8.235.500.12, 1-1-14]

8.235.500.13 TOTAL COUNTABLE INCOME: Earned income remaining after the applicable deductions and disregards are taken, together with the gross amount of any unearned income received by the assistance unit, is compared to 185 percent of the federal poverty level to determine eligibility.

[8.235.500.13 NMAC - Rp, 8.235.500.13 NMAC, 1-1-14]

8.235.500.14 LUMP SUM PAYMENTS: Lump sum payments are considered income in the month received, unless specifically excluded under medicaid regulations. Lump sum payments are considered a resource, if retained, as of the first moment of the first day of the following month.

[8.235.500.14 NMAC - Rp, 8.235.500.14 NMAC, 1-1-14]

8.235.500.15 UNAVAILABLE INCOME:

A. Individuals included in the budget group may have a legal right to income but not access to it; such income is not counted as available income when:

(1) received by someone for the budget group and not made available to the budget group; or

(2) the income not listed as available in this chapter where the budget group cannot gain access to the income; this includes wages withheld by an employer that refuses to pay.

B. Individuals may receive payment of funds "passed through" the individual for the benefit of someone other than themselves. Such pass through payments are not considered available.

C. A recipient of supplemental security income (SSI) is not part of the budget group. His or her income is not available to the budget group.

D. Alien sponsor deeming is not applicable pursuant to 8.200.410 NMAC.

[8.235.500.15 NMAC - N, 1-1-14]

8.235.500.16 EARNED INCOME: Earned income includes wages from employment, profit from self-employment. A dependent child's income is not counted as earned income.

[8.235.500.16 NMAC - N, 1-1-14]

8.235.500.17 EARNED INCOME DEDUCTIONS/DISREGARDS:

A. Self employment: Certain self-employment deductions allowed by the federal internal revenue service (IRS) are allowed.

(1) Self-employment income will be annualized for income projection purposes. If the IRS Form 1040 has been filed, the previous year's tax return is used to anticipate future income, if no significant changes in circumstances have occurred. An alternative method of income anticipation should be used when the amount of self employment income reported on tax returns would no longer be a good indicator of expected income, i.e., loss of cattle or crops due to disease.

(2) If tax returns are used for annualized projected income, self-employment expenses listed on the return are allowable except for:

(a) mileage allowance is the New Mexico department of finance and administration (DFA) rate as detailed in 2.42.2 NMAC unless proof that the actual expense is greater;

(b) rent or purchase of the place of business if the individual operates the business out of his or her residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines;

(c) depreciation;

(d) personal business and entertainment expenses;

(e) personal transportation to and from work;

(f) purchase of capital equipment; and

(g) payments on the principal of loans for capital assets or durable goods.

B. Work related expense (WRE) income disregards: The WRE disregard of $120 and one third of the remaining balance is disregarded from countable earned income for each employed individual during the net income test.

C. Child care expenses:

(1) To be eligible for a child care deduction, the child receiving the care must be: a child of the employed person; under age 13; and included in the budget group.

(2) Standards: The amount deducted depends upon whether the person is employed full or part-time and the age of the child. Full-time employment is considered to be 30 hours or more of employment per week. Part time employment is less than 30 hours per week. The actual costs of child care are not to exceed the applicable limits set forth are deducted from earnings as:

(a) up to $200 per month per child if the person is employed full-time and the child is under two years of age;

(b) up to $100 per month per child if the person is employed part-time and the child is under two years of age;

(c) up to $175 per month per child if the person is employed full-time and the child is two through12 years of age;

(d) up to $87.50 per month per child if the person is employed part-time and the child is two through 12 years of age.

(3) Third party child care payments: Child care costs paid by third parties directly to the child care provider cannot be used as child care deductions. Such payments are classified as vendor payments and are not counted as income. If such payments do not meet the full cost of child care, the difference between the deduction and the vendor payment is the amount allowed, up to the stated child care deductions in Paragraph (2) of this subsection. If the third party child care payments are made to the budget group, the payments would be treated as pass through payments and not counted.

[8.235.500.17 NMAC - N, 1-1-14]

8.235.500.18 UNEARNED INCOME: Unearned income includes benefits, pensions, etc.

A. The following types of unearned income are considered in determining eligibility:

(1) old age, survivors, and disability insurance (OASDI);

(2) railroad retirement benefits (RRB);

(3) veterans administration (VA) benefits:

(a) income available to veterans and their dependents from the VA as compensation for service-connected disability;

(b) pension for non-service connected disability;

(c) dependency and indemnity compensation; and

(d) death benefits paid from a government issue (GI) life insurance;

(4) unemployment compensation benefits (UCB);

(5) military allotments;

(6) worker's compensation;

(7) pension, annuity, and retirement benefits;

(8) union benefits;

(9) lodge or fraternal benefits;

(10) real property income that is not earned income;

(11) shared shelter and utility payments that exceed the budget group's cost are considered income, when the budget group shares shelter with others;

(12) income from the sale of goods or property which are obtained in finished condition;

(13) child support payments received directly by the budget group and retained for its use;

(14) settlement payments which are received from worker's compensation settlements, insurance claims, damage claims, litigation, trust distributions which are made on a recurring basis;

(15) American Indian individual Indian monies (IIM) for payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual member of a tribe; and

(16) bureau of Indian affairs (BIA) or tribal general assistance (GA) payments.

B. The following types of unearned income are not considered in determining eligibility:

(1) cash assistance from HSD or a tribal entity;

(2) supplemental nutritional assistance program (SNAP);

(3) low income home energy assistance program (LIHEAP);

(4) foster care or adoption subsidy;

(5) supplemental security income (SSI);

(6) Child Nutrition and National School Lunch Act;

(7) nutrition programs for the elderly, including meals on wheels and lunches at senior citizen's centers;

(8) bona fide loans from private individuals and commercial institutions as well as loans for the purpose of educational assistance;

(9) work study funds paid by an educational institution, when the purpose is to assist with educational expenses, regardless of the actual use of the funds;

(10) domestic volunteers compensation or any other payments made to or on behalf of volunteers under the Domestic Volunteers Services Act of 1973 including:

(a) volunteers in service to America (VISTA);

(b) university year for action (UYA);

(c) special volunteer programs (SVP);

(d) retired senior volunteer program (RSVP);

(e) foster grandparents program (FGP);

(f) older American community service program (OACSP);

(g) service corps of retired executives (SCORE); and

(h) active corps of executives (ACE);

(11) state and federal income tax returns;

(12) American Indian payments including:

(a) per capita payments distribution of tribal funds to an Indian tribe member by the tribe or by the secretary of the United States (US) department of the interior;

(b) interest derived from retained per capita payments (if kept separately identifiable); and

(c) tribal land claims payments settled by means of case payments;

(13) Job Training Partnership Act of 1982 (JTPA) payments made to dependent children;

(14) Title II Uniform Relocation Assistance and Real Property Acquisition Act of 1970 payments;

(15) supportive service payments made for reimbursement of transportation, child care, or training related expenses under the New Mexico work programs (NMW), tribal work programs, and other employment assistance programs;

(16) division of vocational rehabilitation (DVR) training payments made by the for training expenses;

(17) gifts, donations or contribution from other agencies which are intended to meet needs not covered as a medicaid benefit; to be exempt, the payment must:

(a) be paid under the auspices of an organization or non-profit entity; and

(b) be for a specific identified purpose, to supplement not duplicate medicaid services for the intended beneficiary of the donation or contribution;

(18) educational loans and grants intended for educational expenses; regardless of actual utilization of the funds;

(19) agent orange settlement fund payments or any fund established pursuant to the agent orange product liability litigation settlement;

(20) radiation exposure compensation settlement fund payments;

(21) Nazi victim payments made to individuals per P.L. 103-286, August 1, 1994; and

(22) vendor payments made on behalf of a budget group member when an individual or organization outside the budget group uses its own funds to make a direct payment to a budget group's service provider.
[8.235.500.18 NMAC - N, 1-1-14]

HISTORY OF 8.235.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 290.1000, Medical Assistance for Woman and Children, filed 11-13-84.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
8.235.500 NMAC, Income and Resource Standards, filed 5-13-04 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 235 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - PREGNANCY OR FAMILY PLANNING SERVICES
PART 600 BENEFIT DESCRIPTION

8.235.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.235.600.1 NMAC - Rp, 8.235.600.1 NMAC, 1-1-14]

8.235.600.2 SCOPE: The rule applies to the general public.
[8.235.600.2 NMAC - Rp, 8.235.600.2 NMAC, 1-1-14]

8.235.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.235.600.3 NMAC - Rp, 8.235.600.3 NMAC, 1-1-14]

8.235.600.4 DURATION: Permanent.
[8.235.600.4 NMAC - Rp, 8.235.600.4 NMAC, 1-1-14]

8.235.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.235.600.5 NMAC - Rp, 8.235.600.5 NMAC, 1-1-14]

8.235.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.235.600.6 NMAC - Rp, 8.235.600.6 NMAC, 1-1-14]

8.235.600.7 DEFINITIONS: [RESERVED]

8.235.600.8 MISSION: 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.
[8.235.600.8 NMAC - N, 1-1-14]

8.235.600.9 GENERAL BENEFIT DESCRIPTION: This category provides pregnancy-related medicaid services for women and family planning and related services for both men and women whose income is below 185 percent of the federal income poverty level (FPL). There is no resource test for this category. Applications received on or after January 1, 2014 are evaluated for an Affordable Care Act category.

A. Pregnancy-related services only: Under medicaid eligibility Category 035, the pregnant eligible recipient only receives services related to her pregnancy and for diagnosis and treatment of conditions which could complicate or adversely impact the woman's pregnancy, the fetus's health, or the child's delivery. Coverage extends throughout the pregnancy and for a two-month post-partum period after the month of delivery or after the month in which the pregnancy terminates.

B. Family planning services: Under medicaid eligibility Category 035, a non-pregnant eligible recipient (including a male) only receives services, consultations, and supplies related to birth control, pregnancy prevention and family planning related services which are prescribed and furnished by physicians, hospitals, clinics, pharmacies, and other medicaid providers.
[8.235.600.9 NMAC - Rp, 8.235.600.9 NMAC, 1-1-14]

8.235.600.10 BENEFIT DETERMINATION: ISD determines initial and ongoing eligibility. Refer to 8.100 NMAC, 8.200 NMAC, 8.235.400 NMAC and 8.235.500 NMAC.

A. A pregnant woman may have one presumptive eligibility determination made by a medicaid approved provider.

B. Up to three months of retroactive medicaid coverage is provided to an applicant who has received medicaid services during the retroactive period and who would have met applicable eligibility criteria had she applied earlier. At the earliest point that retroactive eligibility is determined, eligibility extends throughout the pregnancy and the two-month postpartum period. Application for retroactive medicaid enrollment must be made within 180 calendar days from the date of the medicaid application.

C. An eligible woman recipient remains eligible throughout her pregnancy and for two months after the month of delivery or after the month in which the pregnancy terminates. Changes in household income do not affect her eligibility during this period. After the two-month postpartum period, medicaid pregnancy-related services will be converted to medicaid family planning services. Periodic eligibility reviews are not required during this period.

D. Family planning services continue for 12 months. Changes in household income do not affect eligibility during this period.

[8.235.600.10 NMAC - Rp, 8.235.600.10 NMAC, 1-1-14]

8.235.600.11 INITIAL BENEFITS:

A. **Move during eligibility determination:** If an applicant moves to another county while the eligibility determination is pending, the county ISD office in which the application was originally registered transfers the case to the new responsible office.

B. **Delays in eligibility determination:** If an eligibility determination is not made within the time limit, the applicant is notified in writing of the reason for the delay. This notice also informs the applicant or eligible recipient of the right to request an administrative hearing.

[8.235.600.11 NMAC - Rp, 8.235.600.11 NMAC, 1-1-14]

8.235.600.12 ONGOING BENEFITS:

A. A redetermination of eligibility is not required during a pregnancy, the two-month postpartum period or through the first 12 months of the family planning period. For continued family planning services, a redetermination of eligibility is made every 12 months.

B. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change.

C. The family planning program ends after January 31, 2014.

[8.235.600.12 NMAC - Rp, 8.235.600.12 NMAC, 1-1-14]

8.235.600.13 RETROACTIVE BENEFIT COVERAGE: Refer to 8.235.600.10 NMAC.

[8.235.600.13 NMAC - Rp, 8.235.600.13 NMAC, 1-1-14]

8.235.600.14 REPORTING REQUIREMENTS: Refer to 8.200.430.19 NMAC.

[8.235.600.14 NMAC - Rp, 8.235.600.14 NMAC, 1-1-14]

8.235.600.15 CHANGES IN ELIGIBILITY DUE TO INCOME:

A. **Pregnancy-related services only:** A recipient who is pregnant and who loses eligibility solely because of a change in family income remains eligible under Category 035 throughout the remainder of the pregnancy and the two months following the month the pregnancy ends. This provision applies even if the family income exceeds the federal poverty income guidelines.

B. **Family planning services:** A man or woman who is receiving family planning and related services only under medicaid will not lose eligibility at any time during the 12-month certification period, due to an increase in family income which exceeds the federal poverty income limit.

[8.235.600.15 NMAC - Rp, 8.235.600.15 NMAC, 1-1-14]

HISTORY OF 8.235.600 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 290.1000, Medical Assistance for Woman and Children, filed 11-13-84.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2-10-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8-11-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-8-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9-30-88.

MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-1-88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-31-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-8-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-28-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12-29-89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3-1-91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
8.235.600 NMAC, Benefit Description, filed 5-13-04 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 242 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED DISABLED INDIVIDUALS
PART 400 RECIPIENT REQUIREMENTS

8.242.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.242.400.1 NMAC - Rp, 8.242.400.1 NMAC, 1-1-14]

8.242.400.2 SCOPE: The rule applies to the general public.
[8.242.400.2 NMAC - Rp, 8.242.400.2 NMAC, 1-1-14]

8.242.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.242.400.3 NMAC - Rp, 8.242.400.3 NMAC, 1-1-14]

8.242.400.4 DURATION: Permanent.
[8.242.400.4 NMAC - Rp, 8.242.400.4 NMAC, 1-1-14]

8.242.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.242.400.5 NMAC - Rp, 8.242.400.5 NMAC, 1-1-14]

8.242.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility - General Recipient Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.242.400.6 NMAC - Rp, 8.242.400.6 NMAC, 1-1-14]

8.424.400.7 DEFINITIONS: [RESERVED]

8.242.400.8 MISSION: 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.
[8.242.400.8 NMAC - N, 1-1-14]

8.242.400.9 QUALIFIED DISABLED WORKING INDIVIDUALS (QD) - CATEGORY 050:

A. To qualify as a qualified disabled working individual (QD), an applicant or re-determining recipient must meet the following requirements:

(1) lose entitlement to free medicare Part A due to substantial gainful employment;
(2) continue to meet the social security administration (SSA) disability criteria; and
(3) be enrolled for premium Part A medicare.

B. The date of eligibility is based on the date of application and the date that all eligibility standards, including enrollment for medicare Part A, are met.
[8.242.400.9 NMAC - Rp, 8.242.400.9 NMAC, 1-1-14]

8.242.400.10 [RESERVED]

8.242.400.11 ENUMERATION: An applicant or a re-determining recipient must have a social security account number.
[8.242.400.11 NMAC - Rp, 8.242.400.11 NMAC, 1-1-14]

8.242.400.12 CITIZENSHIP: See 8.200.410 NMAC.
[8.242.400.12 NMAC - Rp, 8.242.400.12 NMAC, 1-1-14]

8.242.400.13 RESIDENCE: An individual must be either be physically present in New Mexico on the date of his or her application or re-determination or on the eligibility determination date and intend to remain in the state. A temporary absence from the state does not preclude eligibility. A temporary absence is considered to exist when the eligible recipient leaves the state for a specific purpose with a time-limited goal, after accomplishment of which the eligible recipient intends to return to New Mexico.
[8.242.400.13 NMAC - Rp, 8.242.400.13 NMAC, 1-1-14]

8.242.400.14 NONCONCURRENT RECEIPT OF ASSISTANCE: An applicant or re-determining recipient is not eligible for category 050 if he or she is eligible under another MAD category of eligibility or if receiving medicaid services from another state.
[8.242.400.14 NMAC - Rp, 8.242.400.14 NMAC, 1-1-14]

8.242.400.15 [RESERVED]

8.242.400.16 AGE: A recipient must be under 65 years of age. When a recipient reaches 65 years of age he or she becomes entitled to free medicare Part A.
[8.242.400.16 NMAC - Rp, 8.242.400.16 NMAC, 1-1-14]

8.242.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: It is the responsibility of the applicant or re-determining recipient to provide the required information, documents or undertake the actions necessary for HSD to establish eligibility. The applicant or re-determining recipient must grant HSD permission to contact other persons, agencies or sources of information which are necessary in the establishment of eligibility. Failure of the applicant or re-determining recipient to provide or take action will result in an HSD action to deny eligibility.
[8.242.400.17 NMAC - Rp, 8.242.400.17 NMAC, 1-1-14]

8.242.400.18 ASSIGNMENT OF SUPPORT: Assignment of medical support rights is not a factor of eligibility for this category, since medicaid coverage is limited to medicare Part A premium.
[8.242.400.18 NMAC - Rp, 8.242.400.18 NMAC, 1-1-14]

8.242.400.19 REPORTING REQUIREMENTS: An applicant, re-determining, or eligible recipient must report any change in his or her circumstances which can affect his or her eligibility within 10 calendar days after the change to his or her local ISD office.
[8.242.400.19 NMAC - Rp, 8.242.400.19 NMAC, 1-1-14]

HISTORY OF 8.242.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 842.00, Qualified Disabled Working Individuals, filed 10-11-90.
MAD Rule 842, Qualified Disabled Working Individuals, filed 6-30-92.
MAD Rule 842, Qualified Disabled Working Individuals, filed 9-26-94.

History of Repealed Material:
MAD Rule 842, Qualified Disabled Working Individuals, filed 9-26-94 - Repealed effective 2-1-95.
8.242.400 NMAC, Recipient Requirements, filed 9-15-13 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 242 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED DISABLED INDIVIDUALS
PART 500 INCOME AND RESOURCE STANDARDS

8.242.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.242.500.1 NMAC - Rp, 8.242.500.1 NMAC, 1-1-14]

8.242.500.2 SCOPE: The rule applies to the general public.
[8.242.500.2 NMAC - Rp, 8.242.500.2 NMAC, 1-1-14]

8.242.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.242.500.3 NMAC - Rp, 8.242.500.3 NMAC, 1-1-14]

8.242.500.4 DURATION: Permanent.
[8.242.500.4 NMAC - Rp, 8.242.500.4 NMAC, 1-1-14]

8.242.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.242.500.5 NMAC - Rp, 8.242.500.5 NMAC, 1-1-14]

8.242.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining medical assistance eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.242.500.6 NMAC - Rp, 8.242.500.6 NMAC, 1-1-14]

8.242.500.7 DEFINITIONS: [RESERVED]

8.242.500.8 MISSION: 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.
[8.242.500.8 NMAC - N, 1-1-14]

8.242.500.9 NEED DETERMINATION: An applicant or a re-determining recipient for MAD eligibility Category 050 qualified disabled individuals (QD) must apply for and take all necessary actions to obtain any resources to which he or she may be entitled. See 8.215.500 NMAC.
[8.242.500.9 NMAC - Rp, 8.242.500.9 NMAC, 1-1-14]

8.242.500.10 RESOURCE STANDARDS: The total value of an applicant or a re-determining recipient's countable resources must not exceed $4,000. The resource limit for an applicant or re-determining recipient couple is $6,000. An applicant or a re-determining recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed $6,000 at the time resources are deemed. The resource determination is always made as of the first moment of the first day of the month. An applicant or a re-determining recipient is ineligible for any month in which countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the value of countable resources during a month do not affect eligibility for that month.
[8.242.500.10 NMAC - Rp, 8.242.500.10 NMAC, 1-1-14]

8.242.500.11 RESOURCE TRANSFERS: The social security administration excluded transfer of resources as a factor of eligibility for a non-institutionalized recipient who receives supplemental security income (SSI) benefits. Transfer of resources is not a factor for consideration in categories that use SSI methodology in the eligibility determination.
[8.242.500.11 NMAC - Rp, 8.242.500.11 NMAC, 1-1-14]

8.242.500.12 INCOME STANDARDS: The income ceiling for QD eligibility is 200 percent of the federal income poverty (FPL) guidelines. These guidelines are updated annually effective April 1. See 8.200.520 NMAC and 8.215.500 NMAC.
[8.242.500.12 NMAC - Rp, 8.242.500.12 NMAC, 1-1-14]

8.242.500.13 UNEARNED INCOME: Unearned income exclusions: All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The income support specialist (ISS) must disregard the COLA from January through March when determining or re-determining QD eligibility. For re-determinations made in January, February and March or new QD applications registered in January, February or March, the ISS uses the December social security and railroad retirement benefit amounts. For QD applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April FPL. This exclusion does not apply to other types of income.
[8.242.500.13 NMAC - Rp, 8.242.500.13 NMAC, 1-1-14]

8.242.500.14 DEEMED INCOME: If an applicant or a re-determining recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500 NMAC.
[8.242.500.14 NMAC - Rp, 8.242.500.14 NMAC, 1-1-14]

HISTORY OF 8.242.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 842.00, Qualified Disabled Working Individuals, filed 10-11-90.
MAD Rule 842, Qualified Disabled Working Individuals, filed 6-30-92.
MAD Rule 842, Qualified Disabled Working Individuals, filed 9-26-94.

History of Repealed Material:
MAD Rule 842, Qualified Disabled Working Individuals, filed 9-26-94 - Repealed effective 2-1-95.
8.242.500 NMAC, Income and Resource Standards, filed 9-1-13 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 242 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED DISABLED INDIVIDUALS WHOSE INCOME EXCEEDS QMB AND SLIMB
PART 600 BENEFIT DESCRIPTION

8.242.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.242.600.1 NMAC - Rp, 8.242.600.1 NMAC, 1-1-14]

8.242.600.2 SCOPE: The rule applies to the general public.
[8.242.600.2 NMAC - Rp, 8.242.600.2 NMAC, 1-1-14]

8.242.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.242.600.3 NMAC - Rp, 8.242.600.3 NMAC, 1-1-14]

8.242.600.4 DURATION: Permanent.
[8.242.600.4 NMAC - Rp, 8.242.600.4 NMAC, 1-1-14]

8.242.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.242.600.5 NMAC - Rp, 8.242.600.5 NMAC, 1-1-14]

8.242.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.242.600.6 NMAC - Rp, 8.242.600.6 NMAC, 1-1-14]

8.242.600.7 DEFINITIONS: [RESERVED]

8.242.600.8 MISSION: 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.
[8.242.600.8 NMAC - N, 1-1-14]

8.242.600.9 BENEFIT DESCRIPTION: For Category 050, medicaid coverage is limited to payment of the medicare Part A premium. No medicaid card is issued.
[8.242.600.9 NMAC - Rp, 8.242.600.9, 1-1-14]

8.242.600.10 BENEFIT DETERMINATION: Application for Category 050 is made on the assistance application form. Applications must be acted on and notice of action taken must be sent to the applicant within 45 days of *receipt of* the application.
[8.242.600.10 NMAC - Rp, 8.242.600.10 NMAC, 1-1-14]

8.242.600.11 INITIAL BENEFITS: The effective date of eligibility for QD is based on the date of application and the date on which all eligibility criteria, including enrollment for medicare Part A, are met. Verification of the effective date of medicare Part A enrollment must be obtained from the social security administration (SSA). When the eligibility determination is made, notice of the approval or denial is sent to the applicant. If denied, this notice includes the reason for the denial and an explanation of rights to a hearing.
[8.242.600.11 NMAC - Rp, 8.242.600.11 NMAC, 1-1-14]

8.242.600.12 ONGOING BENEFITS: A redetermination of eligibility must be made every 12 months.
[8.242.600.12 NMAC - Rp, 8.242.600.12 NMAC, 1-1-14]

8.242.600.13 RETROACTIVE SSI BENEFIT COVERAGE: Up to three months of retroactive medicaid coverage can be furnished to applicants who have received medicaid covered services during the retroactive period and *who* would have met applicable eligibility criteria had they applied during the three months prior to the month of application [42 CFR Section 435.914].

A. **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 or re-determination 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 months?" on the application for assistance (ISD 100 S) form. Applications for retroactive supplemental security income(SSI) medicaid benefits for recipients of SSI must be made by 180 days from the date of approval for SSI. Medicaid covered services which were furnished more than two years prior to approval are not covered.

B. Approval requirements: To establish retroactive eligibility, the income support specialist (ISS) must verify that all conditions of eligibility were met for each of the three retroactive months and that the applicant received medicaid covered services. Eligibility for each month is approved or denied on its own merits.

(1) 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 8.200.520 NMAC. 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 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 months in the retroactive period.

(2) Disability determination required: If a determination is needed of the date of onset of blindness or disability, the ISS must send a referral for disability determination services (ISD 305) to the disability determination unit.

C. **Notice:**

(1) Notice to applicant: The applicant must be informed if eligibility in any of the retroactive months is denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISS must notify the the eligible recipient that he or she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the eligible recipient fails to 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 eligible recipient is responsible for payment of the bill.

[8.242.600.13 NMAC - Rp, 8.242.600.13 NMAC, 1-1-14]

8.242.600.14 CHANGES IN ELIGIBILITY: The case is closed when an eligible recipient becomes ineligible and is notified of the ineligibility in an advance notice. The case is closed in the month following the death of an eligible recipient.

[8.242.600.14 NMAC - Rp, 8.242.600.14 NMAC, 1-1-14]

HISTORY OF 8.242.600 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

MAD Rule 842.00, Qualified Disabled Working Individuals, filed 10-11-90.
MAD Rule 842, Qualified Disabled Working Individuals, filed 6-30-92.
MAD Rule 842, Qualified Disabled Working Individuals, filed 9-26-94.

History of Repealed Material:

MAD Rule 842, Qualified Disabled Working Individuals, filed 9-26-94 - Repealed effective 2-1-95.
8.242.600 NMAC, Benefit Description, filed 9-15-13 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 249 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY – REFUGEE MEDICAL ASSISTANCE (RMA) PROGRAM
PART 400 RECIPIENT REQUIREMENTS

8.249.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.249.400.1 NMAC - Rp, 8.249.400.1 NMAC, 1-1-14]

8.249.400.2 SCOPE: The rule applies to the general public.
[8.249.400.2 NMAC - Rp, 8.249.400.2 NMAC, 1-1-14]

8.249.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.249.400.3 NMAC - Rp, 8.249.400.3 NMAC, 1-1-14]

8.249.400.4 DURATION: Permanent.
[8.249.400.4 NMAC - Rp, 8.249.400.4 NMAC, 1-1-14]

8.249.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.249.400.5 NMAC - Rp, 8.249.400.5 NMAC, 1-1-14]

8.249.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual 8.200 NMAC, *Medicaid Eligibility - General Recipients Policies*. Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions policy manual 8.100 NMAC, *General Provisions for Public Assistance Programs*. Refugee medical assistance (RMA): The RMA offers health coverage for a refugee within the first eight months from his or her date of entry to the United States (U.S.) when he or she does not qualify for other medicaid eligibility categories. An RMA eligible refugee has access to a benefit package that parallels the full medicaid services. This program is not funded by medicaid; funds are provided through a grant under Title IV of the Immigration and Nationality Act (INA). The purpose of this grant is to provide for the effective resettlement of a refugee and to assist him or her to achieve economic self-sufficiency as quickly as possible.
[8.249.400.6 NMAC - Rp, 8.249.400.6 NMAC, 1-1-14]

8.249.400.7 DEFINITIONS: "Refugee" is an immigrant, who because of persecution or fear of persecution on account of race, religion or political opinion, fled from his or her home country and cannot return because of fear of persecution because of race, religion or political opinion.
[8.249.400.7 NMAC - N, 1-1-14]

8.249.400.8 MISSION: 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.
[8.249.400.8 NMAC - N, 1-1-14]

8.249.400.9 REFUGEE MEDICAL ASSISTANCE ONLY - CATEGORY 049 AND 059:

A. A medicaid eligible refugee recipient must meet the following non-financial eligibility requirements:

(1) is ineligible for full medicaid coverage;

(2) is not a full-time student in an institution of higher education, except where enrollment is part of an individual employability plan for a refugee enrolled in the refugee cash assistance program;

(3) is in the U.S. fewer than eight months and meets one of the following statuses:

(a) is admitted as a refugee under Section 207 of the INA;

(b) is paroled into the U.S. as a refugee or asylee under Section 212 (d)(5) of the INA;

(c) is granted asylum under Section 208 of the INA;

(d) is admitted as an Amerasian immigrant from Vietnam through the orderly departure program, under Section 584 of the Foreign Operations Appropriations Act, incorporated in the fiscal year 1988 Continuing Resolution P.L. 100-212;

(e) is a Cuban-Haitian entrant who was admitted as a public interest parolee under Section 212 (d)(5) of the INA;

(f) is certified as a victim of human trafficking by the federal office of refugee resettlement (ORR);

(g) is an eligible family member of a victim of human trafficking certified by ORR who has a T-2, T-3, T-4, or T-5 Visa;

(h) is admitted as a special immigrant from Iraq or Afghanistan under Section 101 (a)(27) of the Immigration and Nationality Act (INA); or

(i) is a lawful permanent resident (LPR) when the individual had previously met a status as listed in Paragraph (3) of Subsection A of 8.249.400.9 NMAC;

(4) an individual who meets the following eligibility requirements pursuant to 8.200.410 NMAC and 8.200.420 NMAC of citizenship or alien status, enumeration, residence, non-concurrent receipt of assistance and applications for other benefits;

(5) appropriate to the size of the budget group (not including the ineligible parent due to citizenship or alien status or enumeration), countable gross income must be less than 185 percent of the standard of need (SON) countable net income must be less than the SON pursuant to 8.200.520 NMAC and 8.202.500 NMAC; and

(6) an applicant or an eligible recipient may have other creditable health insurance coverage.

B. An eligible recipient may have other creditable health insurance coverage. If the eligible recipient has other creditable health insurance coverage, RMA is the second payor.

C. An individual who is an inmate of a public institution is not eligible pursuant to 8.200.410 NMAC.

[8.249.400.9 NMAC - Rp, 8.249.400.9 NMAC, 1-1-14]

8.249.400.10 BASIS FOR DEFINING GROUP: At the time of application, an applicant or an eligible recipient and HSD shall identify everyone who is to be considered for inclusion in the assistance unit and budget group. Each member of the assistance unit and budget group, including each unborn child, is counted as one in the household size.

[8.249.400.10 NMAC - Rp, 8.249.400.10 NMAC, 1-1-14]

8.249.400.11 [RESERVED]

8.249.400.12 ENUMERATION: Refer to 8.200.410.10 NMAC.

[8.249.400.12 NMAC - Rp, 8.249.400.12 NMAC, 1-1-14]

8.249.400.13 CITIZENSHIP: Refer to 8.200.410.11 NMAC.

[8.249.400.13 NMAC - Rp, 8.249.400.13 NMAC, 1-1-14]

8.249.400.14 RESIDENCE: Refer to 8.200.410.12 NMAC.

[8.249.400.14 NMAC - Rp, 8.249.400.14 NMAC, 1-1-14]

8.249.400.15 [RESERVED]

8.249.400.16 [RESERVED]

8.249.400.17 AGE: Age is not an eligibility requirement.

[8.249.400.17 NMAC - Rp, 8.249.400.17 NMAC, 1-1-14]

8.249.400.18 ALIEN SPONSORSHIP: The ISD caseworker must notify the refugee's sponsor or local affiliate which provided for the resettlement of the refugee, when a refugee applies for refugee medical assistance.

[8.249.400.18 NMAC - Rp, 8.249.400.18 NMAC, 1-1-14]

8.249.400.19 RECIPIENT RIGHTS AND RESPONSIBILITIES: Refer to 8.200.430 NMAC.

[8.249.400.19 NMAC - Rp, 8.249.400.19 NMAC, 1-1-14]

8.249.400.20 ASSIGNMENT OF SUPPORT:

A. **Assignment of medical support:** Refer to 8.200.420.12 NMAC.

B. **Assignments of child support:** Assignment of child support is not required for refugee medical assistance.

[8.249.400.20 NMAC - Rp, 8.249.400.20 NMAC, 1-1-14]

8.249.400.21 REPORTING REQUIREMENTS: Refer to 8.200.430.19 NMAC.

[8.249.400.21 NMAC - Rp, 8.249.400.21 NMAC, 1-1-14]

8.249.400.22 ELIGIBLE ASSISTANCE UNIT: The assistance unit includes individuals who apply for RMA and who are determined eligible. Individuals may be ineligible for refugee cash assistance and eligible for RMA. An eligible recipient of refugee cash assistance who is not eligible for full medicaid services is eligible for RMA.

[8.249.400.22 NMAC - N, 1-1-14]

8.249.400.23 BUDGET GROUP: The budget group includes all members of the assistance unit. Additional budget group members include individuals who live in the household with the assistance unit and have a financial obligation of support.

A. Except for an supplemental security income (SSI) recipient, the following individuals have a financial obligation of support for medicaid eligibility:

(1) spouses: married individuals as defined under applicable New Mexico state law (New Mexico recognizes common law and same sex marriages established in other states); and

(2) parents for children: there is a presumption that a child born to a married woman is the child of the spouse, or if the individual established parentage by some other legally recognized process.

B. The following individuals do not have a financial obligation of support for medicaid eligibility:

(1) an SSI recipient to the assistance unit;

(2) a father of the unborn child who is not married to the pregnant woman;

(3) a stepparent to a stepchild;

(4) a grandparent to a grandchild;

(5) a legal guardian or a conservator of a child;

(6) an alien sponsor to the assistance unit; and

(7) a sibling to a sibling.

C. Budget group earned income disregards and child care deductions vary based on the age group of the child. Refer to 8.232.500 NMAC.

[8.249.400.23 NMAC - N, 1-1-14]

8.249.400.24 LIVING IN THE HOME

A. To be included in the assistance unit and budget group, an individual must be living, or considered to be living, in the budget group's home.

B. **A child considered to be living in the home:** A child is considered to be part of the budget group as evidenced by the child's customary physical presence in the home. If a child is living with more than one household, the following applies:

(1) when the child is actually spending more time with one household than the other, the child would be determined to be living with the household with whom the child spends the most time; or

(2) when the child is actually spending equal amounts of time with each household, the child shall be considered to be living with the household who first applies for medicaid enrollment.

C. **Extended living in the home:** An individual may be physically absent from the home for longer or shorter periods of time and be a member of the assistance unit and budget group.

(1) Extended living in the home includes:

(a) when an individual is attending college or boarding school; or

(b) when an individual is receiving treatment in a Title XIX medicaid facility (including institutionalized when meeting a nursing facility (NF) level of care (LOC) and intermediate care facilities for individuals with an intellectual disability (ICF-IID) LOC.

(2) When an individual has been a member of the assistance unit, eligibility for another medicaid eligibility category, such as long term care medicaid, should be evaluated; until a determination of eligibility for another category can be made, the individual is considered to be living with the budget group.

D. **Temporary absence such as extended living in the home:** An individual may be physically absent from the home and be a member of the assistance unit and budget group. These other temporary absences include:

(1) an individual not living in the home due to an emergency, who is expected to return to the household within 60 calendar days, continues to be a member of the household;

(2) a child removed from the home of a parent or a specified relative by a child protective services agency (tribal, bureau of Indian affairs, or children, youth and families department), until an adjudicatory custody hearing takes place; if the adjudicatory hearing results in custody being granted to some other entity, the child will be removed from the assistance unit; or

(3) a child residing in a detention center:

(a) continues to be a member of the household if he or she resides fewer than 60 calendar days, regardless of adjudication as an inmate of a public institution; or

(b) is not eligible for medicaid enrollment if he or she resides 60 calendar days or more as an adjudicated inmate of a public institution pursuant to 8.200.410 NMAC.

[8.249.400.13 NMAC - N, 1-1-14]

HISTORY OF 8.249.400 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

MAD Rule 822, Refugee Medical Assistance, filed 5-22-92.

History of Repealed Material:

MAD Rule 822 Refugee Medical Assistance, filed 5-22-92 - Repealed effective 2-1-95.

8.249.400 NMAC Recipient Policies, filed 9-15-13 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 249 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY – REFUGEE MEDICAL ASSISTANCE (RMA) PROGRAM
PART 500 INCOME AND RESOURCE STANDARDS

8.249.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.249.500.1 NMAC - Rp, 8.249.500.1 NMAC, 1-1-14]

8.249.500.2 SCOPE: The rule applies to the general public.
[8.249.500.2 NMAC - Rp, 8.249.500.2 NMAC, 1-1-14]

8.249.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.249.500.3 NMAC - Rp, 8.249.500.3 NMAC, 1-1-14]

8.249.500.4 DURATION: Permanent.
[8.249.500.4 NMAC - Rp, 8.249.500.4 NMAC, 1-1-14]

8.249.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.249.500.5 NMAC - Rp, 8.249.500.5 NMAC, 8-15-14]

8.249.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.249.500.6 NMAC - Rp, 8.249.500.6 NMAC, 1-1-14]

8.249.500.7 DEFINITIONS: [RESERVED]

8.249.500.8 MISSION: 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.
[8.249.500.8 NMAC - N, 1-1-14]

8.249.500.9 NEED DETERMINATION:

A. Financial need: The budget group's eligibility is based on financial need. See Section 1931 of the Social Security Act, the rules in this chapter and in 8.200.520 NMAC.

B. Financial eligibility: Pursuant to Section 1931 of the Social Security Act, enacted by Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), a new medicaid financial eligibility standard was created. Refugee medical assistance (RMA) uses this same standard.

(1) Income eligibility criteria: The income eligibility criteria for Category 049 are based on New Mexico's aid to families with dependent children (AFDC) program as of July 16, 1996. This is defined as the standard of need (SON) used in AFDC as of July 16, 1996. A refugee can be eligible for Category 059 if income would be below AFDC after deducting medical expenses incurred and paid in that month. Eligibility for Category 059 is determined on a month-to-month basis.

(2) Less restrictive income and resource methodology: Pursuant to Section 1931 of the Social Security Act, as a state option, New Mexico may use income and resource eligibility methodologies that are less restrictive than the AFDC methodologies used as of July 16, 1996. This chapter defines less restrictive methodologies to be used by New Mexico for resources, countable and excluded earned or unearned income, available or unavailable income and income deductions or disregards.

C. Gross and net income tests: Determining financial need is a two-step process. When the countable gross or net income is exactly equal to the income eligibility standards, eligibility does not exist.

(1) Gross income test: The first step is determining the countable gross income of the budget group. Gross income includes all countable income before taking into account taxes or deductions. Only self employment

deductions are allowed in the gross income test. The calculated gross income must be less than 185 percent of the SON. If the budget group's income is more than 185 percent of the SON, the assistance unit is not eligible.

(2) Net income test: The second step is determining the countable net income of the budget group. From the countable gross income in step one, deduct all allowable work related expenses (WRE) and unearned income deductions/disregards. The countable net income must be less than the SON appropriate to the budget group size. If the budget group's income is more than the SON, the assistance unit is not eligible.

[8.249.500.9 NMAC - Rp, 8.249.500.9 NMAC, 1-1-14]

8.249.500.10 RESOURCE STANDARDS: Resources are not an eligibility factor.

[8.249.500.10 NMAC - Rp, 8.249.500.10 NMAC, 1-1-14]

8.249.500.11 INCOME STANDARDS: Refer to 8.249.500.9 NMAC.

[8.249.500.11 NMAC - Rp, 8.249.500.11 NMAC, 1-1-14]

8.249.500.12 INCOME ELIGIBILITY: Income consists of money received by a person whose income is considered available to the budget group as described in this chapter.

A. Income from a 30 day-period is used to determine eligibility. The 30-day period may be any consecutive 30-day period that is prior to the date of the application through the date of timely disposition. The applicant and the caseworker must agree on the 30-day period. Income from a terminated source is not counted.

B. Income received less frequently than monthly: If an amount of gross income is received less frequently than monthly, that amount is converted to a monthly amount to determine financial eligibility. The conversion is obtained by dividing the total income by the number of months the income is intended to cover. For the purposes of this calculation, a partial month is considered to be one full month. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It includes contract income as well as income for a tenured teacher who may not have a contract.

C. Use of conversion factors: Whenever a full month's income is received on a weekly or biweekly basis, the income is converted to a monthly amount. Income is rounded down to the nearest whole dollar prior to application of the conversion factor. Weekly income is multiplied by four and biweekly income is multiplied by two.

[8.249.500.12 NMAC - N, 1-1-14]

8.249.500.13 AVAILABLE INCOME:

A. Determination of eligibility for the assistance unit is made by considering income that is available to the assistance unit and budget group. The amount of countable income is determined using allowable income exemptions, deductions and disregards. The income of a budget group member who is not included in the assistance unit is deemed available to the assistance unit.

B. Available income includes:

(1) income received by the budget group;

(2) income received by someone not included in the budget group for someone included in the budget group and which is available to the budget group;

(3) income that is withheld as a result of a garnishment or wage withholding; and

(4) income withheld by a source at the request of a budget group member.

[8.249.500.13 NMAC - N, 1-1-14]

8.249.500.14 UNAVAILABLE INCOME:

A. Individuals included in the budget group may have a legal right to income but not access to it; such income is not counted as available income:

(1) old age, survivors, and disability insurance (OASDI);

(2) railroad retirement benefits (RRB);

(3) veterans administration (VA) benefits:

(a) income available to veterans and their dependents from the VA as compensation for service-connected disability;

(b) pension for non-service connected disability;

(c) dependency and indemnity compensation; and

(d) death benefits paid from a government issue (GI) life insurance;

(4) unemployment compensation benefits (UCB);

(5) military allotments;
(6) worker's compensation;
(7) pension, annuity, and retirement benefits;
(8) union benefits;
(9) lodge or fraternal benefits;
(10) real property income that is not earned income;
(11) shared shelter and utility payments when the budget group shares shelter with others:
(a) payments which exceed the budget group's cost are considered income;
(b) payments which are less than the budget group's cost are not considered; these are the others' share of the shelter cost and are treated as pass-through payments;
(12) income from the sale of goods or property which are obtained in finished condition;
(13) child support payments received directly by the budget group and retained for its use;
(14) settlement payments which are received from worker's compensation settlements, insurance claims, damage claims, litigation, trust distributions which are made on a recurring basis;
(15) individual Indian monies (IIM) payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual member of a tribe;
(16) bureau of Indian affairs (BIA) or tribal general assistance (GA) payments; and
(17) income that is not listed as available in this chapter where the budget group cannot gain access to the income; this includes wages withheld by an employer that refuses to pay.

B. Individuals may receive payment of funds "passed through" the individual for the benefit of someone other than themselves. Such pass through payments are not considered available.

C. A recipient of supplemental security income (SSI) is not part of the budget group. His other income is not considered available to the budget group.

D. Alien sponsor deeming is not applicable pursuant to 8.200.410 NMAC.

[8.249.500.14 NMAC - N, 1-1-14]

8.249.500.15 EARNED INCOME: includes all wages, salaries, tips, and other employee pay from employment and net earnings from self-employment.

[8.249.500.15 NMAC - N, 1-1-14]

8.249.500.16 EARNED INCOME DEDUCTIONS/DISREGARDS:

A. Self employment: Certain self-employment deductions allowed by the federal internal revenue service (IRS) are allowed in the net and gross income test.

(1) Self-employment income will be annualized for income projection purposes. If the IRS Form 1040 has been filed, the previous year's tax return is used to anticipate future income, if no significant changes in circumstances have occurred. An alternative method of income anticipation should be used when the amount of self employment income reported on tax returns would no longer be a good indicator of expected income, i.e., loss of cattle or crops due to disease.

(2) If tax returns are used for annualized projected income, self-employment expenses listed on the return are allowable except:

(a) the mileage allowance is the New Mexico department of finance and administration (DFA) rate as detailed in 2.42.2 NMAC unless proof that the actual expense is greater; and

(b) no deduction is allowed for rent or purchase of the place of business if the individual operates the business out of his or her residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines.

(3) The following deductions are not allowed:
(a) depreciation;
(b) personal business and entertainment expenses;
(c) personal transportation to and from work;
(d) purchase of capital equipment; and
(e) payments on the principal of loans for capital assets or durable goods.

B. Work related expense (WRE) income disregards: The WRE disregard of $120 and one third of the remaining balance is disregarded from earned income during the net income test.

C. Child care expenses:

(1) To be eligible for a child care deduction, the child receiving the care must be:
(a) a dependent of the employed person;

(b) younger than 13; and
(c) included in the budget group.

(2) Standards: Actual costs of child care, not to exceed the applicable limits set forth below are deducted from earnings. The amount to be deducted depends upon whether the person is employed full or part-time and the age of the child. Full-time employment is considered to be 30 hours or more of employment per week; part time is any employment of less than 30 hours per week.

(a) up to $200 per month per child if the person is employed full-time and the child is under age two;

(b) up to $100 per month per child if the person is employed part-time and the child is under age two;

(c) up to $175 per month per child if the person is employed full-time and the child's age is two through12; and

(d) up to $87.50 per month per child if the person is employed part-time and the child's age is two through 12.

(3) Third party child care payments: Child care costs paid by third parties directly to the child care provider cannot be used as child care deductions. Such payments are classified as vendor payments and are not counted as income. If such payments do not meet the full cost of child care, the difference between the deduction and the vendor payment is the amount allowed, up to the stated child care deductions in Paragraph (2) of this subsection. If the third party child care payments are made to the budget group, the payments would be treated as pass through payments and not counted.

[8.249.500.16 NMAC - N, 1-1-14]

8.249.500.17 UNEARNED INCOME: Unearned income includes benefits, pensions, etc.

A. The following types of unearned income are counted:

(1) old age, survivors, and disability insurance (OASDI);
(2) railroad retirement benefits (RRB);
(3) veterans administration (VA) benefits:
(a) income available to veterans and their dependents from the VA as compensation for service-connected disability;
(b) pension for non-service connected disability;
(c) dependency and indemnity compensation; and
(d) death benefits paid from a government issue (GI) life insurance;
(4) unemployment compensation benefits (UCB);
(5) military allotments;
(6) worker's compensation;
(7) pension, annuity, and retirement benefits;
(8) union benefits;
(9) lodge or fraternal benefits;
(10) real property income that is not earned income;
(11) shared shelter and utility payments when the budget group shares shelter with others:
(a) payments which exceed the budget group's cost are considered income;
(b) payments which are less than the budget group's cost are not considered; these are the others' share of the shelter cost and are treated as pass-through payments;
(12) income from the sale of goods or property which are obtained in finished condition;
(13) child support payments received directly by the budget group and retained for its use;
(14) settlement payments which are received from worker's compensation settlements, insurance claims, damage claims, litigation, trust distributions which are made on a recurring basis;
(15) individual Indian monies (IIM) payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual member of a tribe; and
(16) bureau of Indian affairs (BIA) or tribal general assistance (GA) payments.

B. The following types of unearned income are not considered in determining eligibility:

(1) cash assistance from HSD or a tribal entity;
(2) supplemental nutritional assistance program (SNAP);
(3) low income home energy assistance program (LIHEAP);
(4) foster care or adoption subsidy;
(5) supplemental security income (SSI);

(6) Child Nutrition and National School Lunch Act;

(7) nutrition programs for the elderly, including meals on wheels and lunches at senior citizen's centers;

(8) bona fide loans from private individuals and commercial institutions as well as loans for the purpose of educational assistance;

(9) work study funds paid by an educational institution, when the purpose is to assist with educational expenses, regardless of the actual use of the funds;

(10) domestic volunteers compensation or any other payments made to or on behalf of volunteers under the Domestic Volunteers Services Act of 1973 including:

(a) volunteers in service to America (VISTA);
(b) university year for action (UYA);
(c) special volunteer programs (SVP);
(d) retired senior volunteer program (RSVP);
(e) foster grandparents program (FGP);
(f) older American community service program (OACSP);
(g) service corps of retired executives (SCORE); and
(h) active corps of executives (ACE);

(11) state and federal income tax returns;

(12) American Indian payments including:

(a) per capita payments distribution of tribal funds to an Indian tribe member by the tribe or by the secretary of the United States department of the interior;
(b) interest derived from retained per capita payments (if kept separately identifiable); and
(c) tribal land claims payments settled by means of case payments;

(13) Job Training Partnership Act of 1982 (JTPA) payments made to dependent children;

(14) Title II Uniform Relocation Assistance and Real Property Acquisition Act of 1970 payments;

(15) supportive service payments made for reimbursement of transportation, child care, or training related expenses under NMW work programs, tribal work programs, and other employment assistance programs;

(16) division of vocational rehabilitation (DVR) training payments made by the for training expenses;

(17) gifts, donations or contribution from other agencies which are intended to meet needs not covered as a benefit; to be exempt, the payment must:

(a) be paid under the auspices of an organization or non-profit entity; and
(b) be for a specific identified purpose, to supplement not duplicate covered benefits for the intended beneficiary of the donation/contribution;

(18) educational loans and grants intended for educational expenses; regardless of actual utilization of the funds;

(19) agent orange settlement fund payments or any fund established pursuant to the agent orange product liability litigation settlement;

(20) radiation exposure compensation settlement fund payments;

(21) Nazi victim payments made to individuals per P.L. 103-286, August 1, 1994; and

(22) vendor payments made on behalf of a budget group member when an individual or organization outside the budget group uses its own funds to make a direct payment to a budget group's service provider.

[8.249.500.17 NMAC - N, 1-1-14]

HISTORY OF 8.249.500 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

MAD Rule 822, Refugee Medical Assistance, filed 5-22-92.

History of Repealed Material:

MAD Rule 822 Refugee Medical Assistance, filed 5-22-92 - Repealed effective 2-1-95.

8.249.500 NMAC, Income and Resource Standards, filed 3-25-10 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 249 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEES MEDICAL ASSISTANCE (RMA) PROGRAM
PART 600 BENEFIT DESCRIPTION

8.249.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.249.600.1 NMAC - Rp, 8.249.600.1 NMAC, 1-1-14]

8.249.600.2 SCOPE: The rule applies to the general public.
[8.249.600.2 NMAC - Rp, 8.249.600.2 NMAC, 1-1-14]

8.249.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.249.600.3 NMAC - Rp, 8.249.600.3 NMAC, 1-1-14]

8.249.600.4 DURATION: Permanent.
[8.249.600.4 NMAC - Rp, 8.249.600.4 NMAC, 1-1-14]

8.249.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.249.600.5 NMAC - Rp, 8.249.600.5 NMAC, 1-1-14]

8.249.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.249.600.6 NMAC - Rp, 8.249.600.6 NMAC, 1-1-14]

8.249.600.7 DEFINITIONS: [RESERVED]

8.249.600.8 MISSION: 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.
[8.249.600.8 NMAC - N, 1-1-14]

8.249.600.9 BENEFIT DESCRIPTION: Refugee medical assistance (RMA) offers health coverage for refugees within the first eight months from their date of entry to the United States (U.S.), when they do not qualify for medicaid. RMA eligible refugees have access to a benefit package that parallels the full coverage medicaid benefit package. This program is not funded by medicaid. RMA is funded through a grant under Title IV of the Immigration and Nationality Act (INA). The purpose of this grant is to provide for the effective resettlement of refugees and to assist them to achieve economic self-sufficiency as quickly as possible. Refer to 8.100.100 NMAC.
[8.249.600.9 NMAC - Rp, 8.249.600.9 NMAC, 1-1-14]

8.249.600.10 BENEFIT DETERMINATION: Application for refugee medical assistance is made on the assistance application form. The application is acted on and notice of the action sent to the applicant within 45 days of the date of application.
[8.249.600.10 NMAC - Rp, 8.249.600.10 NMAC, 1-1-14]

8.249.600.11 INITIAL BENEFITS:

A. **Approval or denial of application:** After the eligibility determination is made, the income support specialist (ISS) sends notice to the applicant or applicant group. The denial notice contains information on the reason for the denial and explanation of appeal rights to the applicant(s).

B. **Date of eligibility:** Eligibility starts with the first day of the month of application after all eligibility requirements are met. The eight-month period begins with the month the refugee enters the United States, as documented by the INS (form I-94). For cases involving children born in the United States, the child's eligibility

period expires when the refugee parent who arrived last in the United States has been in this country for eight months.
[8.249.600.11 NMAC - Rp, 8.249.600.11 NMAC, 1-1-14]

8.249.600.12 ONGOING BENEFITS: No periodic review is required, since coverage is limited to a maximum of eight months from the date of entry into the United States.
[8.249.600.12 NMAC - Rp, 8.249.600.12 NMAC, 1-1-14]

8.249.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three months of retroactive medical assistance 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 months prior to the month of application [42 CFR Section 435.914].

A. **Application for retroactive benefit coverage:** Application for retroactive medical assistance can be made by checking "yes" in the "application for retroactive medicaid payments" box on the application/redetermination of eligibility for medicaid assistance (MAD 381) form or by checking "yes" to the question "does anyone in your household have unpaid medical expenses in the last three months?" on the application for assistance (ISD 100 S) form. Applications for retroactive medical assistance benefits must be made by 180 days from the date of application for assistance. Covered services which were furnished more than two years prior to application are not payable.

B. **Approval requirements:** To establish retroactive eligibility, the ISS must verify that all conditions of eligibility were met for each of the three retroactive months and that the applicant received medicaid covered services. Each month must be approved or denied on its own merits. Retroactive eligibility can be approved on either the eligibility system or on the retroactive medicaid eligibility authorization (MAD 333) form.

C. **Notice:**

(1) Notice to applicant: The applicant must be informed if eligibility in any of the retroactive months is denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISS must notify the recipient that he or 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.
[8.249.600.13 NMAC - Rp, 8.249.600.13 NMAC, 1-1-14]

8.249.600.14 CASE CLOSURES: Cases are closed when refugee medical assistance recipients no longer meet eligibility standards or after the eight month eligibility period expires, whichever comes first.
[8.249.600.14 NMAC - Rp, 8.249.600.14 NMAC, 1-1-14]

8.249.600.15 CHANGES AND REDETERMINATIONS OF ELIGIBILITY:

A. A re-determination of eligibility is not required.

B. Changes in income are not reportable. Reported income changes are not acted upon.

C. A refugee who received medicaid for seven or fewer months during the RMA period is eligible for RMA for any remaining months in the eight-month RMA period. Eligibility for RMA is determined without a new eligibility determination or application.

D. Residence changes must be reported within 10 days after the change for individuals placed in a public institution or those individuals moving out of New Mexico. Refer to 8.200.450 NMAC.
[8.249.600.15 NMAC - N, 1-1-14]

HISTORY OF 8.249.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 822, Refugee Medical Assistance, filed 5-22-92.

History of Repealed Material:
MAD Rule 822, Refugee Medical Assistance, filed 5-22-92 - Repealed effective 2-1-95.
8.249.600 NMAC, Benefit Description, filed 9-15-13 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 250 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED INDIVIDUALS WHOSE INCOME EXCEEDS QMB AND SLIMB
PART 400 RECIPIENT POLICIES

8.250.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.250.400.1 NMAC - Rp, 8.250.400.1 NMAC, 1-1-14]

8.250.400.2 SCOPE: The rule applies to the general public.
[8.250.400.2 NMAC - Rp, 8.250.400.2 NMAC, 1-1-14]

8.250.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.250.400.3 NMAC - Rp, 8.250.400.3 NMAC, 1-1-14]

8.250.400.4 DURATION: Permanent.
[8.250.400.4 NMAC - Rp, 8.250.400.4 NMAC, 1-1-14]

8.250.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.250.400.5 NMAC - Rp, 8.250.400.5 NMAC, 1-1-14]

8.250.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility, 8.200 NMAC, *Medicaid Eligibility – General Recipient Policies* Processes for establishing and maintaining medicaid eligibility are detailed in the income support division (ISD) general provisions, 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.250.400.6 NMAC - Rp, 8.250.400.6 NMAC, 1-1-14]

8.250.400.7 DEFINITIONS: [RESERVED]

8.250.400.8 MISSION: 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.
[8.250.400.8 NMAC - Rp, 8.250.400.8 NMAC, 1-1-14]

8.250.400.9 QUALIFIED INDIVIDUALS 1 (QI1s) - CATEGORY 042: MAD pays the monthly medicare Part B insurance premium for eligible recipients with income between 120 percent and 135 percent of the federal poverty level who are not otherwise eligible for another medical assistance program category of eligibility (QI1s). A QI1 recipient must be covered by medicare Part A. The Part A insurance is a free entitlement to social security beneficiaries who are 65 years of age or older or who have received social security disability payments for 24 months. Fully or currently insured workers, or their dependents, with end-stage renal disease are also covered under medicare. Eligible recipients will be served on a first come, first served basis, contingent upon availability of federal funds. Eligibility will be offered to individuals on a yearly basis. After 1998, eligible recipients currently enrolled in the program will get the first opportunity to continue to receive benefits under this program.
[8.250.400.9 NMAC - Rp, 8.250.400.9 NMAC, 1-1-14]

8.250.400.10 BASIS FOR DEFINING THE GROUP: QI1s are individuals who would be qualified medicare beneficiaries (QMB) but for the fact that their income exceeds the income levels established for QMB and specified low income medicare beneficiaries (SLIMB). Income eligibility for the QI1s is at least 120 percent of the federal income poverty level, but less than 135 percent. The state of New Mexico (the state) will permit all individuals to apply for assistance during a calendar year beginning 1998. However, because of the capped allotments, the state shall limit the number of participants in QI1s selected in a calendar year so that the aggregate amount of benefits provided to such individuals in the calendar year is estimated not to exceed the state's allocation for the fiscal year ending in that calendar year. The state shall select QI1s on a first-come, first-served basis (in the order in which they apply). For calendar years after 1998, the state shall give preference to individuals who were QI1s, QMBs,

SLIMBs, or qualified disabled working individuals (QDWI) in the last month of the previous year and who continue to be or become QI1s.
[8.250.400.10 NMAC - Rp, 8.250.400.10 NMAC, 1-1-14]

8.250.400.11 [RESERVED]

8.250.400.12 ENUMERATION: QI1 applicants or re-determining recipients must furnish their social security numbers (SSN). QI1 eligibility shall be denied or terminated for applicants or re-determining recipients who fail to furnish social security numbers.
[8.250.400.12 NMAC - Rp, 8.250.400.12 NMAC, 1-1-14]

8.250.400.13 CITIZENSHIP:

A. Undocumented aliens cannot purchase medicare coverage and, therefore, are not eligible for QI1 benefits. To be eligible for QI1 an applicant or re-determining 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 8.200.410 NMAC 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 8.200.410 NMAC.

B. Verification of citizenship: Individuals entitled to or receiving medicare already meet citizenship and identity requirements.
[8.250.400.13 NMAC - Rp, 8.250.400.13 NMAC, 1-1-14]

8.250.400.14 RESIDENCE: An individual must physically present in New Mexico on the date of his or her application or re-determination or on the eligibility determination date and intends to remain in the state. If the applicant or re-determining recipient does not have the present mental capacity to declare intent, the parent, guardian, or adult child can assume responsibility for a declaration of intent. If there is no guardian or relative to assume responsibility for a declaration of intent, the state in which the applicant or re-determining recipient is living is recognized as the state of residence. A temporary absence from the state does not preclude eligibility. A temporary absence is considered to exist when the eligible recipient leaves the state for a specific purpose with a time-limited goal, after the accomplishment of which the eligible recipient intends to return to New Mexico.
[8.250.400.14 NMAC - Rp, 8.250.400.14 NMAC, 1-1-14]

8.250.400.15 NONCONCURRENT RECEIPT OF ASSISTANCE: An applicant or re-determining recipient is not eligible for Category 042 if he or she is eligible under another medical assistance category of eligibility or if receiving medicaid services from another state.
[8.250.400.15 NMAC - Rp, 8.250.400.15 NMAC, 1-1-14]

8.250.400.16 SPECIAL RECIPIENT REQUIREMENTS: An applicant or re-determining recipient for QI1 eligibility must meet the specified age or disability requirements to be eligible for medicare Part A.
[8.250.400.16 NMAC - Rp, 8.250.400.16 NMAC, 1-1-14]

8.250.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: It is the responsibility of the applicant or re-determining recipient to provide the required information, documents or undertake the actions necessary for HSD to establish eligibility. The applicant or re-determining recipient must grant HSD permission to contact other persons, agencies or sources of information which are necessary in the establishment of eligibility. Failure of the applicant or re-determining recipient to provide or take action will result in a HSD action to deny eligibility.
[8.250.400.17 NMAC - Rp, 8.250.400.17 NMAC, 1-1-14]

8.250.400.18 [RESERVED]

8.250.400.19 REPORTING REQUIREMENTS: An applicant, re-determining or eligible recipient must report any change in his or her circumstances which can affect his or her eligibility within 10 calendar days after the change to his or her local ISD office.
[8.250.400.19 NMAC - Rp, 8.250.400.19 NMAC, 1-1-14]

HISTORY OF 8.250.400 NMAC:

History of Repealed Material:
8.250.400 NMAC, Recipient Policies, filed 11-16-09 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 250 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED INDIVIDUALS WHOSE INCOME EXCEEDS QMB AND SLIMB
PART 500 INCOME AND RESOURCE STANDARDS

8.250.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.250.500.1 NMAC - Rp, 8.250.500.1 NMAC, 1-1-14]

8.250.500.2 SCOPE: The rule applies to the general public.
[8.250.500.2 NMAC - Rp, 8.250.500.2 NMAC, 1-1-14]

8.250.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.250.500.3 NMAC - Rp, 8.250.500.3 NMAC, 1-1-14]

8.250.500.4 DURATION: Permanent.
[8.250.500.4 NMAC - Rp, 8.250.500.4 NMAC, 1-1-14]

8.250.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.250.500.5 NMAC - Rp, 8.250.500.5 NMAC, 1-1-14]

8.250.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.250.500.6 NMAC - Rp, 8.250.500.6 NMAC, 1-1-14]

8.250.500.7 DEFINITIONS: [RESERVED]

8.250.500.8 MISSION: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs.
[8.250.500.8 NMAC - Rp, 8.250.500.8 NMAC, 1-1-14]

8.250.500.9 QUALIFIED INDIVIDUALS 1 (QI1s) - CATEGORY 042: MAD pays the monthly medicare Part B insurance premium for qualified individuals (QI1s) with income between 120 percent and 135 percent of the federal poverty level and who are not otherwise eligible for another MAD category of eligibility. Eligible recipients will be served on a first come, first served basis, contingent upon availability of federal funds. Eligibility will be offered to individuals on a yearly basis. After 1998, eligible recipients currently enrolled in the program will get the first opportunity to continue to receive benefits.
[8.250.500.9 NMAC - N, 1-1-14]

8.250.500.10 NEED DETERMINATION: An applicant or a re-determining recipient for the medical MAD eligibility Category 042 qualified disabled individuals (QD) must apply for and take all necessary actions to obtain any resources to which he or she may be entitled. See 8.215.500 NMAC.
[8.250.500.10 NMAC - Rp, 8.250.500.9 NMAC, 1-1-14]

8.250.500.11 RESOURCE STANDARDS: The value of an applicant or re-determining recipient's countable resources must not exceed the amount set forth in 8.200.510 NMAC. The resource limit for an applicant or re-determining recipient couple is cannot exceed the amount for a couple set forth in 8.200.510 NMAC. An applicant or re-determining recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed the amount set forth in 8.200.510 NMAC, when resources are deemed. A resource determination is always made as of the first moment of the first day of the month. An applicant or re-determining 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 8.215.500 NMAC for information on exclusions, disregards, and countable resources.
[8.250.500.11 NMAC - Rp, 8.250.500.10 NMAC, 1-1-14]

8.250.50.12 RESOURCE TRANSFERS: The social security administration excluded transfer of resources as a factor of eligibility for a non-institutionalized recipient who receives supplemental security income (SSI) benefits. Transfer of resources is not a factor for consideration in categories that use SSI methodology in the eligibility determination.
[8.250.500.12 NMAC - Rp, 8.250.500.112 NMAC, 1-1-14]

8.250.500.13 TRUSTS: See 8.281.510 NMAC.
[8.250.500.13 NMAC - Rp, 8.250.500.12 NMAC, 1-1-14]

8.250.500.14 INCOME STANDARDS: Income standards for this category are at least 120 percent but less than 135 percent of the federal income poverty guidelines. The federal income poverty guidelines are adjusted annually, effective April 1. See 8.200.520 NMAC and 8.215.500 for information on exclusions, disregards and countable income. Verification of income must be documented in the case file.
[8.250.500.14 NMAC - Rp, 8.250.500.13 NMAC, 1-1-14]

8.250.500.15 UNEARNED INCOME EXCLUSIONS: All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The ISD caseworker must disregard the COLA from January through March when determining or re-determining QI1s eligibility. For re-determinations made in January, February and March and for new QI1 applications registered in January, February or March, the ISD caseworker uses the December social security and railroad retirement benefit amounts. For QI1 applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April federal poverty levels. This exclusion does not apply to other types of income.
[8.250.500.15 NMAC - Rp, 8.250.500.14 NMAC, 1-1-14]

8.250.500.16 DEEMED INCOME: If an applicant or re-determining recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered. If an applicant or re-determining recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500 NMAC for information on deemed income.
[8.250.500.16 NMAC - Rp, 8.250.500.15 NMAC, 1-1-14]

HISTORY OF 8.250.500 NMAC:

History of Repealed Material:
8.250.500 NMAC, Income and Resource Standards, filed 11-16-09 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 252 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - BREAST AND CERVICAL CANCER PROGRAM
PART 500 INCOME AND RESOURCE STANDARDS

8.252.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.252.500.1 NMAC - Rp, 8.252.500.1 NMAC, 1-1-14]

8.252.500.2 SCOPE: This rule applies to the general public.
[8.252.500.2 NMAC - Rp, 8.252.500.2 NMAC, 1-1-14]

8.252.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.252.500.3 NMAC - Rp, 8.252.500.3 NMAC, 1-1-14]

8.252.500.4 DURATION: Permanent.
[8.252.500.4 NMAC - Rp, 8.252.500.4 NMAC, 1-1-14]

8.252.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.252.500.5 NMAC - Rp, 8.252.500.5 NMAC, 1-1-14]

8.252.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.252.500.6 NMAC - Rp, 8.252.500.6 NMAC, 1-1-14]

8.252.500.7 DEFINITIONS: [RESERVED]

8.252.500.8 MISSION: 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.
[8.252.500.8 NMAC - N, 1-1-14]

8.252.500.9 RESOURCES: Resources are not an eligibility factor.
[8.252.500.9 NMAC - Rp, 8.252.500.9 NMAC, 1-1-14]

8.252.500.10 INCOME: Income is not an eligibility factor.
[8.252.500.10 NMAC - Rp, 8.252.500.10 NMAC, 1-1-14]

HISTORY OF 8.252.500 NMAC:

History of Repealed Material:
8.252.500 NMAC, Income and Resource Standards, filed 6-14-02 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 252 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - BREAST AND CERVICAL CANCER PROGRAM
PART 600 BENEFIT DESCRIPTION

8.252.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.252.600.1 NMAC - Rp, 8.252.600.1 NMAC, 1-1-14]

8.252.600.2 SCOPE: This rule applies to the general public.
[8.252.600.2 NMAC - Rp, 8.252.600.2 NMAC, 1-1-14]

8.252.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.252.600.3 NMAC - Rp, 8.252.600.3 NMAC, 1-1-14]

8.252.600.4 DURATION: Permanent.
[8.252.600.4 NMAC - Rp, 8.252.600.4 NMAC, 1-1-14]

8.252.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.252.600.5 NMAC - Rp, 8.252.600.5 NMAC, 1-1-14]

8.252.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.252.600.6 NMAC - Rp, 8.252.600.6 NMAC, 1-1-14]

8.252.600.7 DEFINITIONS: [RESERVED]

8.252.600.8 MISSION: 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.
[8.252.600.8 NMAC - N, 1-1-14]

8.252.600.9 GENERAL BENEFIT DESCRIPTION: A woman who is determined eligible for medicaid coverage under the breast and cervical cancer program (Category 052) can receive the full range of medicaid covered services under fee-for-service (FFS) provisions, and is exempt from mandatory enrollment into a MAD managed care organization.
[8.252.600.9 NMAC - Rp, 8.252.600.9 NMAC, 1-1-14]

8.252.600.10 BENEFIT DETERMINATION: Completed applications must be acted upon and notice of approval, denial, or delay sent out within 45 days of the date of application. The applicant will have time limits explained, and be informed of the date by which the application should be processed.
[8.252.600.10 NMAC - Rp, 8.252.600.10 NMAC, 1-1-14]

8.252.600.11 INITIAL BENEFITS: Eligibility is always prospective and begins the month of application. When an eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, the notice shall include reason(s) for denial and the applicant's right to request a fair hearing.
[8.252.600.11 NMAC - Rp, 8.252.600.11 NMAC, 1-1-14]

8.252.600.12 ONGOING BENEFITS: An eligible recipient is responsible to report changes affecting eligibility within 10 calendar days from the date on which the change took place. Changes in eligibility status will be effective the first day of the following month. A redetermination of eligibility is made every 12 months.
[8.252.600.12 NMAC - Rp, 8.252.600.12 NMAC, 1-1-14]

8.252.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three 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 months prior to the month of application.

A. **Application for retroactive benefit coverage:** Application for retroactive medicaid is made by indicating the existence of medical expenses in the three months prior to the month of application on the medicaid application form.

B. **Approval requirements:** To establish retroactive eligibility, verification must be provided to demonstrate that all conditions of eligibility were met for each of the three retroactive months, and that the applicant received medicaid covered services. Eligibility for each month is approved or denied on its own merits.

C. **Notice:**

(1) **Notice to applicant:** The applicant must be informed of the disposition of each retroactive month.

(2) **Recipient responsibility to notify provider:** After the retroactive eligibility has been established, the eligible recipient is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the eligible recipient fails to inform all providers and furnish verification of eligibility that 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 eligible recipient is responsible for payment of the bill.

[8.252.600.13 NMAC - Rp, 8.252.600.13 NMAC, 1-1-14]

8.252.600.14 CHANGES IN ELIGIBILITY: A recipient's eligibility ends when MAD receives information from the treating physician or from the recipient that her course of treatment is completed. A case is closed, with provision of advance notice, when the recipient becomes ineligible. The case is closed the month following the death of an eligible recipient.

[8.252.600.14 NMAC - Rp, 8.252.600.14 NMAC, 1-1-14]

HISTORY OF 8.252.600 NMAC:

History of Repealed Material:

8.252.600 NMAC, Benefit Description, filed 6-14-02 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 259 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEES WITH SPEND DOWN PROVISION
PART 400 RECIPIENT REQUIREMENTS

8.259.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.259.400.1 NMAC - Rp, 8.259.400.1 NMAC, 1-1-14]

8.259.400.2 SCOPE: The rule applies to the general public.
[8.259.400.2 NMAC - Rp, 8.259.400.2 NMAC, 1-1-14]

8.259.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.259.400.3 NMAC - Rp, 8.259.400.3 NMAC, 1-1-14]

8.259.400.4 DURATION: Permanent.
[8.259.400.4 NMAC - Rp, 8.259.400.4 NMAC, 1-1-14]

8.259.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.259.400.5 NMAC - Rp, 8.259.400.5 NMAC, 1-1-14]

8.259.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.259.400.6 NMAC - Rp, 8.259.400.6 NMAC, 1-1-14]

8.259.400.7 DEFINITIONS: [RESERVED]

8.259.400.8 MISSION: 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.
[8.259.400.8 NMAC - N, 1-1-14]

8.259.400.9 REFUGEE MEDICAL ASSISTANCE SPEND DOWN ONLY - CATEGORY 059: Refer to 8.249.400 NMAC.
[8.259.400.9 NMAC - Rp, 8.259.400.9 NMAC, 1-1-14]

8.259.400.10 BASIS FOR DEFINING THE GROUP: Refer to 8.249.400 NMAC.
[8.259.400.10 NMAC - Rp, 8.259.400.10 NMAC, 1-1-14]

8.259.400.11 GENERAL RECIPIENT REQUIREMENTS: Refer to 8.249.400 NMAC.
[8.259.400.11 NMAC - Rp, 8.259.400.11 NMAC, 1-1-14]

8.259.400.12 ENUMERATION: Refer to 8.249.400 NMAC.
[8.259.400.12 NMAC - Rp, 8.259.400.12 NMAC, 1-1-14]

8.259.400.13 CITIZENSHIP: Refer to 8.249.400 NMAC.
[8.259.400.13 NMAC - Rp, 8.259.400.13 NMAC, 1-1-14]

8.259.400.14 RESIDENCE: Refer to 8.249.400 NMAC.
[8.259.400.14 NMAC - Rp, 8.259.400.14 NMAC, 1-1-14]

8.259.400.15 SPECIAL RECIPIENT REQUIREMENTS: Refer to 8.249.400 NMAC.

[8.259.400.15 NMAC - Rp, 8.259.400.15 NMAC, 1-1-14]

8.259.400.16 AGE: Refer to 8.249.400 NMAC.
[8.259.400.16 NMAC - Rp, 8.259.400.16 NMAC, 1-1-14]

8.259.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: Refer to 8.249.400 NMAC.
[8.259.400.17 NMAC - Rp, 8.259.400.17 NMAC, 1-1-14]

8.259.400.18 ASSIGNMENTS OF MEDICAL SUPPORT: Refer to 8.249.400 NMAC.
[8.259.400.18 NMAC - Rp, 8.259.400.18 NMAC, 1-1-14]

HISTORY OF 8.259.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 822, Refugee Medical Assistance, filed 5-22-92.

History of Repealed Material:
MAD Rule 822, Refugee Medical Assistance filed 5-22-92 - Repealed effective 2-1-95.
8.259.400 NMAC, Recipient Requirements filed 6-13-03 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 259 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEES WITH SPEND DOWN PROVISION
PART 500 INCOME AND RESOURCE STANDARDS

8.259.500.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.259.500.1 NMAC - Rp, 8.259.500.1 NMAC, 1-1-14]

8.259.500.2 SCOPE: The rule applies to the general public.
[8.259.500.2 NMAC - Rp, 8.259.500.2 NMAC, 1-1-14]

8.259.500.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.259.500.3 NMAC - Rp, 8.259.500.3 NMAC, 1-1-14]

8.259.500.4 DURATION: Permanent.
[8.259.500.4 NMAC - Rp, 8.259.500.4 NMAC, 1-1-14]

8.259.500.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.259.500.5 NMAC - Rp, 8.259.500.5 NMAC, 1-1-14]

8.259.500.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.259.500.6 NMAC - Rp, 8.259.500.6 NMAC, 1-1-14]

8.259.500.7 DEFINITIONS: [RESERVED]

8.259.500.8 MISSION: 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.
[8.259.500.8 NMAC - N, 1-1-14]

8.259.500.9 NEED DETERMINATION: Refer to 8.249.500 NMAC.
[8.259.500.9 NMAC - Rp, 8.259.500.9 NMAC, 1-1-14]

8.259.500.10 RESOURCE STANDARDS: Refer to 8.249.500 NMAC.
[8.259.500.10 NMAC - Rp, 8.259.500.10 NMAC, 1-1-14]

8.259.500.11 INCOME STANDARDS: Refer to 8.249.500 NMAC.
[8.259.500.11 NMAC - Rp, 8.259.500.11 NMAC, 1-1-14]

HISTORY OF 8.259.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records: MAD Rule 822, Refugee Medical Assistance, filed 5-22-92.

History of Repealed Material:
MAD Rule 822, Refugee Medical Assistance filed 5-22-92 - Repealed effective 2-1-95.
8.259.500 NMAC, Income and Resource Standards, filed 5-22-92 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 259 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - REFUGEES WITH SPEND DOWN PROVISION
PART 600 BENEFIT DESCRIPTION

8.259.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.259.600.1 NMAC - Rp, 8.259.600.1 NMAC, 1-1-14]

8.259.600.2 SCOPE: The rule applies to the general public.
[8.259.600.2 NMAC - Rp, 8.259.600.2 NMAC, 1-1-14]

8.259.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12 et seq.
[8.259.600.3 NMAC - Rp, 8.259.600.3 NMAC, 1-1-14]

8.259.600.4 DURATION: Permanent.
[8.259.600.4 NMAC - Rp, 8.259.600.4 NMAC, 1-1-14]

8.259.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.259.600.5 NMAC - Rp, 8.259.600.5 NMAC, 1-1-14]

8.259.600.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.259.600.6 NMAC - Rp, 8.259.600.6 NMAC, 1-1-14]

8.259.600.7 DEFINITIONS: [RESERVED]

8.259.600.8 MISSION: 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.
[8.259.600.8 NMAC - N, 1-1-14]

8.259.600.9 BENEFIT DESCRIPTION: Refer to 8.249.600 NMAC.
[8.259.600.9 NMAC - Rp, 8.259.600.9 NMAC, 1-1-14]

8.259.600.10 BENEFIT DETERMINATION: Refer to 8.249.600 NMAC.
[8.259.600.10 NMAC - Rp, 8.259.600.10 NMAC, 1-1-14]

HISTORY OF 8.259.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 822, Refugee Medical Assistance, filed 5-22-92.

History of Repealed Material:
MAD Rule 822, Refugee Medical Assistance filed 5-22-92 - Repealed effective 2-1-95.
8.259.600 NMAC, Benefit Description, filed 9-15-13 - Repealed effective 1-1-14.

TITLE 8 SOCIAL SERVICES
CHAPTER 285 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - EMERGENCY MEDICAL SERVICES FOR ALIENS
PART 400 RECIPIENT REQUIREMENTS

8.285.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.285.400.1 NMAC - Rp, 8.285.400.1 NMAC, 1-1-14]

8.285.400.2 SCOPE: The rule applies to the general public.
[8.285.400.2 NMAC - Rp, 8.285.400.2 NMAC, 1-1-14]

8.285.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are 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 NMSA 1978, Section 27-1-12.
[8.285.400.3 NMAC - Rp, 8.285.400.3 NMAC, 1-1-14]

8.285.400.4 DURATION: Permanent.
[8.285.400.4 NMAC - Rp, 8.285.400.4 NMAC, 1-1-14]

8.285.400.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.285.400.5 NMAC - Rp, 8.285.400.5 NMAC, 1-1-14]

8.285.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs.
[8.285.400.6 NMAC - Rp, 8.285.400.6 NMAC, 1-1-14]

8.285.400.7 DEFINITIONS: [RESERVED]

8.285.400.8 MISSION: 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.
[8.285.400.8 NMAC - N, 1-1-14]

8.285.400.9 EMERGENCY MEDICAL SERVICES FOR ALIENS - CATEGORY 085: Certain non-citizens who are undocumented or who do not meet the qualifying immigration criteria specified in 8.200.410 NMAC, but who meet all eligibility criteria for other medical assistance program categories 030, 032, 035, 072, 100, 200, 300, 301, 400, 420 or supplemental security income (SSI) can receive coverage for emergency services. See 42 CFR Section 440.225.
[8.285.400.9 NMAC - Rp, 8.285.400.9 NMAC, 1-1-14]

8.285.400.10 BASIS FOR DEFINING THE GROUP: The determination of emergency status is made by the medicaid utilization review contractor. For purposes of determining emergency status, the following definition applies: an emergency condition means a medical or behavioral health condition manifesting itself through acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the health of the individual or with respect to a pregnant woman, the health of the woman or her unborn child ~~is~~ *to result* in serious jeopardy; serious impairment to the individual's bodily functions; or serious dysfunction of any of his or her bodily organs or parts. With respect to a pregnant woman and her unborn child, emergency services includes all emergency labor and delivery services, such as inductions of labor and caesarean sections.
[8.285.400.10 NMAC - Rp, 8.285.400.10 NMAC, 1-1-14]

8.285.400.11 [RESERVED]

8.285.400.12 ENUMERATION: An alien applicant is exempt from the requirement to provide a social security number (SSN). If the applicant is found eligible for coverage of emergency services, the claims are paid using a dummy number. Issuance of the dummy number is done on the current eligibility system.

[8.285.400.12 NMAC - Rp, 8.285.400.12 NMAC, 1-1-14]

8.285.400.13 CITIZENSHIP: An applicant must be a noncitizen who is undocumented or who does not meet the qualifying immigration criteria specified in 8.200.410 NMAC.
[8.285.400.13 NMAC - Rp, 8.285.400.13 NMAC, 1-1-14]

8.285.400.14 RESIDENCE: An applicant must provide proof of New Mexico residence. Undocumented aliens traveling through New Mexico, visiting in New Mexico, or touring New Mexico do not meet the residence requirements for eligibility.
[8.285.400.14 NMAC - Rp, 8.285.400.14 NMAC, 1-1-14]

8.285.400.15 EMPLOYMENT, TRAINING, AND WORK REGISTRATION: Registration for employment or training is not a factor of eligibility.
[8.285.400.15 NMAC - Rp, 8.285.400.15 NMAC, 1-1-14]

8.285.400.16 [RESERVED]

8.285.400.17 SSI STATUS: Applicants who apply under SSI coverage must meet the income and resource limits. Eligibility is determined using the SSI methodology contained in 8.215 NMAC. Disability is determined by disability determination services.
[8.285.400.17 NMAC - Rp, 8.285.400.17 NMAC, 1-1-14]

8.285.400.18 RECIPIENT RIGHTS AND RESPONSIBILITIES: It is the responsibility of the applicant to provide the required information, documents or undertake the actions necessary for HSD to establish eligibility. The applicant must grant HSD permission to contact other persons, agencies or sources of information which are necessary in the establishment of eligibility. Failure of the applicant to provide or take action will result in a HSD action to deny eligibility.
[8.285.400.18 NMAC - Rp, 8.285.400.18 NMAC, 1-1-14]

8.285.400.19 ASSIGNMENT OF SUPPORT: See 8.200.430 NMAC.
[8.285.400.19 NMAC - Rp, 8.285.400.19 NMAC, 1-1-14]

HISTORY OF 8.285.400 NMAC:

History of Repealed Material:
8.285.400 NMAC, Recipient Policies, filed 11-17-08 - Repealed effective 1-1-14.