MEDICAID ELIGIBILITY - GENERAL RECIPIENT POLICIES
GENERAL MEDICAID ELIGIBILITY

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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 medical assistance division (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.

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(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. 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. 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. 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.

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

8.200.400.16 AUTHORIZED REPRESENTATIVE: HSD must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications.

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

B. Representatives may be authorized to:
(1) sign an application on the applicant's behalf;
(2) complete and submit a renewal form;
(3) receive copies of the applicant or beneficiary's notices and other communications from the agency; and
(4) act on behalf of the applicant or beneficiary in all other matters with the agency.

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

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

E. As a condition of serving as an authorized representative, a provider, staff member or volunteer of an organization must sign an agreement that he or she will adhere to the regulations relating to confidentiality (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information. (42 CFR 435.923)

[8.200.400.16 NMAC - N, 4-15-14]

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.