MEDICAID ELIGIBILITY – GENERAL RECIPIENT POLICIES
RECIPIENT RIGHTS AND RESPONSIBILITIES
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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 it 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 support rights to HSD for medical support and 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's responsibilities in identifying and collecting medical and behavioral health support and payments, and an eligible recipient's responsibility to cooperate with HSD in obtaining medicaid support and medicaid payments. Medicaid is the payer of last resort. If health care resources are available from a third party, these health care resources must be used first. To ensure that these resource alternatives are used, an applicant or an eligible recipient assigns his or her rights to medical and behavioral health support and payments to HSD and cooperates in identifying, obtaining, and collecting medical and behavioral health support and medical and behavioral health care payments as a condition of medicaid eligibility.

(1) **Required TPL information:** During the initial determination or re-determinination 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. **Denied emergency room claims:** An eligible recipient is responsible for payment of a hospital outpatient emergency room claim if a determination is made by MAD or its designee that an emergency did not exist at the time the service was furnished.

(1) A medicaid provider can bill the eligible recipient directly for the denied emergency room charge.

(2) The eligible recipient cannot be billed for denied ancillary services, such as laboratory and radiology services.

D. **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.

E. **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, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session, or behavioral health session;

(b) $7 per dental visit;

(c) $20 per emergency room visit;

(d) $20 plus $8 for non-emergency use of the emergency room and FPL is between 100 percent to 150 percent;

(e) $20 plus 20 percent of cost of service, or $50, whichever is less, for non-emergency use of the emergency room and FPL is over 150 percent;

(f) $30 per inpatient hospital admission; and

(g) $5 per prescription, applies to prescription and non-prescription drug items.

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

(a) $5 per outpatient physician visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session, or behavioral health session;

(b) $5 per dental visit;

(c) $15 per emergency room visit;

(d) $15 plus $4 for non-emergency use of the emergency room and the eligible recipient is under age 18;

(e) $15 plus 20 percent of cost of services, or $50, whichever is less, for non-emergency use of the emergency room and the eligible recipient is age 18 or over;

(f) $25 per inpatient hospital admission;

(g) $2 per prescription, applies to prescription and non-prescription drug items; and

(h) $3 per brand name drug when a generic substitute is available.

F. **Prescription:** A co-payment of $3.00 per brand name drug when a generic substitute is available applies to all MAD eligible recipients except WDI and native American recipients.

G. **The following MAD services are exempt from co-payment responsibilities for WDI and CHIP eligible recipients:**

(1) preventive, prenatal care services and contraceptive management services;

(2) services provided at Indian health service facilities, by an urban medicaid native American provider and by a tribal 638;

(3) MAD services rendered during presumptive eligibility or retroactive eligibility periods; and

(4) MAD services provided to an eligible native American recipient.

H. **Non-emergency use of the emergency room co-payment requirements are as follows:**

(1) $4 for exempt eligible recipients above 100 percent of FPL;

(2) $8 for non-exempt eligible recipients between 100 percent to 150 percent of FPL; and

(3) 20 percent of the cost of service, or $50, whichever is less, for non-exempt eligible recipients over 150 percent of FPL;

I. **For non-emergency use of the emergency room the following are considered to be exempt MAD populations and are required to pay the applicable co-payment amount for exempt eligible recipients:**

(1) eligible recipients under age 18;

(2) eligible recipients in foster care regardless of their age;

(3) eligible pregnant women recipients if the service relates to the pregnancy or can complicate the pregnancy;

(4) eligible recipients receiving hospice care;

(5) eligible recipients who are an inpatient in a hospital, nursing facility, intermediate care facility for the individuals with intellectual disabilities (ICF/IID), or other medical institution, if such an eligible recipient is required, as a condition of receiving services in such institution under the state plan, to spend for costs of medical care all but a minimal amount of the eligible recipient's income required for personal needs;

(6) breast and cervical cancer Category 052 eligible recipients; and

(7) disabled eligible recipients receiving MAD services through the Family Opportunity Act.

(8) native American eligible recipients are not required to pay co-payments for non-emergency use of the emergency room.

J. **Co-payment maximum:** The aggregate amount of cost sharing imposed for all individuals in the family as applied during the quarterly period is five 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.