**MEDICAID ELIGIBILITY – AFFORDABLE CARE**
**ELIGIBILITY REQUIREMENTS**
**Tribal Consultation Version 9.18.13**

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

**8.291.400.1 ISSUING AGENCY:** New Mexico Human Services Department (HSD).
[8.291.400.1 NMAC - N, 10-1-13]

**8.291.400.2 SCOPE:** The rule applies to the general public.
[8.291.400.2 NMAC - N, 10-1-13]

**8.291.400.3 STATUTORY AUTHORITY:** The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.291.400.3 NMAC - N, 10-1-13]

**8.291.400.4 DURATION:** December 31, 2013.
[8.291.400.4 NMAC - N, 10-1-13]

**8.291.400.5 EFFECTIVE DATE:** October 1, 2013, unless a later date is cited at the end of a section.
[8.291.400.5 NMAC - N, 10-1-13]

**8.291.400.6 OBJECTIVE:** The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medicaid program and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.291.400.6 NMAC - N, 10-1-13]

**8.291.400.7 DEFINITIONS:**

A. Action: an approval, termination, suspension, or reduction of medicaid eligibility or a reduction in the level of benefits and services, including a determination of income for the purposes of imposing any premiums, enrollment fees, or cost-sharing. It also means determinations made by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determination made by a state with regard to the preadmission screening and resident review requirements. (431.201)

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

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

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

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

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

G. Appeal request: a clear expression, either verbally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have any eligibility determination or redetermination contained in a notice issued, or pursuant to future guidance on Section 1311(d)(4)(H) of the ACA, reviewed by an appeals entity. (45 CFR 155.310 (g), 45 CFR 155.330 (1)(ii), 45 CFR 155.335 (h)(1)(ii), 45 CFR 155.715 (e) or (f).

H. Appeals entity: a body designated to hear appeals of eligibility determinations or redeterminations

contained in notices, or notices issued in accordance with future guidance on exemptions. (45 CFR 155.310(g), 45 CFR 155.330 (e)(1)(ii), 45 CFR 155.335 (h)(1)(ii), 45 CFR 155.715 (e) and (f), and Section 1311(d)(4)(H) of the ACA).

I. Appeals decision: a decision made by a hearing officer adjudicating a fair hearing, including by a hearing officer employed by an exchange appeals entity to which the agency has delegated authority to conduct such hearings.

J. Applicable modified adjusted gross income (MAGI) standard: the income standard for each category of ACA eligibility. (42 CFR 435.911)

K. Application: the single streamlined application required by ACA and other medicaid applications used by the agency. (42 CFR 435.4)

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

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

(2) Representatives may be authorized to:

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

(b) complete and submit a renewal form;

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

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

(3) The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on 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.

(4) The authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual 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.

(5) 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)

M. Beneficiary: an individual who has been determined eligible and is currently receiving medicaid. (42 CFR 435.4)

N. Citizenship: a national of the United States means a citizen of the United States or a person who, though not a citizen of the United States, owes permanent allegiance to the United States. (8 USC 1101)

O. Code: the internal revenue code.

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

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

R. Dependent child: a child who is under the age of 19.

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

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

U. Exempt individuals: individuals within one (or more) of the following categories are exempt from mandatory enrollment in an alternative benefit plan:

(1) the individual is medically frail or otherwise an individual with special medical needs; for these purposes, the state's definition of individuals who are medically frail or otherwise have special needs must at least include those individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness);

(2) individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living;

(3) individuals with a disability determination based on social security criteria or, in states that apply more restrictive criteria than the supplemental security income program, the state plan criteria; or

(4) other exempt individuals include individuals eligible and enrolled for medicaid as children with adoption assistance, foster care, or guardianship care under title IV-E, or as a medicaid recipient who is a former foster care child. (42 CFR 440.315)

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

W. Family size: the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as herself plus the number of children she is expected to deliver.

X. Families and children: individuals whose eligibility for medicaid is determined based on being a pregnant woman, a child younger than age 21, or a parent or other caretaker relative of a dependent child. It does not include individuals whose eligibility is based on other factors, such as blindness, disability, being age 65 years or older, or need for long-term care services.

Y. Flexibility in information and collection and verification: subject to approval by the secretary, the agency may request and use information from a source or sources alternative to those listed in 42 CFR 435.948(a).

Z. Insurance affordability program: a state medicaid program under Title XIX of the act, state children's health insurance program (CHIP) under Title XXI of the act, a state basic health program established under section 1331 of the Affordable Care Act and coverage in a qualified health plan through the exchange with cost-sharing reductions established under Section 1402 of the Affordable Care Act.

AA. MAGI-based income: (see 42 CFR 435.603) For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine a modified adjusted gross income as defined in Section 36B(d)(2) (B) of the Internal Revenue Code, with the certain exceptions.

BB. Married couples: in the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under section 6013 of the code or whether one spouse expects to be claimed as a tax dependent by the other spouse.

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

DD. Minimum essential coverage: the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, medicare, medicaid, CHIP, TRICARE and certain other coverage.

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

FF. National of the United States: either a citizen of the United States, or a person who, though not a citizen of the United States, owes permanent allegiance to the United States.

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

HH. Non-citizen: has the same meaning as the term "alien" and includes any individual who is not a citizen or national of the United States (8 USC 1101(a)(22).

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

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

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

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

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

KK. Pregnant woman: a woman during pregnancy and the post-partum period, which begins on the date the pregnancy ends, extends 60 days, and then ends on the last day of the month in which the 60-day period ends.

LL. Qualified non-citizen: Has the same meaning as the term "qualified alien" (8 USC Section 1641 (b) and (c)).

MM. Secure electronic interface: an interface which allows for the exchange of data between medicaid and other insurance affordability programs.

NN. Shared eligibility service: a common or shared eligibility system or service used by a state to determine individuals' eligibility for insurance affordability programs.

OO. Social security numbers: the agency must require as a condition of eligibility that each individual (including children) seeking medicaid furnish each of his or her social security numbers (SSN). The agency must verify the SSN furnished by an applicant or beneficiary to insure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

PP. Timeliness standards: refer to the maximum period of time within which every applicant is entitled to a determination of eligibility.

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

[8.291.400.7 NMAC - N, 10-1-13]

**8.291.400.8 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.

[8.291.400.8 NMAC - N, 10-1-13]

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

[8.291.400.9 NMAC - N, 10-1-13]

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

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

B. ACA related categories include the following:

(1) other adult;

(2) parent caretaker;

(3) pregnant women;

(4) pregnancy-related services;

(5) children under 19 years of age;

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

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

[8.291.400.10 NMAC - N, 10-1-13]

**8.291.400.11 CONTINUOUS ELIGIBILITY:** Recipients under 19 years of age will remain eligible for the 12 month certification period. 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 applies even

if it is reported that income exceeds the applicable federal income poverty guidelines or there is a change in household composition. This provision does not apply when any of the following circumstances occur:

A. death of the eligible household member;

B. the eligible recipient or the family moves out of state;

C. the child turns 19 years of age;

D. failure to respond to an HSD request for information;

E. the individual or the individual's representative requests a voluntary termination of eligibility;

F. HSD determines that eligibility was erroneously granted at determination or renewal of eligibility because of agency error, fraud, abuse, or perjury attributed to the child or the child's representative; or

G. any factor of eligibility with the exception of increased income is not met.

[8.291.400.11 NMAC - N, 10-1-13]

**8.291.400.12 REPORTING REQUIREMENTS:** A medicaid applicant or recipient is required to report any changes which might affect his or her eligibility. The following changes must be reported to a local income support division (ISD) office within 10 days from the date the change occurred:

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

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

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

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

[8.291.400.12 NMAC - N, 10-1-13]

**8.291.400.13 PRESUMPTIVE ELIGIBILITY:** Presumptive eligibility provides medicaid benefits under one of the eligible groups outlined in section 10 of this part, starting with the date of the presumptive eligibility determination and ending with the last day of the following month.

A. Only one presumptive eligibility period is allowed per pregnancy or per 12 month period.

B. Presumptive eligibility determinations can be made only by individuals employed by eligible entities and certified as presumptive eligibility determiners by the medical assistance division. Determiners must notify the MAD claims processing contractor of the determination within 24 hours of the determination of presumptive eligibility.

(1) Processing presumptive eligibility information: MAD authorizes certain providers to make presumptive eligibility determinations based on the qualified entity. The provider must notify MAD through an established procedure of the determination within 24 hours of the determination of presumptive eligibility.

(2) Provider responsibility: The presumptive eligibility provider must process both presumptive eligibility as well as an application for medical assistance.

(3) Provider eligibility: Entities who may participate must be:

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

(b) a qualified hospital that has as not been disqualified by the medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the medicaid agency; or

(c) a federally qualified health center (FQHC), an Indian health service (IHS) facility, a department of health (DOH) clinic, a school, a children, youth and families department (CYFD) child care bureau staff member, a primary care provider who is contracted with at least one HSD contracted MCO, or a head start agency; or

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

C. Children's health insurance program (CHIP): to be eligible for CHIP, the child cannot have other health insurance coverage.

D. A presumptive eligibility provider must ensure that a signed application for medicaid coverage is submitted to the ISD office within 10 days.

E. For pregnant women, presumptive eligibility allows medicaid payment for ambulatory prenatal

services furnished to a pregnant woman while her application for medicaid is being processed. Only one presumptive eligibility period is allowed per pregnancy. A pregnant woman can receive ambulatory prenatal care from the date of the presumptive eligibility determination until the end of the month following the month the determination was made.

(1) For presumptive eligibility, an approved presumptive eligibility provider must accept self attestation of pregnancy.

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

[8.291.400.13 NMAC - N, 10-1-13]

**HISTORY OF 8.291.400 NMAC:** [RESERVED]