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TITLE 8 SOCIAL SERVICES
CHAPTER 290 MEDICAID ELIGIBILITY - HOME AND COMMUNITY-BASED SERVICES WAIVER (CATEGORIES 090, 091, 092, 093, 094, 095 AND 096)
PART 400 RECIPIENT POLICIES

8.290.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.290.400.1 NMAC - Rp, 8.290.400.1 NMAC, 1/1/2019]

8.290.400.2 SCOPE: The rule applies to the general public.
[8.290.400.2 NMAC - Rp, 8.290.400.2 NMAC, 1/1/2019]

8.290.400.3 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 and by the state human services department pursuant to state statute. See Section 27-2-12 *et seq*., NMSA 1978.
[8.290.400.3 NMAC - Rp, 8.290.400.3 NMAC, 1/1/2019]

8.290.400.4 DURATION: Permanent.
[8.290.400.4 NMAC - Rp, 8.290.400.4 NMAC, 1/1/2019]

8.290.400.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.290.400.5 NMAC - Rp, 8.290.400.5 NMAC, 1/1/2019]

8.290.400.6 OBJECTIVE: The objective of this rule is to provide eligibility criteria for the medicaid program.
[8.290.400.6 NMAC - Rp, 8.290.400.6 NMAC, 1/1/2019]

8.290.400.7 DEFINITIONS:

A. Adaptive behavior: The effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for their age and cultural group.

B. Comprehensive care plan (CCP): The comprehensive care plan of services that meets the member's physical, behavioral and long-term care needs in managed care.

C. Developmental disability: For the purposes of the developmental disabilities (DD) waiver, a developmental disability is limited to an intellectual disability or a specific related condition as defined by the department of health/developmental disabilities supports division (DOH/DDSD) that is likely to continue indefinitely and results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency.

D. Developmental period: The time between birth and the 18th birthday.

E. Disability determination unit (DDU): The unit that determines disability as described in Section 8.200.420.11 NMAC.

F. General intellectual functioning: The results of one or more individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.

G. Individual service plan (ISP): A treatment plan for an eligible recipient that includes the eligible recipient's needs, functional level, intermediate and long range goals, statement for achieving the goals and specifies responsibilities for the care needs. The plan determines the services allocated to the eligible recipient within program allowances.

H. Intermediate care facility for individuals with intellectual disabilities (ICF/IID): This term replaces all references to intermediate care facility for mental retardation (ICF/MR).

I. Intellectual disability (ID): Refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Intellectual disability replaces all references to mental retardation.

J. Letter of allocation: Written notice to the applicant that they may proceed with the home and community-based services (HCBS) waiver application process.

K. Level of care: The level of institutional care needed by the eligible recipient.

L. Medically Fragile: For the purposes of the medically fragile waiver (MFW), medically fragile is a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary.

M. Primary Freedom of Choice (PFOC): The form included in the allocation packet that allows a registrant to confirm his or her interest in pursuing the opportunity to apply for community benefits.

N. Prospective: A period of time starting with the date of application going forward.

O. Restricted coverage: Medicaid eligibility without long term care services coverage.

P. Significantly subaverage intellectual functioning: IQ of 70 or below.

Q. Unduplicated recipient positions (UDR): Space available in a particular HCBS waiver program.

R. Waiver: Permission from the centers for medicare and medicaid services (CMS) to waive certain medicaid requirements in order for a state to furnish an array of home and community-based services to state-specified target group(s) of medicaid recipients who need a level of institutional care.

[8.290.400.7 NMAC - Rp, 8.290.400.7 NMAC, 1/1/2019]

8.290.400.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.290.400.8 NMAC – A/E, 12/15/2020]

8.290.400.9 HOME AND COMMUNITY-BASED SERVICES WAIVER - Category 091, 093, 094, 095, 096: The human services department (HSD) is the single state agency designated to administer the medicaid program in New Mexico. HSD is charged with developing and implementing the community benefit to elderly, blind, and disabled individuals who meet both financial and medical criteria for nursing facility (NF) level of care (categories 091, 093, and 094). The department of health (DOH) and HSD are charged with developing and implementing HCBS waivers to medicaid applicants/recipients who meet both financial and medical criteria for intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care, for medically fragile (category 095) and developmentally disabled (category 096) individuals. Provision of these services under a waiver allows applicants/recipients to receive the care required at home at less cost than in an institution. The services to be furnished under the waiver must be cost-effective. This means the aggregate cost of care must be an amount less than the cost of maintaining individuals in institutions at the appropriate level of care. The types of services for which recipients are eligible vary based on the individual waiver.

[8.290.400.9 NMAC - Rp, 8.290.400.9 NMAC, 1/1/2019]

8.290.400.10 BASIS FOR DEFINING THE GROUP: Eligibility for applicants/recipients who apply for waiver services is determined as if he or she were actually institutionalized, although this requirement has been waived. Entry into some of the waiver programs may be based upon the number of UDRs (i.e., slots) available. The individual waiver program manager notifies the income support division (ISD) when a UDR is available.

A. Elderly, blind, and disabled individuals (categories 091, 093, and 094): For applicants/recipients who are under age 65 to qualify as disabled or blind, disability or blindness must have been determined to exist by the social security administration or the DDU. To qualify as an elderly person, the applicant/recipient must be 65 years of age or older. Applicants/recipients must also meet both the financial and non-financial eligibility requirements and meet the medical level of care for nursing facility services.

B. Developmental disabilities (DD) waiver: The DD waiver identified as category 096 was approved effective July 1984, subject to renewal. DD waiver services are intended for eligible recipients who have developmental disabilities limited to intellectual disability (IID) or a related condition as determined by the DOH/DDSD. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated. The eligible recipient must also require the level of care provided in an intermediate care facility for individuals with developmental disabilities (ICF/IID), in accordance with Section 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements.

(1) Intellectual disability: An individual is considered to have an intellectual disability if she/he has significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(a) General intellectual functioning is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.

(b) Significantly sub-average is defined as an intelligence quotient (IQ) of 70 or below.

(c) Adaptive behavior is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group.

(d) The developmental period is defined as the period of time between birth and the 18th birthday.

(2) Related condition: An individual is considered to have a related condition if she/he has a severe chronic disability, other than mental illness, that meets all of the following:

(a) is attributable to a condition, other than mental illness, found to be closely related to ID because this condition results in limitations in general intellectual functioning or adaptive behavior similar to that of persons with ID and requires similar treatment or services;

(b) is manifested before the person reaches age twenty-two (22) years, is likely to continue indefinitely; and

(c) results in substantial functional limitations (adaptive behavior scores ≤70) in three or more of the following areas:

(i) self-care;
(ii) receptive and expressive language;
(iii) learning;
(iv) mobility;
(v) self-direction;
(vi) capacity for independent living; and
(vii) economic self-sufficiency.

C. Medically fragile (MF) waiver: The medically fragile (MF) waiver identified as category 095 was established effective August, 1984 subject to renewal. Medically fragile is characterized by one or more of the following: a life threatening condition characterized by reasonable frequent periods of acute exacerbation which require frequent medical supervision, or physician consultation and which in the absence of such supervision or consultation would require hospitalization; a condition requiring frequent, time consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include but are not limited to ventilators, dialysis machines, enteral or parenteral nutrition support and supplemental oxygen. The eligible recipient must require the level of care provided in an ICF/IID, in accordance with 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements and must have:

(1) a developmental disability, developmental delay, or be at risk for developmental delay as determined by the DDU, and

(2) a diagnosed medically fragile condition prior to the age of 22, defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary, and which is characterized by one or more of the following:

(a) a life threatening condition characterized by reasonably frequent periods of acute exacerbation, which require frequent medical supervision or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(b) frequent, time-consuming administration of specialized treatments, which are medically necessary;

(c) dependency on medical technology such that without the technology a reasonable level of health could not be maintained; examples include, but are not limited to, ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen; and

(d) periods of acute exacerbation of a life-threatening condition, the need for extraordinary supervision or observation, frequent or time-consuming administration of specialized treatments, dependency on mechanical (life) support devices, and developmental delay or disability.

D. Acquired immunodeficiency syndrome (AIDS) and AIDS related condition (ARC) waiver: The acquired immunodeficiency syndrome (AIDS) and AIDS related condition waiver designated as category 090, was established effective July 1987, subject to renewal. The AIDS and AIDS related condition waiver stopped covering new individuals effective January 01, 2014 as the waiver was sunset and not renewed. Individuals already on the AIDS and AIDS related condition waiver are grandfathered and remain eligible as long as eligibility requirements are met.

E. Brain injury (BI): The brain injury category 092 stopped covering new individuals effective January 01, 2014. Individuals already on the brain injury category are grandfathered and remain eligible as long as eligibility requirements are met.

[8.290.400.10 NMAC - Rp, 8.290.400.10 NMAC, 1/1/2019; A/E, 12/15/2020]

8.290.400.11 GENERAL RECIPIENT REQUIREMENTS: Eligibility for the waiver programs is always prospective per 8.290.600.11 NMAC. Applicants/recipients must meet, or expect to meet, all non-financial eligibility criteria in the month for which determination of eligibility is made including any mandatory income or resources deemed to a minor child per 8.290.500.17 and 8.290.500.21 NMAC.

A. Enumeration: An applicant/recipient must furnish his social security number in accordance with 8.200.410.10 NMAC.

B. Citizenship: Refer to 8.200.410.11 NMAC for citizenship requirements.

C. Residence: To be eligible for medicaid, an applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have declared an intent to remain in the state. If the applicant/recipient does not have the present mental capacity to declare intent, the applicant's/recipient's representative may assume responsibility for the declaration of intent. If the applicant/recipient does not have the mental capacity to declare intent and there is no representative to assume this responsibility, the state where the applicant/recipient is living will be recognized as the state of residence. If waiver services are suspended because the recipient is temporarily absent from the state but is expected to return within 90 consecutive days at which time waiver services will resume, the medicaid case remains open. If waiver services are suspended for any other reason for 90 consecutive days, the medicaid case is closed after appropriate notice is provided to the recipient.

D. Non-concurrent receipt of assistance: HCBS waiver services furnish medicaid benefits to an applicant/recipient who qualifies both financially and medically for institutional care but who, with provision of waiver services, can receive the care he needs in the community at less cost to the medicaid program than the appropriate level of institutional care. Individuals receiving services under a HCBS waiver may not receive concurrent services under nursing facility (NF), ICF/IID, personal care or any other HCBS waiver.

(1) SSI recipients: Applicants receiving supplemental security income (SSI) benefits are categorically eligible for waiver services. No further verification of income, resources, citizenship, age, disability, or blindness is required. The applicant must, however, meet the level of care requirement. (An SSI recipient must meet the assignment of rights and TPL requirements and not be ineligible because of a trust).

(2) Married SSI couples: All married SSI couples where neither member is institutionalized in a medicaid-certified facility are treated as separate individuals for purposes of determining eligibility and benefit amounts beginning the month after the month they began living apart. See Section 8012 of the Omnibus Budget Reconciliation Act of 1989. In the case of an initial application, or reinstatement following a period of ineligibility, when members of a married couple are not living together on the date of application or date of request for reinstatement, each member of the couple is considered separately as of the date of application or request, regardless of how recently the separation occurred.

E. INTERVIEW REQUIREMENTS: An interview is not required in accordance with 8.281.400.11 NMAC.

[8.290.400.11 NMAC - Rp, 8.290.400.11 NMAC, 1/1/2019; A/E, 12/15/2020]

8.290.400.12 SPECIAL RECIPIENT REQUIREMENTS:

A. Age: To be considered elderly, an applicant/recipient must be 65 years of age or older. See Section 8.281.400.16 NMAC, AGE, for information on verification of age.

B. Blind: To be considered blind, an applicant/recipient must have central visual acuity of 20/200 or less with corrective lenses or must be considered blind for practical purposes. The ISD worker is responsible for submitting medical reports to the DDU, if necessary. See Section 8.281.400.17 NMAC, *Blind*, For Information on documentation and verification of blindness.

C. Disability: To be considered disabled, an applicant/recipient must be unable to engage in any substantial gainful activity because of any medical determinable physical, developmental, or mental impairment, which has lasted, or is expected to last, for a continuous period of at least 12 months. The ISD worker is responsible for submitting medical reports to the DDU, if necessary. See Section 8.281.400.18 NMAC, *Disability*, for information on documentation and verification of disability.

D. Requires institutional care: An institutional level of care must be recommended for the applicant/recipient by a physician, nurse practitioner or a doctor of osteopathy, licensed to practice in the state of

New Mexico. Institutions are defined as acute care hospitals, nursing facilities (either high NF or low NF as defined by medicaid regulations) and ICF/IID. Level of care reviews are completed by the medical assistance division (MAD) utilization review contractor or a member's selected or assigned managed care organization (MCO), as applicable to the applicant's HCBS program.
[8.290.400.12 NMAC - Rp, 8.290.400.12 NMAC, 1/1/2019]

8.290.400.13 RECIPIENT RIGHTS AND RESPONSIBILITIES: An applicant/recipient is responsible for establishing his eligibility for medicaid. As part of this responsibility, the applicant/recipient must provide required information and documents or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. An applicant/recipient must also grant the human services department (HSD) permission to contact other persons, agencies or sources of information, which are necessary to establish eligibility. See 8.200.430 NMAC, *Recipient Rights And Responsibilities* for specific information.
[8.290.400.13 NMAC - Rp, 8.290.400.13 NMAC, 1/1/2019]

8.290.400.14 REPORTING REQUIREMENTS: A medicaid applicant/recipient, case manager, direct service provider or any other responsible party must report any changes in circumstances which may affect the applicant's/recipient's eligibility within 10 days of the date of the change to the county income support division (ISD) office. These changes include but are not limited to: changes in income, resources, living arrangements, or marital status. The ISD worker must evaluate the effect of the change and take any required action as soon as possible; however, the action must take effect no later than the end of the month following the month in which the change took place.
[8.290.400.14 NMAC - Rp, 8.290.400.14 NMAC, 1/1/2019]

HISTORY OF 8.290.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records-State Records Center and Archives:
MAD Rule 898, Transfers Of Assets, 12/29/1994.

History of Repealed Material:
8.290.400 NMAC - Recipient Policies, filed 4/16/2002 Repealed effective 1/1/2019.